BATTLING MORALITIES:

COMPETING FOR MEDICAL MARIJUANA LEGISLATION

by

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ABSTRACT OF THE DISSERTATION

Battling Moralities: Competing for Medical Marijuana Legislation

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In the 2012 election cycle, Massachusetts became the 20th state (including Washington, DC) to pass legislation favoring medical marijuana. As momentum builds for more states to pass medical marijuana laws, the federal government continues to classify the drug as a Schedule I, illegal narcotic that has a high likelihood of abuse and dependence and that should continue to be treated punitively. In this work, I take a holistic approach to uncover some of the larger, national patterns that have allowed for some states to pass legislation favorable to medical marijuana in a relatively hostile federal climate. This work will demonstrate that the battle over medical marijuana legislation is about much more than just the drug's medical efficacy. Medical marijuana policy is symbolic of the nation's attitudes toward illicit substances and medical science, an illustration of the power of rhetoric and the struggles between different moralities, and an example of the forces at work in the battles over morality policies. Put simply, these legislative battles are contesting the moral meaning of marijuana itself.

The complex nature of these morality policy struggles necessitates a varied methodological approach. By analyzing the battles between science and morality and the

path to medicalization, the historical constructions of the drug and its associated policies, the statistical differences between those states that have passed medical marijuana and those that have not, and the rhetoric and ideological arguments used in the media (and elsewhere) that serve to bound the marijuana debate, patterns of partially changing morality surface that suggest a level of inconsistency and ambiguity in the national understanding of the drug. In order for the construction of marijuana to shift from a criminal to a medical designation, this research highlights the four battles within which medical marijuana legislation is fought: federal vs. state control, entrepreneurial struggles for bureaucratic power, constructing an image of the marijuana user, and moral vs. scientific struggles over the meaning of the drug. As these battles are being waged, multiple marijuana moralities are emerging, giving shape to the changing landscape of medical marijuana legislation.

Acknowledgements

The journey to this point has been a long one with many twists and turns along the way. At times, it was filled with excitement and wonder that brought the momentum of forward progress. At other times, the journey appeared treacherous, slow, and never-ending. Whether the path was rocky or smooth, uphill or down, there were a number of individuals who walked with me on this journey, helping me along the way. Without their support the journey would never have been as fulfilling, the view not as awe-inspiring, and the destination not as gratifying.

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a mood when the rest of the world seems heavy, and to inspire the best in those whose lives you touch is truly magical. You were the only two year old who could not only pronounce the word "dissertation", but who knew what it meant. Thank you for your years of understanding when your view of mommy was from behind a keyboard.

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Dedication

To Michael and Gabrielle:

For providing patience,
support, love, and joy
throughout this journey

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MEDICAL MARIJUANA MOMENTUM AND FEDERAL RESISTANCE

Setting the Medical Marijuana Stage

In 1996, with a vote of 55.6% to 44.4%, California became the first in the nation to pass a bill, Proposition 215, which allows patients to use marijuana for medicinal purposes. With public support for medical marijuana growing, and policies following, the War on Drugs has found a formidable foe. The campaign to ensure public support for Proposition 215 in California in the mid-90s was hard fought by a number of non-profit groups, including two of the more prominent groups, the Lindesmith Center and the Marijuana Policy Project (MPP). Then drug czar Barry McCaffrey was very displeased with the results of the vote suggesting that, "This is a carefully camouflaged, exorbitantly funded, well heeled elitist group whose ultimate goal is to legalize drug use in the United States," (Barak 2007: 432). Although many states have followed California's lead, permitting the distribution of marijuana for medicinal purposes and allowing medical defenses in cases brought against individual users of marijuana, under federal law, marijuana is still classified as a Schedule I illegal substance, recognized as having no medical utility and a high likelihood of abuse and dependence.[1]

A month after the California vote, a summit was held with state Attorney General Dan Lungren in order to decide how to reconcile the contradictory laws of the state of California with the federal government's strict legal stance against marijuana. According

[1] Currently, drugs are classified into five schedules with Schedule I being completely prohibited because of significant dangers posed from use and the likelihood of abuse. Schedule II drugs are recognized as being those drugs that can have medical use, however only under extreme restrictions. Morphine, cocaine, and methadone are a few examples of Schedule II drugs. Schedules III-V pose increasingly less risk and are less regulated.

to an article published in the San Francisco Chronicle the day after the summit, of 300 participants from legal, law enforcement, and political realms, most of whom were opposed to the legislation, "most of the meeting's participants acknowledged that they still have little idea of how to respond to Proposition 215," (Martin 4 Dec 1996). Lungren, who wanted to ensure that there were very strict guidelines that physicians must follow in order to "prescribe" the drug, was concerned about how to prosecute marijuana users. Meeting attendees included anti-drug "law-enforcement heavies" (Lee 2012: 249) such as DEA and ONDCP employees. (For more information on this meeting, see, for instance, Barak 2007; Fox, Armentano, and Tvert 2009; Lee 2012). The consensus seemed to be that very little was accomplished at the meeting. The confusion created as a result of the discrepancy between federal and state law is only just the tip of the medical marijuana iceberg.

There is a contradiction that exists between some states' laws regarding marijuana and federal policy toward the drug. In this dissertation, I will investigate both how this contradiction came about and how it is playing out in the national scene. The tension created as a result of the vastly different responses to marijuana as a medicine has led not only to inconsistent public policies, but an ambiguity in the meaning of the drug itself. If there were a singular interpretation of marijuana as an enemy in the War on Drugs, discussed only as a legally dangerous, criminal, and immoral substance, there would have been no space within which states could reach their own legal recognition of marijuana's medicinal possibilities. In order to understand the likely success or failure of state-level medical marijuana policy it is necessary to unpack the contested nature of the meaning of marijuana. The paradoxical constructions of marijuana as a dangerous Schedule I illegal

substance by the federal government (and many states) and as a potentially useful medicine in 19 states and Washington, DC, suggest a level of complexity in the ways by which this substance has been and is being characterized, categorized, and understood. Although science plays a role in the path toward the recognition of marijuana as a legitimate medicine, this research will show that just touting its medical efficacy through science is not enough to delegitimize the criminal and immoral constructions that have been grounded in our historical understanding and have informed public debate and policy. A change in the *moral* reactions to the drug is, as will be demonstrated throughout the chapters in this work, the most influential force in leading to a change in marijuana policy.

Put simply, this dissertation will take a holistic perspective, exploring the factors that impact the likelihood that states will pass medical marijuana legislation. Although there are certainly idiosyncrasies to each individual state's journey toward medical marijuana acceptance or rejection, the trend of states considering medical marijuana policy and the growing public support for these policies suggest that it is too coincidental to argue that these are 20 separate and individual stories. Instead, I argue that a situation has arisen in which the drug's image has changed enough, although not completely, to allow for a degree of legal recognition of the drug as a medical treatment. As the story of medical marijuana unfolds, I will uncover some of the larger, national patterns that have helped some states along in their journey toward medical marijuana passage, and ensured that others would stay firm in their conservative stance on the drug. Although the focus will not be on any one individual state's story, from the historical, quantitative, and

qualitative data presented in this research, patterns will surface that will explain the movement of states toward the legal recognition of medical marijuana.

Medicalizing Morality

Marijuana policy is a reflection of the meaning the drug has to those who are in the position to shape that policy. Since the 1930s, the meaning of marijuana in the United States has undergone dramatic shifts and has been at the center of sometimes intense battles over its (symbolic) construction. Groups challenging the status quo position on the drug, whatever it was during that particular historical context, did so in order to have the power to control the definition of the drug and, therefore, the policy trajectory. Within the past century in the United States, marijuana has been constructed as a little known medicinal remedy listed in the United States Pharmacopoeia[2], a violent drug brought into the country by our Southern neighbors in order to wreak havoc on middle class youth, an aid to African American musicians who played "voodoo" music (jazz), a "drop out" drug leading to the downfall of potentially participatory citizens, a tool to spur resistance against the government, an enemy in a war, a therapeutic medicine for a various ailments and diseases. Its constructions have greatly fluctuated.

"What appears to be 'natural' and 'given'…can be seen as *social products*, social accomplishments with particular histories and situated biographies claiming 'universally valid' discoveries and accomplishments," (Conrad and Schneider 1992: 279, *emphasis added*). Defined by the federal government as an illegal substance, marijuana's current classification seems, to many, to be a natural rejoinder to its alleged harms. To others,

[2] Cannabis was first entered in the United States Pharmacopoeia in 1850 as a drug to treat a number of ailments including diseases dealing with pain, cholera, dysentery, leprosy, even extreme menstrual bleeding, among approximately 100 other disorders. It was removed from the Pharmacopoeia due to political pressure in 1942, only a few years after the Marihuana Tax Act was passed. (See, for instance, Bonnie and Whitebread 1999; Booth 2003; Gerber 2004; Herer 2010; Lee 2012; Werner 2011).

the punitive reactions to this illicit drug may appear to be inconsistent with the purported, relatively benign threats marijuana poses to the body or society. Just as its status as an enemy in the War on Drugs had to be constructed through the political process, for the drug to be legitimized as a medicine, that definition must also be constructed, produced via political means. For medical marijuana policies to take hold, marijuana must be medicalized. Defined as a "definitional issue: defining a problem in medical terms," and creating "new medical categories with the subsequent expansion of medical jurisdiction" (Conrad 2005: 3), medicalization typically looks at the changes in definitions of behavior. In the case of marijuana, it is the treatment that is currently undergoing a process of medicalization as more states are passing or are considering medical marijuana legislation.

In an analysis of "compulsive buying," authors Lee and Mysyk suggest that "labelling [*sic*] compulsive buying as a psychiatric illness constructs a framework for the medicalization of compulsive buying," (2004: 1713). Similarly, as marijuana begins to obtain the label of medicine, it brings with it a resulting framework that changes the ways by which the drug is discussed, debated, and understood. A shift from a punitive to a medical framework imposes a new meaning, and therefore, new reactions and policy responses. As will be shown throughout this work, the process of medicalization is a complex one that relies much less on science and the jurisdiction of the medical profession than may be expected. Medicalizing marijuana involves a new moral understanding of the drug. "…if only people understood the facts, we'd be fine. Wrong. The facts alone will not set us free. People make decisions about politics and candidates based on their value system, and the language and frames that invoke those values."

(Lakoff 2004: xiii). In order to understand the processes involved in the path toward medical marijuana legislation, it is necessary to uncover and highlight the language choices and frames that elicit particular value sets that allow for the medicalization of marijuana. As marijuana policy moves from a criminal to a medical issue, the *moral* meaning of the drug must shift with it. Marijuana policy is a morality policy.

> Morality policy stems from mores, which are commonly held beliefs among communities derived from cultural norms. As long as mores are almost uniformly observed, no political controversies occur. … A problem arises, however, when there is sufficient questioning of these mores to make laws enforcing them controversial. (Studlar 2001: 37).

This research will take an in-depth look into the debates that surround the controversial nature of marijuana policy and explore the recent "questioning of [marijuana] mores" (ibid). Because of the very clear tension, and often contradiction, that exists between morality crusaders (on both sides of the medical marijuana issue) and arguments supported by science (also on both sides of the issue), the specific case study of medical marijuana legislation sits well within the morality policy academic literature. Using the example of medical marijuana, I intend not only to demonstrate, as has been done in previous research, that morality policy is guided by sets of values, but also to uncover the sources and structures (pathways) of information that actually shape those values. Within this analysis of the morality policy of medical marijuana, I will go beyond the conclusion that there *is* a tension between scientific and moral arguments within the medical marijuana debates and begin to examine *why* this tension exists and *where/how* it originates. In doing so, a key question will be answered: how have some states been able to medicalize a drug that is concurrently embedded with deeply rooted, negative moral constructions?

In order to understand the context within which state-wide – and nation-wide – medical marijuana policy is debated, and (potentially) passed today, four separate and related pieces of the marijuana story will be analyzed, including: (1) the battles between science and morality; (2) historical constructions of the drug and its associated policies; (3) demographic differences between states that have passed marijuana policy and those that have not; and (4) the rhetoric and ideological arguments used in the media (and elsewhere) that serve to bound the marijuana debate. Patterns of partially changing morality will emerge as the following questions are considered throughout the dissertation: What changes have occurred that have allowed for some states to be able to pass medical marijuana policy in such a hostile federal climate? How have states overcome the historically embedded construction of marijuana as harmful, dangerous, and immoral? To what extent might newer constructions of the drug, as a medical treatment for patients who garner our sympathy, be able to withstand the more cemented federal stance on marijuana? Specifically, are there patterns in the process toward this morality based policy that explain marijuana's ability to be accepted as a medicine in certain states, held illegal in others, and that may foreshadow the policy path the drug will likely take in the near future?

STATE OF THE STATES

Medical Marijuana Momentum

Currently there are 19 states, in addition to Washington, D.C., with laws similar to California's Compassionate Use Act. Only two years after California passed Proposition 215, three more states, Alaska, Oregon, and Washington, passed ballot initiatives

allowing for medical marijuana, with between 55% and 59% of voters supporting these early bills. Voters in Maine followed the next year, passing ballot initiative Question 2 with 61% of the vote. In each of these states, state level criminal penalties were removed for patients who have been given a recommendation (or some kind of valid documentation) from their doctor to use marijuana as a medical treatment. The states above, and Colorado[3] and Nevada that followed with similar legislation in 2000, forged an early path to medical marijuana legislation through ballot initiative, having to earn a majority of state level voters to support the policy. In fact, of all states with medical marijuana legislation today, 11 have passed through ballot initiative. Supporters of medical marijuana point to these ballot initiative successes as an indicator that the public stands behind the medical marijuana cause.

In 2000, with five states already having sanctioned the medical use of marijuana for their citizens (and Colorado and Nevada close behind only five months later), Hawaii was the first state to pass medical marijuana through its state legislature with Senate Bill 862 (by a vote of 32-18) and House Bill 1157 (by a vote of 13-12). Also aimed at removing state level criminal penalties for patients using marijuana with a doctor's permission, these legislative bills received bi-partisan support, led by Democratic Governor Benjamin Cayetano. After the legislation was passed, Governor Cayetano was quoted in the *Honolulu Advertiser* saying, "it's time that Congress finally gets around to understanding that the states should be allowed to provide this kind of relief to the people. Congress is way, way behind in their thinking," (Piper, Briggs, Huffman, and

[3] Although there was an expectation that the medical marijuana initiative be on the ballot in Colorado in 1998, and despite finding "stacks of uncounted petition sheets" after the ruling, a Colorado judge ruled that there were not enough signatures to warrant a place on the 1998 ballot. It took two years of legal wrangling to get the initiative back on the ballot in 2000. (Piper et al. 2003: 16).

Lubot-Conk 2003: 19). Four years later, Vermont became the second state to pass medical marijuana through its legislative process, as opposed to a ballot initiative, and, in total, 7 states that have removed criminal sanctions for the medical use of marijuana have done so through their state legislatures.

Not all proposed medical marijuana legislation has been successful; most has not. Although 20 states successfully passed medical marijuana policies, 24 other states have (unsuccessfully) considered at least one bill. Although more states have considered and *not* passed medical marijuana legislation than have successfully passed such policies, only 7 states have *never* considered medical marijuana. The battle for medical marijuana legislation is a hard fought one within state populations and legislatures. In many cases, a proposed bill has died before reaching a vote. Although some have reached the level of committee and/or hearings, many have been faced with enough resistance that they never gained momentum past the initial proposal. Alabama, Iowa, Florida, Missouri, Pennsylvania, and West Virginia are some of the states where state legislators have proposed a bill more than once that never reached the level of a vote. Democratic house delegate for West Virginia, Mike Manypenny, has tried twice to pass a "compassionate use" act, and twice the bill was denied a public hearing. Not willing to let go of the issue, he has offered "a resolution, HCR 144, for the legislature to study the issue more thoroughly," (MPP 5 Jul 2012).

Championing a Cause: Leadership on Both Sides of Medical Marijuana

In order for a bill to be proposed, there needs to be a "champion" of the bill, such as Manypenny above. Although most of the sponsors are Democrats, there are a number of Republicans who have been at the forefront of the medical marijuana legislative

attempts. In 2007, South Carolina Republican Senator William Mescher led the charge to pass medical marijuana in his state. In April of that same year, the Senator died from a stroke. Since his death, there was no one behind him in line waiting to take up the issue. The bill has languished and died, and since, no one has sponsored another bill in the South Carolina legislature.

There are those on the other side of the issue who are also willing to stand behind their beliefs and who are committed to ensuring medical marijuana's defeat. In a dramatic move to demonstrate "how asinine it would be to legalize 'medical marijuana'," Iowa Republican state representative, and a former state trooper, Clel Baudler went to California in 2011 in order to purposefully fraudulently obtain a medical marijuana card, (Clayworth 26 Jan 2011). His claim of suffering from depression and hemorrhoids was successful, and he returned to Iowa, with his deceitfully obtained marijuana card in hand, hoping to prove that passing medical marijuana was the wrong move for Iowans. Although many citizens called for his resignation for what many claimed to be unethical behavior, the Iowa House Ethics Committee cleared him of any wrong-doing in a "bipartisan and unanimous vote," (Jacobs 17 Feb 2011: B1). Since, not only has Iowa not put forth any medical marijuana legislation proposals, but three pieces of legislation have been proposed that would have placed tougher restrictions on any attempt to medicalize the drug in the state. None were successful. In the case of Iowa, there was an individual willing to go to (arguably) extreme lengths in order to fight for his position that medical marijuana would bring significant problems to the state were it passed. In four other cases, those who were willing to fight proposed bills had more power even than the legislature itself: state governors.

Minnesota, New Hampshire, Connecticut, and Rhode Island were all able to pass medical marijuana legislation through their state legislatures, but quickly faced a veto by the states' governors. In 2009, a bi-partisan group was able to pass medical marijuana legislation through the Minnesota house and senate floors. Republican governor at the time, Tim Pawlenty, vetoed the bill, and current Governor, Democrat Mark Dayton, has suggested that he has similar views on medical marijuana as Pawlenty. After having been defeated in the state legislature in 2005 and 2007, New Hampshire passed Senate Bill 409 in 2009 and 2011 (with overwhelming support in 2011), but both were vetoed by Democratic Governor John Lynch. In both cases, the bills, which were sponsored by Republican Senator Jim Forsythe, fell just short of enough votes to overturn Governor Lynch's vetoes. Although the Governors of Rhode Island and Connecticut (both Republicans) vetoed similar legislation, both states currently have a medical marijuana policy on their books. After Governor Carcieri of Rhode Island vetoed a bill that passed his state legislature in 2005, the Senate and House were able to gather enough votes to override his veto which finally passed in 2006. Although the state legislature of Connecticut did not have enough votes to overturn Governor Rell's veto in 2007, once she was out of office, the bill came to the legislative floor again in 2012. It passed by a vote of 96-51 in the House and 21-13 in the Senate, making Connecticut the 18th state with medical marijuana legislation.

Try, Try Again

These are not the only states that have had to vote successfully for medical marijuana passage more than once. One of the earlier states to pass medical marijuana legislation, under Nevada state law, "initiatives have to be approved twice before they

can take effect," (Piper, Briggs, Huffman, and Lubot-Conk 2003: 22). The medical marijuana ballot initiative passed in Nevada with 59% of the vote in 1998 and 65% of the vote in 2000. In Vermont, although both the house and senate passed medical marijuana bills in 2002, these bills had competing agendas, the former would have removed criminal penalties for medical marijuana use (and growing the drug), while the latter would have only allowed for a medical defense in court. With the sense that the Governor would veto both of these bills, the legislature went "back to the drawing board", and finally passed a bill in 2004. Although Vermont's Republican Governor James (Jim) Douglas did not support the bill, he allowed it to be passed into law without his signature, signaling that he recognized the vast amount of support for medical marijuana in his state.

As a district, as opposed to a state, the District of Columbia has had an uphill battle in its fight for medical marijuana legislation even though there has been immense support by D.C. politicians and citizens. In 1998, Washington, D.C. residents easily passed a medical marijuana ballot initiative with 69% of the vote. In an amendment to a federal resolution in which Congress voiced support for its own drug laws and drug approval process, the Barr Amendment stopped the district from spending federal money to implement the medical marijuana program reasoning that it was against federal law. Using the same argument, that D.C. was not allowed to use federal money to implement a district policy that went against federal drug policy, a federal appeals court blocked another attempt at medical marijuana in the district in 2002. In 2010, after years of court battles, the Democrat-controlled Congress permitted the bill to move forward, allowing D.C. to finally set up medical marijuana dispensaries, actualizing the district's 1998 vote.

MAJOR COURT BATTLES

State Policy vs. Federal Law

While each state has its own, sometimes very interesting, story of its relationship to medical marijuana legislation, there is one definitive commonality across all states that have allowed for legal medical use: these state policies are in direct contradiction with federal policy on the drug. Although California is noted to be the first state to pass medical marijuana legislation, in the same year, 1996, Arizona also successfully passed legislation that would have allowed patients to use marijuana with a doctor's *prescription*. Proposition 200, which passed with 65.4% of the vote, was deemed to be incompatible with federal policy since doctors are unable to legally write a prescription for a Schedule I, illegal drug.[4] States have side-stepped this federal limitation by avoiding the term "prescription" in their policies. Instead, doctors can make recommendations or provide documentation to support a patient's use of the drug.

Although many states have found a way around the federal government's strict stance against marijuana by, for instance, paying close attention to language used in each piece of medical marijuana legislation, the policies that allow for the legal use of medical marijuana end at each state's border. While citizens may be protected from state laws, there is nothing protecting medical marijuana users from federal prosecution. For the most part, the government has stood firm in its resolve to uphold marijuana's Schedule I status. In 2011, the Department of Justice made its position very clear in letters to 9 medical marijuana states and the city of Oakland, California. Although some of the details of the letters differed, each included (a version of) the following paragraph:

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[4] Since this early vote, Arizona repealed Proposition 200 and placed a similar bill as a referendum in 1998. It was defeated. Arizona did not pass medical marijuana legislation again until 2010.

> The prosecution of individuals and organizations involved in the trade of any illegal drugs and the disruption of drug trafficking organizations is a core priority of the Department [of Justice]. This core priority includes prosecution of business enterprises that unlawfully market and sell marijuana. Accordingly, while the Department does not focus its limited resources on seriously ill individuals who use marijuana as part of a medically recommended treatment regimen in compliance with state law as stated in the October 2009 Ogden Memorandum, we maintain the authority to enforce the CSA [Controlled Substances Act] vigorously against individuals and organizations that participate in unlawful manufacturing and distribution activity involving marijuana, even if such activities are permitted under state law. The Department's investigative and prosecutorial resources will continue to be directed toward these objectives. (Durkan and Ormsby 14 Apr 2011).

The federal government has allowed some room to respect state-level policies by indicating that the DOJ will not target the patients who use medical marijuana, however these letters offered a clear indication of the government's intent to uphold federal law and prosecute those who provide the illegal drug to patients. There is here an acknowledgement of the discrepancy between federal- and state-level marijuana policies, and the government holds firm to its strict status quo. Because of this contradiction between some more lenient state laws and the strict federal stance against marijuana, there is a lack of clarity regarding the extent to which a state can enforce its own laws.

Doctors 1, Federal Government 2

These policy conflicts have invited legal disputes resulting in a number of high profile court cases that have pitted the federal government against state laws. One of the biggest victories for medical marijuana advocates came shortly after California's Compassionate Use Act was passed. In an effort to assert federal authority over the drug, then Director of the Office of National Drug Control Policy (ONDCP), Barry McCaffery, under the Clinton administration, issued a policy that "declared that physicians who recommended or prescribed medical marijuana risk revocation of their DEA license to

prescribe controlled substances," (Boire and Feeney 2006: 115). Feeling their freedom to practice medicine was being infringed upon, a number of California doctors and physicians filed suit. In *Conant v. Walters* (which changed from *Conant v. McCaffery* when Walters replaced McCaffery as "drug czar"), the doctors won their fight to be able to freely discuss marijuana with their patients. Although the 3-0 ruling did not go so far as to allow doctors to prescribe the drug, the protection of doctors' rights to discuss marijuana with their patients was upheld, and the Supreme Court refused to re-try the case when the Bush administration tried to appeal the decision. (For other discussions on this court case, see, for instance, Barak 2007; Boire and Feeney 2006; Chapkis and Webb 2008; Eddy 2010; Gerber 2004; Lee 2012; Werner 2011).

Two of the other major medical marijuana court cases, however, were victories for opponents of medical marijuana and dealt more directly with legal protection for patients and their caregivers. In 2002, in response to a DEA raid of their medical marijuana crops, patients and caregivers filed suit against the federal government in a case that would be known as *Gonzales v. Raich*.

> They [the plaintiffs] argued that applying the Controlled Substances Act to a situation in which medical marijuana was being grown and consumed locally for no remuneration in accordance with state law exceeded Congress's constitutional authority under the Commerce Clause, which allows the federal government to regulate interstate commerce. (Eddy 2010: 16).

This particular case involved the extent to which the federal government could have control over the growth and distribution of marijuana that was recognized as legal under state law. Although the Ninth Circuit Court of Appeals initially protected defendants Raich and Monson from federal prosecution and interference, finding that the commerce clause did not apply to such local activities, the U.S. Supreme Court ruled against that

decision and in favor of the U.S. government. (Chapkis and Webb 2008; Eddy 2010; Lee 2012; Werner 2011). The final ruling on the matter suggested that "Congress … has the authority to regulate lawful and unlawful markets alike," and that although, in this case, the marijuana did not make it to the market, "some homegrown medical marijuana could find its way into the commercial market…[legitimizing] federal authority over all of it," (Chapkis and Webb 2008: 193). Put simply, federal authority over the drug trumps state law.

Four years before the *Raich* case was concluded, opponents of medical marijuana had won another victory, although with a slightly different focus. Since 1976 when Robert Randall won the first medical necessity defense case, medical marijuana advocates have recognized the application of the common-law, "necessity" defense. In such cases, "a person caught breaking a criminal law argues that less harm was done by breaking the law than by complying with it," (Boire and Feeney 2006: 39). Part of the medical necessity defense involves proving that not using marijuana would cause more harm than using the drug and that other medical treatments have not been successful. There have been a number of medical necessity defense cases brought by patients facing federal criminal charges for the use and/or possession of a Schedule I drug; some have been successful, others have not. Perhaps the most well-known of the medical necessity cases was the *U.S. v. Oakland Cannabis Buyers' Cooperative*. In this case, the federal government was trying to shut down one of the larger non-profit, medical marijuana dispensaries in California, the Oakland Cannabis Buyer's Cooperative (OCBC). In its defense, leaders of the OCBC argued that they were helping to fulfill a "medical necessity" by distributing the drugs to patients who were legally receiving marijuana

under California law. Although the case did not tackle the issue of an individual patient's rights to use the medical necessity defense, the Supreme Court issued a final ruling in 2002 that a medical dispensary could not legally use that defense. (For more information regarding U.S. v. OCBC, see Barak 2007; Boire and Feeney 2006; Chapkis and Webb 2008; Eddy 2010; GAO Nov 2002; Lee 2012).

Government Grown Marijuana

Robert Randall, founder of the Alliance for Cannabis Therapeutics (ACT) and glaucoma patient, was the first individual to successfully use the medical necessity defense when he was put on trial for using marijuana in the late 70s. Demonstrating in court that marijuana successfully lowered ocular pressure and, without it, he would go blind, he won his case in 1976. He advanced his victory further by petitioning the government to provide him federally grown marijuana through the Compassionate Investigational New Drug Program (IND). In 1978, the government agreed to supply him with pre-rolled marijuana cigarettes grown at the University of Mississippi, the only federally run marijuana "farm". (For more on Randall's story, see, for instance, Boire and Feeney 2006; Chapkis and Webb 2008; Gerber 2004; Lee 2012; Randall and O'Leary 1998; Sloman 1998[1979]; Werner 2011; Zeese 1997).

The IND, designed as a way to test the safety of a drug before it is available on the market, was initially applied to marijuana at the state level in the mid-70s, giving states the option to implement tightly controlled marijuana research studies (that will be discussed further in chapter 2). After Randall's successful court battles, other individuals began to go through the tedious process of applying for federally grown and sanctioned marijuana through the individual Compassionate IND program. Met with bureaucratic

and legal obstacles, less than a dozen individuals were successfully granted access to the government's marijuana until the late-1980s. In 1990, a husband and wife who had contracted HIV/AIDS from a blood transfusion, were brought to trial for growing two marijuana plants in their house. The Jenkses won their case and were granted access to the Compassionate IND program. The national media attention the case received at the height of the AIDS epidemic brought more awareness to the claim that marijuana was successful in treating the AIDS wasting syndrome, and "the FDA was inundated with new requests from AIDS sufferers," (Grinspoon and Bakalar 1993: 22).

Although, through the IND program, the federal government was, at some level, legitimizing marijuana's medicinal claims, it had also just refused to reschedule marijuana as a lesser scheduled drug. The federal government's position seemed undeniably contradictory and ambiguous. "The same government that issues repeated denials of pot's medical benefits conceived the Compassionate Investigational New Drug Program in 1975 to allow sick people to use government-grown and supplied marijuana precisely for its medical benefits," (Gerber 2004: 144). In 1992, in response to the increased numbers of applications for the IND program, and to try to put to rest the government's contradictory position, Bush, Sr. closed the program (Aldrich 1997; Chapkis and Webb 2008; Eddy 2010; Gerber 2004; Grinspoon and Bakalar 1993; Lee 2012; Werner 2011). Although more than two dozen applications had already been approved when the program closed, only 12 patients were grandfathered in. Currently, there are about a half-dozen individuals who are still receiving federally grown and sanctioned marijuana.

SUPPORT IN AN AMBIGUOUS CONTEXT

Growing Public Support for Medical Marijuana

As the federal government's position on marijuana teeters between quasi-acceptance and complete prohibition, public opinion has been slowly, but steadily favoring medical marijuana access. In the decade and a half since the CA vote, 19 states plus Washington, DC have passed laws favorable to medical marijuana. Public support has grown to 70% of the U.S. population who think that marijuana should be legally available for medicinal purposes (Mendes 2010), and support from the medical community and other organizations has become more vocal. In the year prior to the CA vote, the American Academy of Family Physicians called for the federal government to allow for more research to determine the effectiveness of marijuana as a medicine (MPP 2008). In the years following the landmark proposition, the pleas for more research that may lead to the federal government backing down from their punitive position on the drug increased. In 1997, an editorial appeared in *The New England Journal of Medicine* which stated "that a federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane," (Kassirer: 337). *The New England Journal of Medicine* has continued to publish articles supporting medicinal marijuana and note that they are not alone in their position. "Criticizing the patchwork of state laws as inadequate to establish clinical standards for marijuana use, the American Medical Association (AMA) has joined the Institute of Medicine, the American College of Physicians, and patient advocates in calling for changes in federal drug-enforcement policies to establish evidence-based practices in this area," (Hoffman and Weber 2010: 1453). Members of the American

Society of Clinical Oncology (1991) and the American Medical Student Association (1993), the American Academy of Family Physicians (1995), the American Medical Association House of Delegates (1998), the National Institutes of Health (1998), the American Nursing Association (2003), the American Public Health Association, the American College of Physicians (2008), and physician writers for *The New England Journal of Medicine* and other medical and scientific academic publications are some of the more prominent groups that have emerged from their places within the medical community to voice support both for research into marijuana's medicinal potential, and for the legal space for doctors to be able to prescribe marijuana should they see fit. (For more details about medical groups' support, see, for instance, Barak 2007; Chapkis and Webb 2008; Eddy 2010; Herer 2010; IOM 1999; MPP 2008; ProCon.org 28 June 2012; Sloman 1998[1979]).

In addition to support by the medical community, medical marijuana advocates are found within political realms and are not limited to only one political party. Most of the proposed changes in laws regarding medical marijuana (and marijuana in general) have come from the Democratic side of the "aisle", but even Republican politicians and pundits have voiced their support for loosening marijuana laws. Four term Republican senator Bob Barr was once stridently against any policy that hinted at loosening up drug laws, so much so that the Amendment to deny Washington, D.C.'s medical marijuana ballot initiative became known as the Barr Amendment. Currently, however, his stance has altered dramatically. He is now a lobbyist for the Marijuana Policy Project (MPP), one of the leading medical marijuana advocate groups. To list only a few of the other Republicans who have taken a stance in favor of medical marijuana, California

Republican John Dennis and Massachusetts Republican Sean Bielat (backed by the Tea Party) "lean libertarian on the issue [of decriminalization]", and Republican supporters Grover Norquist and Glenn Beck have made fiscal and national security arguments in favor of less restrictive policies toward marijuana (Conant and Maloney 1 Nov 2010). In a recent PEW survey, although a higher percentage of citizens who identify as Democrat support medical marijuana, at 80%, still more than half of all of those who identify as Republican are in favor of medical marijuana legislation, at 61% (Pew 1 April 2010: 2).

Among some of the other agencies that have engaged in the medical marijuana debate are the American Civil Liberties Union (ACLU), Department of Veterans Affairs, the Presbyterian Church, and the American Association for Retired Persons (AARP). Responding to Alaska's 1998 vote, the ACLU's executive director Mary Jane Defrank noted "when you have people very, very ill, it is really the humane thing to allow them to use marijuana so they can keep their food down and keep their pills down," (quoted in Barak 2007: 433). The Department of Veterans affairs recently circulated a Health Directive that emphasized that no veteran would lose his or her health benefits obtained through the Veterans Health Administration for using medical marijuana under a recognized state law (Petzel 22 July 2010). In 2006, the Presbyterian Church supported a resolution that "declares support for the medicinal use of cannabis sativa (also known as marijuana), and directs the Presbyterian Church (U.S.A.) to actively urge the Federal government to amend and adopt such laws as will allow the benefits of marijuana treatment for such diseases as cancer, AIDS, and muscular dystrophy," (cited at ProCon.org 28 June 2012). A study done for *AARP The Magazine* in 2004 found that 72% of respondents 45 years and older supported medical marijuana use, with 59%

believing in the medicinal benefits of marijuana, and 55% saying that they would obtain marijuana for a loved one if necessary (Kalata: 2).

In the same study done for AARP (conducted by International Communications Research), about the same percentage of respondents who were supportive of medical marijuana (72%) also thought that marijuana is addictive (74%), and only 23% thought that marijuana should be legalized completely (ibid). Older Americans' support of medical marijuana co-existing with their fear of the drug being addictive and their unwillingness to support complete legalization of marijuana is illustrative of the muddled and varied constructions of the drug. Support for marijuana is conditional, nuanced, and complex. It is, in the minds of many of these respondents, seen to be both addictive and medicinal, legally acceptable in some cases and legally reprehensible in others. This contradictory and mixed construction of marijuana adds to the complex nature of its associated policies.

Federal Ambiguity and Mixed Messages

As support for medical marijuana appears to have been gaining momentum in recent years, it has found an unyielding enemy in federal law. In fact, the prohibition of marijuana and its inclusion as an enemy in the War on Drugs seems almost natural, innate. The high from caffeine, alcohol, even tobacco is, although regulated, legally and, to some extent, socially acceptable. A high from marijuana, even if it is in the name of medicinal remedy, is seen as morally wrong, socially repugnant, even perhaps, a sin. The assumed natural classification of marijuana as an inherently dangerous drug has led to and emboldened the federal government's unwavering stance that marijuana should stay

illegal and its users punished. This is in direct opposition to the movement by about 37% of states that allow medicinal use.

The government has had more than one opportunity to change its strict policies toward marijuana. In 1972, two years after the Controlled Substances Act (CSA) was passed, the National Organization for the Reform of Marijuana Laws (NORML) and ACT petitioned the government to reschedule marijuana to a lesser scheduled drug. Initially the courts refused to hear the petition, however advocates of medical marijuana used Randall's successful medical necessity defense and the government's willingness to supply the glaucoma patient with marijuana in order to push the petition further in the courts. After many years of legal back-and-forth, the petition to reschedule marijuana as a Schedule II drug finally received a hearing in 1984. Although Judge Francis J. Young ruled in favor of the rescheduling petition, the DEA rejected his ruling and refused to reschedule the drug. (See Chapter 3 for more details on the Young ruling.) There have been other attempts for rescheduling that have not gained traction, most recently in 2011 when a 2002 petition was denied, and 2001 when a 1995 petition was denied.

And yet, even as the government has stood firm in its *legal* position that marijuana stay a criminal substance, there has been rhetoric from federal officials to indicate that perhaps, on an informal level, there will be more acceptance of medicinal marijuana. Over the past few decades, the federal government's stance toward the drug has been contradictory and ambiguous, and the Obama administration is no exception. In one author's opinion, "lip service and mixed signals, rather than fresh thinking and novel approaches, characterized Obama's stance on marijuana," (Lee 2012: 375). In his 2008 run for the Presidency, the media, from time to time, made light of Obama's admission to

smoking marijuana when he was younger: “I inhaled, frequently. That was the point.” Although opponents of marijuana did not make too much of his statement, advocates for medical marijuana, and even those who support the complete legalization of marijuana, saw that statement as one of a potential ally in their cause.

With wars and economic woes facing the nation, marijuana is certainly not a priority for the administration, however they have not stayed silent on the matter either. In October 2009, the Department of Justice, backed by President Obama, issued a memorandum that has become known as the “Ogden Memo”. In this note, from Deputy Attorney General David Ogden, formally announced by Attorney General Eric Holder, the DOJ, in essence, gives wiggle room for federal officials to use discretion when applying the CSA to marijuana. It suggests that valid medicinal uses of marijuana should not be the priority in the battle against the drug, while at the same time being clear that marijuana is still, under the eyes of the federal government, a dangerous and illegal drug.

> The prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks continues to be a core priority in the Department’s efforts against narcotics and dangerous drugs, and the Department’s investigative and prosecutorial resources should be directed towards these objectives. As a general matter, pursuit of these priorities should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana. For example, prosecution of individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or those caregivers in clear and unambiguous compliance with existing state law who provide such individuals with marijuana, is unlikely to be an efficient use of limited federal resources. On the other hand, prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department. (Ogden 19 Oct 2009).

Although medical marijuana advocates were relieved by the administration’s apparent position to let state medical marijuana laws “be”, raids on medical dispensaries

continued, and in 2011 the administration issued another memo, from Deputy Attorney General James M. Cole, that, while patients suffering from debilitating diseases are not the government's priority, the DOJ will turn its focus to "large-scale, privately-operated industrial marijuana cultivation centers" that have become commercialized (Cole 29 Jun 2011). Perceived by medical marijuana advocates as a setback, and by medical marijuana opponents as a welcome and clearer federal stance, this more recent memo has added to the lack of clarity regarding how to handle state-level policies that are in direct contradiction to federal policies. This memo, and the administration's position, was tested when patients and medical marijuana dispensary owners in California tried to sue the Obama Administration for breaking a promise made in the Ogden memo. Judge Garland Burrell dismissed the lawsuit on the grounds that the Ogden memo was not, in fact, a promise, and that federal officials have the right to enforce federal policy, even when it is in conflict with state-wide policy. (Egelko 1 Mar 2012; ProCon.org 28 June 2012).

UNCOVERING THE PATH TOWARD MEDICAL MARIJUANA LEGISLATION

The movement toward accepting marijuana as a medicine in 19 states and the District of Columbia, and the corresponding increase of public support for medical marijuana seems, perhaps, surprising when thinking of the federal and historical constructions of the drug as dangerous, immoral, illegal. And yet, as the government carries on digging in its heels, insisting on marijuana's social harms, there continues to be blatant disregard for the federal government's position, illustrated not just by the medical marijuana policies that have landed on many states' books, but also by the number of

states that have been *willing* to consider such legislation. As stated earlier in this chapter, this dissertation will explore the conditions that have bred such inconsistencies and ambiguities in the meanings of the drug and the incompatible federal and state policies toward it. The goal of this project is to investigate how state level policies favoring medical marijuana have been able to be successful in such a seemingly inhospitable federal climate and to uncover the patterns that have allowed for medical marijuana momentum.

The path toward medical marijuana is a nuanced and complex one, so the analysis will be similarly multifaceted, looking at the issue from a number of different angles. In order to begin to get an understanding of the complexities of the medicinal claims of marijuana, Chapter 2 will begin by looking at the need to medicalize the drug. Although science would appear to guide the medical claims of marijuana, scientific discussions are bounded by its moral constructions. Chapter 3 will dig deeper into the historical ways by which the drug has been constructed as immoral and dangerous by uncovering the similarities of the two most influential marijuana policies in American history: the 1937 Marihuana Tax Act and the Controlled Substances Act of 1970. The current demographic picture of the states will be depicted in Chapter 4, using quantitative analyses to uncover the statistical differences between those states that have passed medical marijuana and those that have not. Although drug use data, crime data, and demographic and economic indicators are considered, the variables that will be shown to be the most influential in determining a state's likelihood of having a policy favoring medical marijuana policy have a moral element to them, such as the political party affiliation and the percentage of a state's citizens who identify themselves as religious.

Chapter 5 shifts the angle from a quantitative snapshot to a more qualitative approach. The analysis looks at the ways by which three newsmagazines cover the topic of marijuana in order to understand how the language surrounding marijuana has changed in national debates. Although initially the data show that there appears to be relatively balanced coverage of the many marijuana issues, once the textual details of the news articles and the characters who appear within them are analyzed, a partial reshaping of marijuana morality surfaces. Finally, the work will conclude by bringing each of these chapters together to determine the extent to which morality has played a role within the medial marijuana debate, the extent to which marijuana morality has changed, and the likelihood that that partially changing morality will continue its momentum.

As a whole, this project will highlight the importance of gaining control of the *moral meaning* of marijuana in order for an associated policy to follow. Medical marijuana policy represents much more than just the medical efficacy of one drug. It is symbolic of the nation's attitudes toward illicit substances and medical science, an illustration of the power of rhetoric and the struggles between different moralities, and an example of the forces at work in the battles over morality policies. Multiple marijuana moralities have squared off, and will continue to do so. The winning construction of the drug will give shape to the pathway toward future marijuana policy.

Chapter 2:
Medicalizing and Moralizing Marijuana

SCIENCE AND MEDICALIZATION

The Language of Marijuana

The nationwide and state-level struggles regarding marijuana's classification and policies, at their core, revolve around the very definition of the drug itself. Currently, under federal law, and in the minds of many Americans, marijuana is perceived to be a dangerous and harmful substance, bolstered by its federal-level criminal status. The success of medical marijuana policy depends, in part, upon a change in the perception of the drug – from a criminal substance to a legitimate medical treatment. Recognizing marijuana as a *treatment*, an acceptable medical intervention, is a definitional process. Even defining the term "drug" on a broader level is complex.

> There are many ways to define drugs – at the very least, as medical substances, as illegal or controlled substances, as publicly defined substances, as substances taken for certain effect. Some definitions even rely on a *subjective* criterion: A drug is what members of a society say or *think* it is. There is no single definition that is definitive or correct for all contexts. (Goode 1997: 9).

That is true for marijuana as a treatment for medical diagnoses. Although using leeches to help with pain or blood circulation or taking cocaine to cure a headache may once have been popular and may even have been, at least for some, very effective, defining the above reactions to an illness as appropriate medical treatments is no longer accepted. Definitions of drugs or treatments are, at least partially, contextual, considering not just the basic biochemical effects on the body, but also the *purpose* for using the drug. "'Medicines' are substances used in treating illness," (Geest and Whyte 1989: 345). What is defined as appropriate to treat an illness is subject to disagreement, and

marijuana certainly is no exception. Definitions of appropriate medical interventions can change over time or be hotly contested in political, public, medical, and other forums for debate. For medical marijuana policy to be successful, marijuana as a treatment must be medicalized.

One of the earliest scholars to work with the concept of medicalization on a theoretical level, Zola defines medicalization as a "process whereby more and more of everyday life has come under medical dominion, influence and supervision," (1983: 295). The medicalization framework examines the process of changing definitions of behavior: from behavior that was labeled either as deviant or "normal" to behavior that becomes defined as a sickness, illness, or under the jurisdiction of the medical community. Medicalization research typically emphasizes the social construction of medically created categories, highlighting the power of language and labels.

> Medicalization is first and foremost a conceptual phenomenon: a change in discourse and a concurrent change of the way people see and understand certain things in their lives. Laypersons redefine life events and activities in medical terms. (Verweij 1999: 92).

The path toward medical marijuana legislation would, therefore, require a change in the rhetoric surrounding the drug. If medical marijuana advocates are to be successful, discussions of the drug should be packaged, at least partially, within a medical framework. Although, as will be discussed later, science is certainly not morally neutral, it is, most often, the language of medicine. Science has historically been assigned a central role in legitimizing what constitutes behaviors and treatments that should fall within the realm of medicine and medical knowledge. The development of modern medicine in the 1800s coincided with remarkable advances in science, and the two

became inextricably linked, adding weight to the medical community's claims over successes in their battles with diseases. (Conrad and Schneider 1992).

> The rise of *scientific medicine* marked a death knell for medical sectarianism (e.g., the homeopathic physicians eventually joined the regulars). The new laboratory sciences provided a way of testing the theories and practices of various sects, which ultimately led to a single model of medical practice. The well-organized regulars were able to legitimate their form of medical practice and support it with 'scientific' evidence. (ibid: 14, *emphasis added*).

Science, cloaked in ultimate legitimacy, has become the dominant form of legitimizing the medical community's control not only over the right to treat behaviors defined in medical terms, but also to define certain problems, and reactions to problems, as being medical ones. (See, for instance, Brown 1995; Conrad 2005; Conrad and Schneider 1992; Cooter 2004; Horwitz 2002; Jordanova 2004; Mizrachi and Shuval 2005; Munson and Roth 1994; Verweij 1999). If there is science to support the biochemical effects of a drug on the body, then the assumption might follow that the drug would be labeled as a medical intervention.

The Uses and Pharmacology of Marijuana

Evidence of use of the marijuana plant, a naturally growing, hearty "weed", has been found as early as 8000 B.C.E. Most ancient discoveries revolve around the use of the hemp fiber from the plant, a durable fiber used for rope, cloth, paper, soaps and oils, and even bowstrings in Ancient China. Its medicinal use can be traced back at least as far as five thousand years ago as a Chinese herbal remedy for a number of disorders, and has been used medicinally in a number of cultures around the world for thousands of years, including India, China, the Middle East, Africa, South America, the Roman Empire, and classical Greece. (See, for instance, Booth 2003; Fox, Armentano, and Tvert 2009; Iversen 2008; Werner 2011).

> The Chinese compendium of herbal medicines, the *Pen T'sao Kang Mu,* first published around 2800 B.C., recommended cannabis for the treatment of constipation, gout, malaria, rheumatism, and menstrual problems. Chinese herbal medicine texts continued to recommend cannabis preparations for many centuries. (Iversen 2008: 116).

In 2008, a 2700 year old Chinese tomb was uncovered with about two pounds of the plant buried with its inhabitant, "an ancient shaman" (Fox, Armentano, and Tvert 2009: 4), thought to have been used either medicinally or as "an aid to divination" (ProCon.org 28 June 2012). Medieval Europe lauded the medicinal value of marijuana in medical writings, and its recognition as a medicine continued from the 16th century to the current day. (See, for instance, Aldrich 1997; Boire and Feeney 2006; Bonnie and Whitebread 1999; Booth 2003; Earleywine 2002; Eddy 2010; Fox, Armentano, and Tvert 2009; Grinspoon and Bakalar 1993; Iversen 2008; Werner 2011).

The marijuana plant contains more than 400 different chemicals, with more than 60 categorized as cannabinoids. There are four cannabinoids that have been of most interest to the scientific community and are considered to be some of the most "active components" of the drug, thought to produce the psychoactive effects of the marijuana: delta-9 tetrahydrocannabinol (THC), delta-8 THC, cannabidiol, and cannabinol. Delta-9 THC is the most abundant of the cannabinoids found in the marijuana plant, and is therefore attributed to be the primary psychoactive agent in the drug. However, because of the vast numbers of different chemicals found in the plant, scientists have been unable to determine which of the cannabinoids, by themselves or in combination with others, have which therapeutic effects. In 1990, leading a research team at the National Institute of Mental Health, researcher Miles Herkenham discovered the cannabinoid receptors in the brain, a finding that has helped scientists better understand the pharmacological

effectiveness of marijuana as a medicine. These cannabinoid receptors, which bind with the THC of marijuana, are a way by which the body is able to react to a cannabis-like compound that it produces, endocannabinoids.

> Cannabinoid receptors in the brain stem and spinal cord play a role in pain control … [as well as] controlling the vomiting reflex, appetite, emotional responses, motor skills, and memory formation. It is the presence of these natural, endogenous cannabinoids [endocannabinoids] in the human nervous and immune systems that provides the basis for the therapeutic value of marijuana and that holds the key, some scientists believe, to many promising drugs in the future. (Eddy 2010: 28).

(For further discussions on the science and pharmacology of marijuana, see, for instance, Brazis and Mathre 1997b; Earleywine 2002; Eddy 2010; Fox, Armentano, and Tvert 2009; IOM 1999; Iversen 2008; Mack and Joy 2001; Onaivi, Sugiura, and DiMarzo 2006; Petro 1997b; Werner 2011).

Marijuana's medicinal claims are vast. Proponents of medical marijuana point to the efficacy of using marijuana to treat a number of diseases, including glaucoma, cancer, AIDS, seizure disorders, chronic pain, psychiatric ailments, asthma, among others. Specifically, the drug has been said to reduce ocular pressure, quell nausea, stimulate appetite, relax muscles and decrease spacticity, help with depression, anxiety, and schizophrenia, and work as an antipsychotic, to list some of the most studied aspects. (See, for instance, Brazis and Mathre 1997a; Burglass 1997; Chapkis and Webb 2008; Dansak 1997; Eddy 2010; Gerber 2004; Grinspoon and Bakalar 1993; Herer 2010; Iversen 2008; Krampf 1997; Lee 2012; Petro 1997a; Randall and O'Leary 1998; Werner 2011; West 1997; Zeese 1999). There have been a number of studies looking at the extent to which marijuana, or a derivative of the plant, have helped patients with a number of very specific ailments, however one of the major critiques of this research is

that it is based mostly on anecdotal evidence and case studies on small numbers of individuals. The vast majority of the case study based (and anecdotal) research has argued in favor of marijuana's medicinal potential, however it has not been without its controversy.

Studying the Harms and Benefits of Marijuana

Some of the earlier American based studies on marijuana were in response to two of the major pieces of federal legislation dealing with the drug. In response to the 1937 Marijuana Tax Act, Mayor of New York City, Firorello LaGuardia wanted to employ rigorous scientific research to investigate the drug's effects both on his city (the social consequences of marijuana use) as well as on the human body. In 1938 LaGuardia "authorized [the New York Academy of Medicine] to appoint a blue ribbon committee of thirty-one scientists to make the sociological and clinical studies," (Bonnie and Whitebread 1999: 200). The 1970 Controlled Substances Act, which initially scheduled marijuana as a dangerous, type I substance, was passed with the intent to revisit marijuana's classification by studying the harms and potential health benefits of the drug. In 1972, with the aim to condemn marijuana once and for all as a justifiably illegal and dangerous drug, President Nixon appointed a conservative committee whose task it was to find indisputable scientific evidence refuting marijuana's medical potential. This committee, known as the Shafer Commission, like the LaGuardia panel, in fact, came down in support of marijuana. Although the medicinal claims were made hesitantly, both scientific panels found that marijuana does little to no biological harm and both recommended looser marijuana laws, finding enough evidence of the therapeutic value of the drug to call for more scientific study. (See, for instance, Bonnie and Whitebread

1999; Booth 2003; Chapkis and Webb 2008; Fox, Armentano, and Tvert 2009; Gerber 2004; Herer 2010; Iversen 2008; Lee 2012; Sloman 1998[1979]; Werner 2011). Although each study came up with similar findings, each also faced staunch political ramifications because of those findings, and both were, eventually, deemed to be unreliable; contested not by science, but by politics. (The following chapter on the history of marijuana legislation will look in more detail at the political reactions to these studies.)

As new marijuana legislation has been debated throughout the decades, science and politics have often come head to head. There was a short time period, however, when the political struggle over the drug opened up opportunities for federally approved research on marijuana. While the DEA was still fighting in court over the rescheduling of marijuana after the passage of the CSA, many states decided to use the time of federal uncertainty to pass their own medical marijuana laws. The Investigational New Drug Program (IND) (discussed in the previous chapter), allowed federally grown marijuana to be available for research purposes, and by 1984, 17 states were supplying government provided marijuana cigarettes to patients for medicinal use. The government distributed the drug with the caveat that it would only be granted if the patients getting the marijuana were a part of a research program. (For discussions on the state-level IND research programs, see, for instance, Chapkis and Webb 2008; Dansak 1997; Lee 2012; Randall and O'Leary 1998; Werner 2011; Zeese 1997; Zeese 1999). Although many states had smaller scale studies, six states, California, Georgia, New Mexico, New York, Michigan, and Tennessee

> conducted studies focusing on the anti-emetic properties of marijuana for cancer patients under research protocols approved by the US Food and Drug

> Administration. The studies compared marijuana to prescription anti-emetics, including synthetic THC or Marinol. In each study, marijuana was found to be an effective and safe anti-emetic that for many patients is more effective than other available drugs. (Zeese 1999: 321).

Each study differed in its research model, size, and percentages that found marijuana to be effective, but the combined studies suggested that marijuana could serve some therapeutic purpose. All of these studies, however, were case based, focusing on patients who had already attempted, and in many cases were simultaneously engaged in other forms of treatment. Perhaps the largest and most well-known of these IND supported research studies was the Lynn Pierson Therapeutic Research Program in New Mexico[1]. The study looked at almost 170 patients and analyzed the change in nausea and appetite for patients undergoing chemotherapy treatments when using marijuana, both in pill and smoked form. Both synthetic THC, administered in pill form, and inhaled marijuana were found to be more successful than other more traditional pharmaceutical anti-emetics, but inhaled marijuana was shown to be slightly more effective in its results than its synthetic counterpart. (Chapkis and Webb 2008; Dansak 1997; Randall and O'Leary 1998; Werner 2011; Zeese 1999).

When the IND program was shut down in 1992, NIDA severely limited its supply of marijuana for medical research purposes. In fact, "from 1986 – when the last of the [IND] state studies was completed – until 1998, not a single new patient in the United States received cannabis in an FDA-approved study despite ongoing interest within the medical community," (Chapkis and Webb 2008: 65). Once California passed Proposition 215 in 1996, a new opportunity for FDA and NIDA approved research emerged. Dr.

[1] This study was named for a cancer patient from New Mexico who fought to obtain legal marijuana cigarettes from the government's Compassionate IND program. Although he eventually won his legal battle, he died of cancer before he was able to receive the medical treatment promised to him by the government. (Dansak 1997; Randall and O'Leary 1998; Werner 2011).

Donald Abrams, a researcher at University of California, San Francisco and Assistant Director of the AIDS Program at San Francisco General Hospital, and Rick Doblin, founder of the Multidisiplinary Association for Psychedelic Studies (MAPS) reaped the scientific benefit of California's liberal policies on marijuana (Chapkis and Webb 2008; Werner 2011). Although his proposed research on the effects of marijuana to stimulate appetite for AIDS patients suffering from Wasting syndrome had been approved by the FDA prior to California's Compassionate Use Act, NIDA, the organization that controlled the only federal marijuana plants, would not allow him to use the drug to carry out his research. It was only because of the new California law that NIDA backed down and allowed Dr. Abrams' use of the drug, but only if he focused on the potential *harms* of marijuana for AIDS patients, as opposed to its therapeutic benefits. Although the focus of his study had changed, he was able to "sneak a peek" into the potential benefits to his patients, (Chapkis and Webb 2008: 67). His research, consistent with the conclusions drawn from previous studies, uncovered the therapeutic potential of marijuana. "Not only did [Abrams] find no risk to AIDS patients consuming cannabis, but, in fact, his study suggested that patients appeared to benefit from the use of the drug," (ibid).

Federal Responses to the Science of Marijuana

Although the evidence is mostly case study based, the science appears relatively consistent and unified in support of the potential therapeutic benefits and minimal harms caused by the use of the drug. To answer the growing public attention being paid to medical marijuana issues, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine (IOM) to compile a report that investigates the

many claims made of marijuana's potential health benefits and harms. The study, "Marijuana and Medicine: Assessing the Science Base", was published in 1999.

> This report summarizes and analyzes what is known about the medical use of marijuana; it emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science). (IOM 1999: 3).

Most analyses of the report point to its very cautious approach to the subject, giving quotable findings and support to both proponents and opponents of medical marijuana. (See, for instance, Chapkis and Webb 2008; Earleywine 2002; Iversen 2008; Lee 2012; ProCon.org 28 June 2012; Werner 2011). The study found strong support for the therapeutic use of marijuana for "pain relief, control of nausea and vomiting, and appetite stimulation," moderate support for muscle spasticity, and minimal support for "muscle movement disorders, epilepsy, and glaucoma," (IOM 1999). After highlighting its therapeutic possibilities, the authors counter that "it does not follow from this that smoking marijuana is good medicine," (ibid: 177). Designating a medicine as "good" necessitates a judgment regarding whether or not the medicine provides enough benefits to overlook the detriments. Opponents of medical marijuana argue that not only is there not enough scientific evidence to merit marijuana's medicinal claims, but the potential harms from the drug are too great to simply be "overlooked". The IOM study suggests quite strongly that smoked marijuana has the potential to cause harm to the body.

Opponents of marijuana, supported by the IOM study, suggest that there are two major reasons why the plant form of marijuana does not make "good medicine". The first of which is the harms done because of its most common delivery system: inhalation of a marijuana cigarette. Currently, there are no medical treatments that are delivered to

the body through smoking. There have been studies to show that smoking marijuana causes harm to the lungs and the bronchial system, although, like most marijuana science, it is controversial (Bonner 1992; Chapkis and Webb 2008; Earleywine 2002; IOM 1999; Lawn 1989).[2] In fact, more recent studies have suggested that "unlike tobacco smoke, cannabis smoke does not cause any changes in the small airways, the area where tobacco smoke causes long term and permanent damage," (Herer 2010: 145). While some scientists have found that marijuana can be used as a treatment for bronchial issues such as asthma, and may even lower the risk of lung cancer (Fox, Armentano, and Tvert 2009; Herer 2010; Iversen 2008; Lee 2012), the IOM report clearly states that "numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease," (1999: 6).

The second major critique by medical marijuana opponents has to do with the vast numbers of different chemicals found in the plant itself. In his rejection to rescheduling marijuana as a Schedule II substance, DEA administrator Bonner states, "the effect of taking a drug in combination with other chemicals is seldom the same as taking just the pure drug. As already noted, marijuana contains over 400 other chemicals, not just THC," (1992). Although most government documents investigating the medicinal potential of marijuana admit the potential for therapeutic value in the THC found in the plant, the inability to identity all of the other chemicals in the plant and their particular

[2] Although advocates of medical marijuana point out that there are many other delivery systems for the plant form of marijuana, such as tinctures, vaporizers, used like a tea in milk, baked into food products, among others, the debate has not focused on these other ways by which to imbibe the botanical drug. Aside from the synthetic pill of marijuana, there have not been systematic studies looking to see if these different delivery methods have different effects, although anecdotal evidence would suggest that they would. Perhaps because of the ease of smoking, there is an assumption in the literature on both sides of the debate that smoking would continue to be the most common delivery method for the marijuana plant as a medicine. (See, for instance, Boire and Feeney 2006; Chapkis and Webb 2008; Earlywine 2002; Fox et al. 2009; IOM 1999; Iversen 2008).

effects on the body would make marijuana a very difficult drug to systematically study and regulate. Plant scientists, including Dr. Raskin, a plant scientist at Rutgers University, and studies done by the European Herbal Practitioners Association for the European Union, have begun to look at the "synergistic effects of components found within plants and plant extracts," (Chapkis and Webb 2008: 77), however the unknown nature of marijuana's specific chemistry are problematic for the reproduction and standardization of the drug "by any currently accepted scientific criteria," (Bonner 1992).

> Medicines today are expected to be of known composition and quality. Even in cases where marijuana can provide relief of symptoms, the crude plant mixture does not meet this modern expectation. The future of medical marijuana lies in classical pharmacological drug development. (IOM 1999: 193).

Synthetic THC, The Marinol Pill

In fact, marijuana can be found on the market as an FDA approved, "classical pharmacological drug". In 1985, the FDA approved Marinol (also known by its international nonproprietary name, Dronabinol), a synthetic pill version of THC, for treating nausea and vomiting resulting from chemotherapy treatments[3]. Seven years later, the drug was approved for use by those suffering from Wasting syndrome, such as those with AIDS and anorexia. Although initially a Schedule II drug, Marinol was reclassified as a less harmful Schedule III drug in 1999.[4] The presence of an FDA and DEA approved pill version of THC which is available by prescription suggests that the

[3] According to an account by Werner (2011), the government was afraid that rescheduling dronabinol would invite challenges from groups who were trying to reschedule the plant version of THC (marijuana) from a Schedule I to a Schedule II drug. In order to avoid the delays that these challenges may spur, "DEA representatives contacted…[representatives from ACT and NORML] and offered them a deal"; if they did not stand in the way of this rescheduling, the DEA would allow a public hearing to reschedule marijuana. The deal was agreed upon. (92).

[4] In 2011, after years of clinical trials, the U.S. government granted a patent for Sativex, a THC-based oral spray used to treat spasticity due to Multiple Sclerosis as well as cancer pain. The drug, manufactured by British Company GW Pharma and approved for use in Canada and a number of European countries, has not yet been approved by the FDA.

government is accepting of the scientific evidence suggesting that cannabinoids can be medically beneficial. Because of its method of delivery and its ability to isolate the THC from the many other chemical compounds found in the marijuana plant, this drug has faced little resistance from the federal government.

This synthetic version of THC has also had a financial incentive for its success. Unimed, the manufacturer of Marinol and a subsidiary of Solvay Pharmaceuticals, reported (world-wide) Marinol sales of $105 million (U.S.) in 2007 (WatsonPharmaceuticals 30 Jun 2008). Unlike Marinol, and other THC pharmaceuticals that are being developed with the promise of profit, "commercial interest in bringing [the marijuana plant] to the market appears nonexistent," (IOM 1999: 219). Recent writings on medicalization have suggested that whether or not a behavior or treatment gains legitimacy as medical is dependent upon whether or not there is a market for such a designation (See, for instance, Clarke, Shim, Mamo, Fosket, and Fishman 2003; Conrad 2005; Fukuyama 2002; Horwitz 2002). As Conrad points out, "while physicians are still the gatekeepers for many drugs, the pharmaceutical companies have become a major player in medicalization," (2005: 5). An easy to grow and inexpensive weed, marijuana does not have the financial potential for pharmaceutical and other companies to stand on its side. Nor, argue some, should they.

THC's presence within the medical marketplace in the form of Marinol has not ended the battle for medical marijuana. In fact, many patients and advocates point to the cost of the drug (upwards of $13/pill) as well as its moderate effectiveness compared to using the botanical version of the plant to suggest that Marinol is not an adequate substitute for marijuana. "The results of studies with synthetic THC were uniformly

unimpressive," (Werner 2011: 91). Based mostly on anecdotal evidence, many patients complain that Marinol is not only less effective than the marijuana plant, but also has more adverse side effects. These studies, comparing the efficacy of Marinol to its natural counterpart, have faced many of the same criticisms as other marijuana studies discussed above. (See, for instance, Boire and Feeney 2006; Chapkis and Webb 2008; Earleywine 2002; Eddy 2010; Krampf 1997; Randall and O'Leary 1998; Werner 2011).

The Barriers to "Rigorous" Marijuana Science

In a Department of Justice publication, the government's position on the science of marijuana is succinctly summarized: "Specifically, smoked marijuana has not withstood the rigors of science – it is not medicine, and it is not safe," (DOJ 2011: 2). The lack of rigor of marijuana science is at the heart of the government's arguments against rescheduling marijuana to allow for legal, federally recognized medicinal marijuana, as has been stated in each denial of the petitions for rescheduling. In the 1992 denial of the rescheduling petition, written by Robert C. Bonner, he questions the validity of the IND state studies discussed earlier.

> During the 1970's and 1980's, a number of states set up research programs to give marijuana to cancer and glaucoma patients, on the chance it might help. Some people point to these programs as proof of marijuana's usefulness. Unfortunately, all research is not necessarily good scientific research. These state programs failed to follow responsible scientific methods. Patients took marijuana together with their regular medicines, so it is impossible to say whether marijuana helped them. Observations or results were not scientifically measured. Procedures were so poor that much critical research data were lost or never recorded. Although these programs were well-intentioned, they are not scientific proof of anything. (Bonner 1992).

Although many advocates of medical marijuana would strongly disagree with Bonner's critiques of the scientific rigor of these studies, individuals on all sides of the marijuana debate agree that more scientific studies should be carried out to investigate

the belief that the benefits of the marijuana plant for medicinal purposes outweigh the detriments. Seemingly more sympathetic to scientific researchers than Bonner's criticism of the science above, the IOM report highlights not only the lack of rigorous science, but also the difficulties in working through the bureaucracy to perform that science.

> Clinical studies of marijuana are difficult to conduct: researchers interested in clinical studies of marijuana face a series of barriers, research funds are limited, and there is a daunting thicket of regulations to be negotiated at the federal level (those of the Food and Drug Administration, FDA, and the Drug Enforcement Agency, DEA) and state levels. Consequently, the rapid growth in basic research on cannabinoids constrasts with the paucity of substantial clinical studies on medical uses. (IOM 1999: 137).

One of the biggest barriers to science is the availability of a drug that is seen in the eyes of the federal government as a Schedule I, illegal substance. Because the controls on Schedule I drugs are so strict, the only federally sanctioned marijuana is controlled by the National Institute on Drug Abuse (NIDA). "NIDA control[s] access to muggles [marijuana] from Ole Miss, the only legal source of reefer for research purposes," (Lee 2012: 169). Although researchers looking into studying other Schedule I drugs have a choice among other licensed suppliers, the ability of the DEA and NIDA to "block even carefully designed, FDA-approved research on the medical value of marijuana" and deny the use of the government's crop of marijuana has been likened to a "legal monopoly" on the drug, (Chapkis and Webb 2008: 65). A researcher at the University of Massachusetts, Amherst, attempted to gain permission from the federal government to grow marijuana to be used for federally approved research studies. After years of paperwork and delay, Dr. Lyle Cracker, the director of the university's Medicinal Plant Program, sued the DEA for their inattention to his request. Six years after Dr. Cracker's initial license application, Administrative Law Judge Mary Ellen

Bittner concluded "that there is currently an inadequate supply of marijuana available for research purposes" and her decision was: "I recommend that Respondent's application be granted," (12 Feb 2007: 87). Two years later, the DEA rejected her ruling and barred Dr. Cracker from obtaining his license. (ProCon.org 28 June 2012; Werner 2011).

THE MORAL LIMITS OF SCIENCE

Moral Authority over Marijuana

For purposes of medicalizing marijuana, science has, in some ways, hit a dead end. Almost everyone involved in the debate agrees that more rigorous scientific studies are necessary in order to better understand both the harms and benefits of marijuana. However, FDA- and DEA-approved research studies that meet the government's criteria of "rigorous" and "scientific" are currently unable to be performed. To suggest that the science is unequivocal, as do advocates on both sides of the marijuana issue, would be naïve. In the same vein, however, to suggest that the acceptance of marijuana as a legitimate medicine depends solely on science would be similarly naïve. Typically there is an assumption that science has an unquestioned power over the realm of medical knowledge, including healing and treatment options. If this were the case, however, then the science of marijuana discussed above would suggest that the battle over medical marijuana would not be such a hard fought one. It would be a battle of the best science, the most reliable methods, the most consistent outcomes. Scientific investigations would be unfettered, and the findings trusted. Although it is true that "the authority of science [is used] to differentiate alternative from conventional medicine," (Mizrachi and Shuval

2005: 1652), this "scientific authority" is vulnerable to power struggles and moral judgments.

Hiding under the guise of science, the moral elements that are involved in the construction of medical knowledge and treatments become masked. Using Zola, Conrad and Schneider say, "the medical model and the associated medical designations are assumed to have a scientific basis and thus are treated as if they were morally neutral. They are not considered moral judgments but rational, scientifically verifiable conditions," (1992: 35). But, Conrad and Schneider and others point out that science is not, in fact, morally neutral; science is guided by value judgments.

> The phrase 'medical knowledge'…reflects the centrality of knowledge claims in social constructionist approaches. The term 'knowledge' is hardly neutral, since it implies claims that have been validated in some way and foregrounds the cognitive dimensions of medical and scientific practice. (Jordanova 2004: 339).

Reviewing Lauden's theoretical claims of "normative naturalism" (that the success of science is accounted for, in part, by its reliance on following the rules of particular methodologies), Munson and Roth suggest that when choosing among the thousands of rules to follow when faced with a medical decision, "we consult the moral values, economic constraints, risk factors, opportunity costs, and so on that form the background to the decision about rules," (1994: 577). In other words, even when making what would seem to be routine medical decisions, doctors and other medical professionals must rely on value judgments in order to decide what course of action to follow. Medicalizing a drug with such strongly embedded moral meaning attached to it, therefore, becomes much more than just a matter of science. An unwillingness or inability to recognize that medical decisions are guided by values and embedded within a social context appears to reify scientific knowledge and obscures the role that morality

plays in all medical decisions. If moral judgments are involved in regulating choices that need to be made regarding *commonly accepted* standard medical practices, then it becomes necessary to acknowledge that morality plays a significant factor in designating the controversial treatment of marijuana as medical (or non-medical). Specifically, there are three factors that add a moral element to the science of marijuana: the designation of the side effects of the drug as either medical or non-medical (in the case of marijuana, medical or recreational), the existence of competing definitions of the drug (as medical or criminal), and *whose* and *which* version of morality gets legitimated within the debate.

A Legitimate High? Constructing Appropriate Side Effects

All drugs come with side effects. Drugs that are used for recreational purposes are often used *because* of the side effects, the alteration of one's state of mind. For medicinal drugs, the side effects tend to be weighed against the beneficial therapeutic impact. What is considered to be acceptable as a side effect is often a moral judgment call. Discussing the issues of "acceptable risks," Herer (2010) comments, "every day we trust physicians to determine whether the risks associated with therapeutic, yet potentially dangerous, drugs are acceptable for their patients," (78); there are varying opinions regarding whether or not the marijuana "high" is an "acceptable risk." In the third chapter of the IOM report, "First, Do No Harm: Consequences of Marijuana Use and Abuse," in which the authors discuss the degree of harm associated with marijuana use, the first section of that chapter is entitled "The Marijuana 'High'", (1999: 83). There is an assumption, both in the report as well as made by many opponents of medical marijuana, that the "high" associated with marijuana use is a negative side effect of the drug. This psychological alteration of consciousness that one gets from the use of the

drug is wrapped up with recreational images of marijuana users: lethargic, snack-munching ne'er do wells who are likened to images of Cheech and Chong and unmotivated hippies. This perception associated with the high not only undermines the claims of medical uses for the drug, but it also undermines the status of marijuana users as patients.

For opponents, the high is seen as an uncontrollable and unwelcome side effect; for advocates and medical users, the high may be perceived as either a part of the therapy itself or just another side effect that is tolerated, like the side effects would be with other more traditional pharmaceutical drugs. While many patients claim that the psychoactive properties are (eventually) not felt, often developing a tolerance to the mind-altering aspect of the drug (Chapkis and Webb 2008; Randall and O'Leary 1998), others point out that this side-effect could be just as easily constructed as positive as negative. Discussing one patient's use of marijuana to help with post-polio symptoms, Chapkis and Webb point out that "it is significant that Suzanne doesn't claim that cannabis fully masks her pain but rather that it produces a shift in attitude toward pain. This was a frequent formulation by WAMM [Wo/Men's Alliance for Medical Marijuana] members discussing the effects of cannabis on pain management and depression," (2008: 121). Even the IOM report, at the end of the section discussing the high as a negative aspect of the drug, suggests that the side effects from marijuana are not always negative.

> The high associated with marijuana is not generally claimed to be integral to its therapeutic value. But mood enhancement, anxiety reduction, and mild sedation can be desirable qualities in medications – particularly for patients suffering pain and anxiety. Thus, although the psychological effects of marijuana are merely side effects in the treatment of some symptoms, they might contribute directly to relief of other symptoms. They also must be monitored in controlled clinical trials to discern which effect of cannabinoids is beneficial. (IOM 1999: 84).

The ability to scientifically monitor the high, however, is a sticking point for those who suggest the drug is not an appropriate medicine. Federal claims against the drug have noted that the high associated with marijuana use makes it difficult to measure the drug's efficacy. Opponents question whether marijuana is actually having a therapeutic impact, or instead, if it just masks patients' symptoms. (Bonner 1992; DOJ 2011; IOM 1999; Lawn 1989). Whether or not the psychological high is perceived to be a hindrance to an ability to measure the drug's efficacy scientifically, a negative side effect, bound up with the negative images of recreational use, an aid to its therapeutic potential, or a side effect that is tolerated is a judgment call. Science cannot determine whether this drug's side effects are positive or negative, to be tolerated or avoided.

> To say *the* aim of medicine is the promotion of health is not controversial. Of course, disagreements may arise over how the aim is to be expressed. Some may say, for example, that the aim of medicine is 'preventing, treating, curing disease' or 'meeting the health needs of people'. Also, other disagreements may arise over exactly what activities may be legitimately regarded as promoting health (e.g., using mild electrical shocks to treat headache, making smoking illegal). (Munson and Roth 1994: 573).

The biological and pharmacological impact of THC on the body may not be highly disputed. But, whether or not the use of THC from a plant leads to the aim of "promoting health" while there is a concurrent mind-altering side effect is outside of the boundary of scientific medicine. Science, here, gives way to moral decision making. Although the physiological mechanisms that cause the marijuana high may be better understood through scientific inquiry, placing a value judgment on this high as a side effect exists within a moral, not scientific, realm.

Marijuana's Contested Definitions: A Medical-Legal Hybrid

Also masking the morality of marijuana science, the existence of competing constructions of marijuana may serve to hinder the likelihood that the drug will become medicalized (recognized as a legitimate medical treatment). In the influential book Deviance and Medicalization (1992), Conrad and Schneider refer to medical-legal hybrids, particularly in regards to drug use and addiction. The status of "hybrid" is such that different social institutions attempt to take control of and define particular behaviors. Within this category, behavior is constructed as both a criminal act and a sickness (using an illegal drug and succumbing to the illness of addiction, for instance). Both medical and legal social control agencies would be responsible for treating the addict, however, the authors point out that, "the medical profession's mandate to treat addiction was directly dependent on the government's policies…in matters related to criminal law, treatment by the medical profession is accomplished at the determination of the state," (142). Medical marijuana also fits under this model. In the struggle to gain recognition of marijuana as a medicine, it is constrained by its status as a medical-legal hybrid.

As demonstrated earlier, the use of marijuana, either for the purpose of scientific study or as a medical treatment is currently "at the determination of the state." Because of marijuana's Schedule I status, the medical and scientific community must go through legal and bureaucratic channels in order to gain permission to study the drug. Patients using medical marijuana legally under state law may, at any time, be prosecuted at the federal level for engaging in an illegal activity. Since the passage of the Harrison Act in 1914[5], the federal government has taken control of drugs and has adopted a punitive

[5] The Harrison Act is recognized as the first piece of legislation which placed drugs, opiates specifically, under the control of the Federal Government, limiting doctors' and states' rights to distribute opiates. (See,

stance toward any illicit drug use, including marijuana (see, for instance, Bonnie and Whitebread 1999; Booth 2003; Himmelstein 1983; Inciardi 1999; Luper-Foy and Brown 1994). "Drug policy is a product of the legislative process, and its variations…are shaped by the ways in which political institutions mediate the fortunes of policy agendas," (Benoit 2003: 270). The medical and scientific communities do not have control over marijuana, whether medicinally or not. The strong foothold that the government has over control of the drug (its meanings and policies) and the lack of control by the medical and scientific communities may, in fact, serve to undermine the drug's ability to be fully medicalized.

While marijuana may have reached a partial medical designation, "politicized challenges to medicalized concepts can affect the degrees of medicalization," (Conrad 1992: 220). With its dual construction, marijuana may have a difficult time reaching a completely medical categorization. Conrad and Schneider (1992) use the medical-legal hybrid example of methadone maintenance to demonstrate that the *behavior* (or illness) of heroin addiction can be treated medically through methadone maintenance programs. Although they point out that "its promotion by the medical profession was limited mostly to the relatively few individuals engaged in methadone research or treatment programs," (141), their focus is how this form of treatment was an influential factor in the medicalization of drug addiction. Looking at this same example from a different perspective, I suggest that not only is the definition of addiction contested as a medical diagnosis, but that the treatment itself has a highly contested definition, with critics questioning methadone maintenance as a valid medical response. The existence of two

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for instance, Bonnie and Whitebread 1999; Booth 2003; Himmelstein 1983; Lee 2012; Meier 1992; Sloman 1998).

very powerful competing definitions, methadone as an illegal and harmful drug vs. methadone as a helpful treatment for drug addicts, severely inhibits the treatment's ability to be recognized as being fully medicalized. Marijuana, too, struggles with the same competing and conflicting constructions. Marijuana policy, therefore, is at least partially dependent upon the extent to which the different images of the drug, as a criminal substance or a legitimate medicine, have been fully embraced. When analyzing the decision making processes of legislators regarding reproduction legislation, Oldmixon notes "that legislators do not simply disagree over instrumental policy goals, but on the fundamental framing of issues," (2002: 785). Marijuana policy, too, can be framed in a number of ways; as long as legislators (and others) frame marijuana as a criminal issue, efforts to frame marijuana as a legitimate medicine will be weakened. These frames are not based in scientific inquiry and outcomes, but on a social and moral understanding of what the use of the drug may mean.

With drug policy fully controlled by the government instead of the medical community, the ways by which meaning is made of the drug is also at the mercy of the state. "Drug policy everywhere must manage the tension between the state's interests in protecting public health and maintaining public order," (Benoit 2003: 270). Drugs in general, and marijuana specifically, are constructed as being both helpful and harmful, both treatments (reactions) and behaviors (actions), both medicine and poison. Marijuana can be constructed both as an illegal behavior that should be punished as well as an effective treatment used to help treat epilepsy, glaucoma, multiple sclerosis, relieve nausea, induce appetite, etc. (Grinspoon and Bakalar 1993; Herer 2010; Iversen 2008; Mathre 1997; Werner 2011). Marijuana's status as a hybrid drug indicates that there are

a number of powerful voices within the debate, each vying for its own constructed definition of marijuana. Science has not guided which of these polarized constructions of the drug are seen as fundamental to understanding marijuana, instead, "the scientific facts about the drug [marijuana] were obscured by its social meaning," (Shafer 1999: xi). In prioritizing one definition of the drug over another, medical marijuana policy, therefore, is at least as symbolic as it is pragmatic. The reliance of legislation on moral constructions of the drug, then, further diminishes the role and impact of science within the medical marijuana debate.

UNDERSTANDING MORALITY POLICY

Contentious vs. Consensual Marijuana Moralities

One of Meier's concluding remarks in his book, The Politics of Sin: Drugs, Alcohol, and Public Policy, a detailed policy analysis of U.S. drug policies, is that "a person without any prior knowledge of U.S. drug control policies would be struck by the irrationality of overall policy," (1994: 252). And, in fact, particularly when thinking about marijuana, he is not the only scholar to suggest a disconnect between the harsh drug policies that exist and the lack of scientific evidence to support that harsh stance. (See, for instance, Anderson 1981; Earleywine 2002; Fox, Armentano, and Tvert 2009; Grinspoon and Bakalar 1993; Herer 2010; Himmelstein 1983; Nadelmann 1988). One possible explanation for the inability to point to science as directly informing drug control policies is that drug legislation represents much more than just the passage of a particular law, (See, for instance, Duster 1970; Gusfield 1972; Meier 1992; Meier 1994). These policies fall within a category that has been termed morality policy, "those

[policies] which seek to regulate social norms or which evoke strong moral responses from citizens for some other reason," (Mooney and Lee 1995: 600). Because, as is supported by the literature and will be demonstrated further in this research, morality policy appears to have different patterns of adoption compared to non-morality policy, and because morality and values play a large part in shaping the marijuana debates, medical marijuana can be both informed by and inform the morality policy literature.

Morality policy scholars have pointed out that there are two types of morality policy: those for which there are two sides, and those for which the side of the "other" is not easily represented and very easily demonized. (Meier 1994; Mooney and Lee 2000; Sharp 2003). It would be difficult, for instance, for groups to organize to argue that laws against drinking and driving should be lifted, or that child pornography is acceptable (Meier 1994; Sharp 2003; Smith 2001). Mooney and Lee (2000) distinguish between "consensus" and "contentious" morality policy in which the former has "no legitimate opposition" and the latter has "at least two legitimate, substantial, and recognized positions on the issue," (225). On the one hand, the unwavering stance by the federal government that marijuana should remain a Schedule I, illegal enemy in the war on drugs would suggest that there are elements of the marijuana debate that would place it in the category of a consensual morality issue. On the other hand, *medical* marijuana, I suggest, represents an issue that has (at least) two morally "acceptable" sides.

Morality necessitates a cultural reference point (Duster 1970: 81). While most individuals may well be opposed to allowing their 14-year old son or daughter to use marijuana to help with the social ailment of unpopularity, the majority of the country appears to be in support of allowing an adult, with permission from a doctor or not, to use

the drug to help ease the discomfort of chemotherapy treatments without being punished, for instance. The cultural reference point may, in fact, be a moving target for the same drug. Historically embedded constructions of the drug as, at most biologically and socially harmful and dangerous, and, at least, an unnecessary and illegal social annoyance, are still the most powerful constructions of the drug when being used for recreational purposes. Although there may be more tolerance for the drug recreationally, its status as illegal is seen as a way to protect citizens from the potential harms that may result from the use of the drug. There appears to be a "natural" legal consensus regarding the drug's illegal status for recreational use.

The cultural reference point used to assess the extent to which *medical* use is seen as morally acceptable, even necessary, has appeared to have undergone moderate shifts. The struggles that medical marijuana legislation have faced would suggest that there is more than one version of morality guiding these debates. The tension, and often direct contradiction, that exists between morality crusaders (on both sides of the medical marijuana issue) and arguments supported by science (also on both sides of the issue) brings these policy debates outside of the realm of consensual morality. Although, as discussed above, science is often at the heart of decisions regarding the medical efficacy of drugs, in the case of marijuana, science may play a secondary and, at times, superfluous role in deciding whether or not marijuana is a morally acceptable medicine.

Which Morality

> Empirical reality being staggeringly complex, permits and even *demands* factual selection. We characteristically seek support for our views: contrary opinions and facts are generally avoided. This opens the way for the maintenance of points of view which are contradicted by empirical evidence. (Goode 1997: 87).

Marijuana policy cuts across a wide variety of issues – criminality, science, health, economics, social values, etc. There can, therefore, be more than one type of morality influencing the medical marijuana debate such as the desire to: protect the nation's youth, lower incarceration and/or crime rates, protect the free market, shield doctors' and/or patients' rights, uphold the free will of citizens, etc. In order to fully understand the attempts to medicalize marijuana, it is necessary to uncover *which* morality is guiding the medical marijuana debates and how that morality is being shaped. Moral reasoning that is guided by science has the potential of being very different than moral reasoning that is guided by emotions, fear, even religious ideology, for instance. Often, however, it is not the factual information that matters in polarizing the different sides of the debate. Morality is not embedded within the information itself. The role of morality comes to the fore when looking at who controls that information, how it is presented, and the choices made in its interpretations.

The science that serves as the foundation for arguments regarding marijuana's medical efficacy discussed above have not hindered either side's claims of medical and scientific support of their views. The debate is not about the science as much as it is about the control of the information and the interpretation of the scientific findings.

> There is an abundance of information regarding the characteristics of marijuana. What is known about the substance tends to be presented in ways that are contradictory, supporting the special interests of those who advocate legal regulation of marijuana because of its alleged harmful effects or who advocate legalization because of its helpful and benign characteristics. (Isralowitz 2002: 137).

Recounting a similar story, regarding the construction of opium as an "evil" drug, Conrad and Schneider also point out that "both sides drew on medical evidence to support their claims" and that "sometimes these medical claims became explicitly moralistic," (1992:

117-118). The ability of both sides to use the same evidence to make their (different) points regarding the appropriateness of marijuana as a medicine serves as yet more ammunition to attack the other side's selective interpretation of "facts".

In a book section entitled "Research Yields to Ideology," Gerber levels an accusation that the government dismisses the science that does not fit their agenda, highlighting the "government officials' consistent pattern of convening expert research commissions to investigate pot, mandating their objectivity and impartiality, and then repudiating their unwelcome findings," (2004: 136-137). Outlining a 2009 study done, in which "researchers took cells from (nonhuman) animals and bacteria [and] … essentially suffocated them with marijuana and tobacco smoke, and compared the results," Werner lambasts these methods as "pseudoscience [which] is geared to produce results 'proving' marijuana to be harmful and dangerous," (Werner 2011: 155, 154). Other advocates for marijuana more gently point to NIDA's unwillingness to support any research on marijuana that does not specifically set out to demonstrate the harms of the drug. (See, for instance, Chapkis and Webb 2008; Lee 2012).

The federal government makes the same claims about marijuana researchers. The 1989 denial of the rescheduling petition emphasizes the lack of "reliable, credible, scientific evidence" to support medical marijuana claims, and notes further that "this agency [DEA], and the Government as a whole, would be doing the public a disservice by concluding that this complex psychoactive drug with serious adverse effects has a medical use based upon anecdotal and unreliable evidence," (Lawn). In the rescheduling denial three years later, the DEA Administrator also claims that because of unreliable and faulty scientific methods, researchers "are mistaken" in their conclusions of the safety

and efficacy of the drug (Bonner 1992). The 2011 DOJ "Position on Marijuana" continues to emphasize the government's reliance on sound science and their adversaries' questionable motives and problematic use of science when pushing for medical marijuana. "The legalization movement is not simply a harmless academic exercise. [There is] mortal danger of thinking that marijuana is 'medicine'," (6). Both sides, those advocating for the medical efficacy of the drug and those claiming its harms, place a high value on their own scientific claims while delegitimizing their rivals' scientific claims, blaming the others' morality, value judgments, and faulty reasoning for distorting the interpretations of the science.

Advocates and opponents of medical marijuana use science to mask their own constructions of the morality behind marijuana. "If the facts don't fit the frame, the frame will be kept and the facts dropped," (Lakoff 2004: 37). This selective interpretation of the information that grounds medical marijuana debates, and the finger pointing at one's adversaries for taking part in this moral manipulation of science, emphasizes that value judgments and morality, not science, guide the medical marijuana debate. As the story of medical marijuana legislation unfolds throughout this work, the different versions of morality will be highlighted as they become the foundation for constructing marijuana either as a helpful medicine or a harmful drug.

Whose Morality

If it will be necessary in this dissertation to explore *which* morality, then another important question when thinking about the forces that shape the medical marijuana debate and likelihood of medicalization is: moral *to whom*? In his book suggesting that morality policy is one way by which certain groups in power reinforce and legitimate

their own morality (and in doing so, their own status), Gusfield notes that "a symbolic victory through legislation…did indicate whose morality was publicly dominant," (1972: 111). The battle over medical marijuana legislation, therefore, is not only a battle over the scientific and pragmatic elements involved in defining appropriate medicines, but is also a battle over the right take the moral reigns over that definition.

There has been some attention paid to the role of the "expert" within the morality policy literature, however the role of the "expert" is often seen less as its own influential force, and more as a choice to which politicians (and others) can turn to legitimate and justify their own political stances (see, for instance, Esterling 2004; Featherman and Vinovskis 2001; Pawson 2006). As morality policy debates become more impassioned, the role of the expert in informing debates becomes not only secondary, but often superfluous (Meier 1994; Mooney and Lee 1995; Roh and Haider-Markel 2003; Sharp 2002). Defining expertise as "the extent to which a speaker is perceived to be capable of making correct assertions," (Pornpitakpan 2004: 244), it would seem as if the role of "expert" within medical marijuana debates would fall within the realm of science. And, in fact, if medical marijuana legislation were solely based on the medicinal merits of the drug, then doctors and scientists would be constructed as the primary experts. Because of marijuana's status as an enemy in the war on drugs (and its categorization as a medical-legal hybrid), politicians, law enforcement, parents' groups, and others are also able to claim expertise in this area. The very definition of who can claim expert status within these debates has widened as the debate moves from a scientific to a moral realm. As this study progresses, the role of these competing voices on the journey toward medical marijuana will be explored. For now, it is important to recognize that science does not

hold a monopoly on marijuana knowledge. In fact, science often loses when faced with those who claim expertise regarding the morality of drug use.

Science and Symbolic Legislation

> It should be clear that many elements of drug control policy lie outside the realm of biology and medicine. Ultimately, the complex moral and social judgments that underlie drug control policy must be made by the American people and their elected officials. (IOM 1999: 14-15).

Although, as the IOM indicates in their 1999 report, science should be a *part* of the conversation surrounding the medicalization of marijuana as a treatment, there are more elements to the debate than its scientific efficacy. The "complex moral and social judgments" lie not only in the morality of the drug itself, but also in the moral and social interpretations of science. Legislating on marijuana as a medicine, in fact, is about much more than just the efficacy of the drug itself. Drug policy, as will be shown throughout this dissertation, is symbolic. It is a way by which groups can maintain (or gain) control, further their own conceptions of morality, and protect the social order, however it may be defined (Goode 1997; Grinspoon and Bakalar 1993; Gusfield 1972; Meier 1992; Meier 1994).

The current and often contradictory constructions of the morality of marijuana that contour today's debates are grounded in history. Like a tower made of building blocks, there has been an evolution of marijuana moralities, each providing a new layer to the conception of the drug, but resting on previous assumptions and constructions. It is necessary, therefore, to look back at the ways by which the U.S. has dealt with marijuana in the past in order to create a more complete and richer understanding of the definition of marijuana today and the policies and policy debates that follow.

Chapter 3:
History of Marijuana Policy in the United States

If you want to understand today, you have to search yesterday. – Pearl Buck

WHY HISTORY?

Meaning Making

> So instead they [medical marijuana advocates] fight federal policy with initiative after initiative, while also defending local pro-pot laws. Their side got a major media boost in California in September, when federal agents busted Santa Cruz's Wo/Men's Alliance for Medical Marijuana in an early-morning raid. The feds dragged the farm's owners, who were legally growing pot under California law, to a federal building in San Jose for breaking federal law and held a paraplegic resident at the farm for hours. "I opened my eyes to see five federal agents pointing assault rifles at my head. 'Get your hands over your head. Get up. Get up.' I took the respirator off my face, and I explained to them that I'm paralyzed," said Suzanne Pheil, 44, who is disabled by the effects of postpolio syndrome. Her story was broadcast everywhere, since the pro-pot people had basically been waiting for her to be harassed, punching every phone number on their media list minutes after the raid. Pot people, surprisingly, can move pretty fast when they want to. (Stein 4 Nov 2002: 56).

How have we gotten to a place in this country when a woman suffering from a debilitating illness is used as a pawn in the game of political chess? To the victor goes the ability to define marijuana as either helpful and necessary medicine or a dangerous and rightfully illegal drug. To understand this contradiction between state and federal law and how both sides of the debate have gone to such dramatic ends in order to tout their side of the issue, the current political and demographic context of the situation is not the only important piece of the puzzle. History matters. Issues such as how the media cover current medical marijuana stories, whether or not it would be political suicide for a politician to stand up in vocal support of medical marijuana, the degree to which public

opinion gets heard, the general tone and ideological and semantic framework of the debates, and other demographic and political factors are all necessary elements to understand the complexities of the process of medical marijuana policy adoption or defeat. The current political environment within which marijuana debates operate today, however, is bounded by history. What is "common knowledge" regarding the effects of marijuana on an individual, or, perhaps more importantly for policy considerations, on society, is not necessarily an objective truth. The ways by which the policies of the past were initiated, debated, and constructed have not only influenced our policies of today, but also how we think and talk about the drug in a general sense.

The editorial flourish that ends the quote at the beginning of this chapter, that, "pot people, surprisingly, can move pretty fast when they want to," (Stein 4 Nov 2002: 56) rests in the assumption that readers will hold a particular image of what a marijuana user should look like. The construction of the marijuana user as lethargic and lazy, in direct opposition to the image of the user of the 1930s and 40s as being violent and "crazed", is a result of many years of rhetoric and policy that have impacted our knowledge of the drug and its users today. In Himmelstein's The Strange Career of Marihuana, the author makes the argument that drug ideology is not a "mask" used to hide other, more important forces that shape marijuana policy, but that the ideology itself is "an integral part of those social forces" at work in shaping marijuana policy. He emphasizes the importance of understanding "the social and historical rootedness of the conceptions that have framed public discussions of marihuana [*sic*]," (Himmelstein 1983: 146).

Today's facts are based in yesterday's queries. Looking at the history of marijuana policy is more than a matter of answering the often researched question: "how do social facts…come into being," (Jenness 2004: 148). In this case, how did marijuana get defined as a dangerous drug with limited and controversial medical utility? Answering this question is more than a matter of satisfying historical curiosity; understanding how social facts became "factual" elucidates the patterns of the adoption and acceptance of social facts and ideology.

Borrowing from the path dependence literature, in which "choices or events (possibly contingent, but nonetheless critical) at a given point will often shape, constrain, even determine the range of choices 'actors' face subsequently," (Brown 2010: 664), the rhetorical and ideological tools available today to make meaning of marijuana are based in past constructions. (For more detailed discussions of path dependence, see, for instance, Brown 2010; Haeder 2012; Mahoney 2000; Pierson 2000; Shostack, Conrad, and Horwitz 2008; Wilsford 2010). Were it not for the conflicting images of violent marijuana users in the 1930s and 40s and the drop-out drug of the 1960s and 70s, our understanding of the drug would be very different. The way marijuana was constructed in the early part of the 20th century had a major impact on the way the drug was constructed in the middle and later part of the 20th century, which, similarly has a major impact on how we view marijuana today. The same can be said of the policy process. Unless the influence of historical constructions on current day constructions is recognized, historical analyses become mere stories.

In his examination of legislating drug use as a moral phenomenon, Duster (1970) argues that we become attached to a particular moral stance because of what we have

learned from our communities. "Such issues…concern the question of knowing and of coming to truth by culturally prescribed paths," (87). This chapter delves into the history of marijuana legislation in order to highlight that the knowledge set and associated language and rhetoric that underlies the debates around medical marijuana today is built upon the foundation that was *created* in the past. Our collective knowledge is not formed (and debated) in an historical vacuum; even if the knowledge (and morality) sets in the past were inherently questionable, its mere presence has shaped not only what we come to know, but which questions we decide to ask.

Placing today's debates within an historical context and understanding why marijuana has taken its place as an enemy in the war on drugs will provide important insight to the policy process.

> The only way to answer such questions about the emergence of deviance designations is to attempt to locate their origins in history and identify the social groups and activities that generate and support them. In this fashion we can begin to understand the meanings we attribute to certain forms of behavior. (Conrad and Schneider 1992: 20)

Beyond looking at the history of marijuana policy in the United States, three goals will be accomplished in this chapter. (1.) The historical analysis will identify the social groups that have been influential in shaping marijuana policy and ideology and establish the interconnectedness and hierarchies of power between these interested parties. (2.) Claimsmakers' ability to shape the perceived image of the marijuana user and harness the power of moral arguments over scientific evidence will be established. (3.) Finally, by highlighting similarities in the *process* of policy adoption across seemingly incongruent time periods, patterns will emerge that will add insight to today's processes of marijuana policy formation.

History's Struggles Repeat Themselves

"The public discussion of marihuana *[sic]* at any given time has not been a haphazard collection of observations and beliefs but has been organized around a coherent set of assumptions about the drug, its users, and the law," (Himmelstein 1983: 6). These assumptions have been constructed because of the history. As a new marijuana era is ushered in, the initial assumptions about the drug are based in the idea that past constructions have been grounded in objective fact. At that point, ideas surrounding the drug have become second nature, assumed to be true. So, in order to reconstruct the assumptions of the past, not only does new information have to surface, but there has to be a way to break down the information of the past that has structured people's commonsense assumptions about the drug, its use, its harms, its users, its relationship to morality and science, etc. In other words, only by looking at the history of marijuana policy can we understand why we think the way we do about the drug today.

When looking to history to try to better understand how current drug policy has been shaped by the past, there are two policies that, most scholars agree, were the most influential in shaping today's attitudes and federal and state-wide policies toward marijuana: the Marijuana Tax Act of 1937 (MTA) and the Controlled Substances Act of 1970 (CSA). (See, for instance, Bertram, Blachman, Sharpe, and Andreas 1996; Bonnie and Whitebread 1999; Booth 2003; Duke and Gross 1993; Gerber 2004; Grinspoon and Bakalar 1993; Himmelstein 1983; Lee 2012; Meier 1992; Sloman 1998[1979]; Werner 2011). In the first case, the drama that preceded the adoption of the MTA cemented the federal government's control over the drug (as opposed to state control), and positioned the marijuana issue as one of morality as opposed to science. In the second case, the

fierce and nearly two decade-long battles that ensued after the CSA was instituted not only reinforced the federal government's power over the drug, but prioritized ideology based in morality over science in being more salient to marijuana debates. In both cases, victims, villains, and heroes emerged, interested parties grasped for bureaucratic power, state governments looked to the federal government for reassurance, and morality was pitted (and won) against science.

Most scholarly accounts of the history of marijuana policy (and ideology) tell the story of marijuana chronologically, focusing initially on its entrance into the United States from Mexican immigrants in the early 1900s, and often culminating, if not in the present, in the unsuccessful battle in the 1970s and 80s to get marijuana rescheduled as a less severe drug under the CSA. The two time periods, on their surface, seem to be very different and incomparable, as will be detailed in the following section. Although each have led to the construction of marijuana as dangerous and threatening to American society (as will be demonstrated later in this chapter), and each have imposed heavier sanctions on the drug, the policies were enacted in very different political and historical contexts with seemingly different constructions of who the heroes, villains, victims, and opponents were in the fight against the evils of marijuana. But the fundamental battles remained the same.

> The core of cultural history is its attention to the making of meaning – to how people in the past made sense of their lives, of the natural world, of social relations, of their bodies. This definition [of cultural history] suggests that meaning is not inherent, that it does not reside within a text or a practice, waiting to be called on. Meaning is not uniform or transhistorical or even apparent. It must be made, and *"making" is not an easy or simple process; it admits of struggle, perhaps even of contest*. Meanings that are made can be unmade and remade. (Fissell 2004: 365, *emphasis added*).

While the specifics of the meanings given to marijuana, its users, science, and morality may have differed across these time periods, the same basic struggles were waged in the 1930s/40s and the 1960s/70s. After establishing the specific histories, the lens will be pulled back, focusing not on the details, but on the *patterns* of these struggles that led to the adoption of very similar policies. A pattern can be seen in the way these battles were waged. First, states began the call for attention to the issue of marijuana, followed by the federal government stepping in and taking control. Entrepreneurs who were both invested in the issue (for any number of reasons) and who were linked to the power of a federal bureaucratic organization were able to lead the charge in battle. Users were constructed as an enemy to the nation. And, to clinch the outcome of the war, science was delegitimized by morality.

There are two major sections in this chapter. First, the historical details of the passage of the MTA and CSA will be chronicled, adding contextual understanding to these policy outcomes. Then, the time periods will be compared to each other, highlighting the often concealed similarities in the struggles and processes of policy adoption. In order for the war against marijuana to have been won in each of these two time periods, four similar mini-battles were waged: state and federal government rallied for control, entrepreneurs competed for power, the image of the user was challenged and constructed, and science was pitted squarely against morality.

HISTORIES OF MARIJUANA POLICY

The Path Leading up to the Marihuana Tax Act of 1937

In 1937, Harry J. Anslinger, head of the Federal Bureau of Narcotics (FBN), won a major victory. He was on a mission to protect U.S. citizens from what he saw as evils of an addictive drug: marijuana.

> How many murders, suicides, robberies, criminal assaults, holdups, burglaries, and deeds of maniacal insanity it [marijuana] causes each year, especially among the young, can only be conjectured. The sweeping march of its addiction has been so insidious that, in numerous communities, it thrives almost unmolested largely because of official ignorance of its effects. (Anslinger and Cooper 2004: 115, originally written 1937).

Anslinger used scare tactics, catchy rhetoric, (arguably skewed) data, and the media (the now popular "camp" film *Reefer Madness* was made as part of his anti-marijuana campaign) in order to ensure the passage of the Marihuana Tax Act (MTA). Although this piece of legislation did not make marijuana fully illegal, it assigned such harsh punishments on users and such onerous paperwork for doctors who would consider prescribing marijuana as medicine to their patients, it did, in essence, create an inhospitable climate for any use of marijuana, setting the stage for the prohibition of the drug.

Anslinger did not set out initially to take marijuana under the wing of the federal government's purview. Marijuana made its entry into the United States from the Mexican border around the turn of the century. Although there was little public awareness of marijuana in the United States, certain political and law enforcement officials saw Mexican immigration as problematic, and marijuana, according to some U.S. officials, was just one more example of the harms that our Southern neighbors would bring with them upon entry into the United States.

In the late 1920s, early 1930s, a few politicians from New Orleans, El Paso, and a few other southern cities, were becoming fearful of what they perceived to be a dangerous drug that Mexicans were bringing into their cities. Local politicians wanted help from the federal government, and so decided to try to convince Anslinger, the commissioner of the newly formed Federal Bureau of Narcotics (FBN), that it was in the nation's best interest for the federal government to take charge of marijuana policy. (Belenko 2000; Bonnie and Whitebread 1999; Booth 2003; Fox, Armentano, and Tvert 2009; Himmelstein 1983; Sloman 1998[1979]). As the head of a newly structured agency, Anslinger's budget was tight, and he was afraid if the FBN had to take on one more issue it would stretch the resources and the power of the organization too thinly. Instead, Anslinger decided to push for legislation that would offer a standardized suggestion for how each state was to handle the marijuana issue. This became known as the Uniform Narcotics Drug Act (UNDA). Although there was some minor squabbling over some of the details, the public was largely unaware of the marijuana issue, and it was quietly passed in October of 1932. States now had guidelines by which to draft their own state-wide legislation against the new drug, and Anslinger pressured states to do so. (Bonnie and Whitebread 1999; Booth 2003; Himmelstein 1983; Lee 2012; Sloman 1998[1979]).

Although there is little evidence to demonstrate that there was widespread use, or even that most Americans even knew what the drug was (Bonnie and Whitebread 1999; Himmelstein 1983), Anslinger went on a campaign against the drug, rallying support for his UNDA. Using the FBN's close ties to the media and the American Medical Association, a vociferous media campaign against marijuana was underway in the mid-

1930s. Stories found their way to the newspapers telling stories of murder, insanity, rape, and a host of immoral activity, all caused as a result of "tea", "reefer", marijuana. Although only about 10 states had passed the UNDA by 1934, Anslinger's media blitz was so successful, that only a few years after UNDA had passed, enough attention had been raised regarding the dangers of marijuana, calls began to get louder for a centralized federal policy against the drug.

With some voices speaking out against the FBN (because it could not get the "marijuana problem" in check), and with threat of budget cuts, some scholars argue that Anslinger now saw marijuana as a way to justify the existence of the bureau (Becker 1977; Bertram, Blachman, Sharpe, and Andreas 1996; Bonnie and Whitebread 1999; Booth 2003; Duke and Gross 1993; Grinspoon and Bakalar 1993; Himmelstein 1983; Isralowitz 2002; Lee 2012).

> Anslinger didn't pay much attention to cannabis until 1934, when the FBN was floundering. Tax revenues plummeted during the Great Depression, the bureau's budget got slashed, and Harry's [Anslinger's] entire department was on the chopping block. Then he saw the light and realized that marijuana just might be the perfect hook to hang his hat on. (Lee 2012: 49).

In order not to step on the toes of the then powerful hemp industry, and so that the legislation would not conflict with the Harrison Act of 1914[1], the Marihuana Tax Act of 1937 was based on the National Firearms Act. It did not outlaw the drug, but was instead, a piece of legislation focusing on stiff transfer taxes, serving, in essence, as a prohibitive tax law against the drug. (See, for instance, Bonnie and Whitebread 1999; Booth 2003; Fox, Armentano, and Tvert 2009; Grinspoon and Bakalar 1993; Herer 2010; Sloman 1998[1979]). There was little fanfare when the bill was reviewed by the House

[1] The Harrison Act, passed in 1914, was a way for the government to tax and regulate the sale and possession of opiates. (See, for instance, Bertram et al. 1996; Bonnie and Whitebread 1999; Dickson 1977; Fox, Armentano, and Tvert 2009; Himmelstein 1983; Lee 2012; Meier 1992; Sloman 1998.)

Ways and Means Committee before its passage. Serving as the spokesman for the American Medical Association, W.C. Woodward was the only voice to be heard that stood in opposition to the bill. Testifying at the House Ways and Means Committee hearings, Woodward, the legislative counsel for the American Medical Association (also a physician), was the only witness presented who called for "less restrictive legislation on the grounds that future investigators might discover substantial medical uses for cannabis," (Grinspoon and Bakalar 1993: 9). There was hostile reaction to his testimony and his claims were later dismissed as being the sour grapes of a man who was not asked to help draft the legislation. Woodward's protestations were quickly rebuffed by the Committee, continually referring to Anslinger's "evidence" (mostly media reports for which he was the main source) that has now been shown to have been falsified. (Bonnie and Whitebread 1999; Booth 2003; Fox, Armentano, and Tvert 2009; Grinspoon and Bakalar 1993; Herer 2010; Himmelstein 1983; Sloman 1998[1979]).

Throughout the late 30s and 40s, Anslinger's campaign to blacken the reputation of marijuana worked so successfully that the rhetoric of the harms of marijuana use (to individual users and society) have been constructed as being so real that they have stood the test of time and have withstood scientific evidence that demonstrated otherwise. Just after the passage of the MTA, New York City's Mayor Fiorello LaGuardia wanted to look more scientifically at the possible harms (and medical benefits) of marijuana. His committee of doctors, city officials, and other public health and scientific experts concluded in their findings first published in 1945 that "marijuana was not addicting, did not seriously disturb mental or physical functioning, and did not lead to violence or harder drugs," (Bertram, Blachman, Sharpe, and Andreas 1996: 82). Although the AMA

initially stood behind and defended the committee's findings (and published reports in its own journal), the FBN, led by Anslinger, pressured the AMA until it withdrew its support for marijuana and took a public and punitive stance condemning the drug. (Becker 1977; Booth 2003; Dickson 1977; Grinspoon and Bakalar 1993; Herer 2010; Lee 2012; Werner 2011).

After the passage of the MTA in 1937, Anslinger used all of the powers available to him to seek out and vilify any user or assumed user of the drug. He went on a personal vendetta against jazz musicians and immigrant groups. Although arrests for marijuana use went up dramatically after the act was passed, the marijuana "problem" was quickly put to rest. (See, for instance, Bonnie and Whitebread 1999; Booth 2003; Herer 2010; Himmelstein 1983; Isralowitz 2002; Sloman 1998[1979]).[2]

The MTA is often cited as the work of one man who vilified a drug so successfully it became the popular image of the drug for years to come (and perhaps still, for some groups). The drug became linked with lower class users (immigrants, musicians, any perceived threat to society), and was, for the most part, unknown to most Americans until the media told them it was a problem about which they should be worried. Anslinger and federal policies became the "natural" answer to the marijuana "problem".

The Controlled Substances Act of 1970

In contrast to the lack of public awareness of the problems with marijuana in the 1930s, there was plenty of awareness (and a moderate amount of acceptance) of marijuana in the 1960s and 70s. The political and social context that served as a

[2] Anslinger continued his mission against marijuana into the next few decades, once again, creating a "problem" that he could use the bureau to "fix". The Boggs Act of the 1950s is another example of ever increasing sanctions against the use of marijuana.

precursor to the Controlled Substances Act of 1970 seemed to be in complete contrast to Anslinger's version of marijuana as a drug that created immoral, dangerous monsters who set out to harm other functioning members of society. Marijuana use was on the rise in the '60s, and social acceptance was more widespread, including across different sociodemographic groups than had been seen in the past. "By 1967 use of the drug [marijuana] was associated in the public mind with life on the campus," (Bonnie and Whitebread 1999: 223). Middle class youth, with access to resources and perhaps more power than in the past (mostly in the form of professional parents), was the group most associated with the user category. Referring to this period in the drug's history as the "embourgeoisement of marihuana", Himmelstein (1983) notes that, unlike in the past, marijuana users were both political actors and a political audience who could use their own power, and that of their professional parents, to sway public opinion.

The political climate of the 1960s would seem to indicate that the country was ready to rethink the uncompromising stance toward marijuana. Rhetoric of the drug was focused not around its link to criminality, but instead was seen as an issue of public health, supported by popular media as well as the American Medical Association and other notable organizations. President Kennedy not only forced Anslinger to resign, but organized a commission in order to investigate the link between marijuana and violent crime and/or hard drugs. According to the commission, no link was found. (Bonnie and Whitebread 1999; Booth 2003; Gerber 2004; Herer 2010; Lee 2012; Sloman 1998[1979]). This commission seemed to open the door to other scientific research on the drug. "In the laboratories and on the campuses medical researchers were gradually

permitted to seek answers to the basic scientific questions [about marijuana]," (Bonnie and Whitebread 1999: 230).

As responses toward marijuana were changing, and even while the Kennedy White House seemed to be looking to loosen its grip of the drug as a federal crime, the FBN, led now by Henry Giordano, and other law enforcement agencies, including Hoover's FBI dug in their heels and continued to propagate the idea that marijuana and crime are inextricably linked. There was a considerable amount of tension and conflict between the strict stance of enforcement agencies and the attempts for political actors to be more lenient. This tension was ever present when part of the Health, Education, and Welfare Department (HEW) joined with the FBN to form the Bureau of Narcotics and Dangerous Drugs (BNDD) in 1968. This new structure to oversee drugs (which eventually becomes today's DEA) did not have the history the FBN had had with harsh penalties for users, and began, at least initially, to target narcotics at the level of distribution instead of use. (Bonnie and Whitebread 1999; Booth 2003; Sloman 1998[1979]). But this would not last.

As a response, in part, to harsh drug penalties that were established in the 1950s[3], and in an attempt to streamline the classification system, and therefore the ways by which *all* drugs are legislated, Congress debated and eventually passed the Comprehensive Drug Abuse Prevention and Control Act in 1970 (also known as the Controlled Substances Act). Under this new federal policy, drugs would be classified into five schedules based

[3] The 1950s saw incredibly harsh policies toward not only marijuana, but all drugs. The harshest policy was, arguably, the Boggs Act, passed in 1951 which increased penalties for the possession and use of marijuana, using the stepping-stone theory as its justification. It was followed in 1956 by the Narcotics Control Act, cementing even harsher federal penalties.

on medical usefulness, potential for abuse, and the likelihood for producing dependence.[4] Perhaps the biggest point of contention in the bill's passage was who would be the final decision maker regarding how a drug should be scheduled. There were some discrepancies between the House and Senate versions of the bill, the former of which would have given the attorney general the final say, although seeking the advice of the secretary of HEW. In the final version, most representative of the House version, the HEW secretary's opinion was binding on the attorney general[5]. Although some of this debate concerned the schedule of other drugs, the placement of marijuana within the scheduling system was at the heart of the debates. To try to address states' calls for more leniency with regard to marijuana (and associated public opinion), and as a way to overcome some of the tension that formed as a result of the clash between the House and Senate, the bill called for a commission to be established that would be responsible for investigating the potential harms (and benefits) of marijuana. In other words, the Controlled Substances Act of 1970 was passed with marijuana classified, perhaps temporarily, in the most dangerous category, Schedule I, with an understanding (and promise to certain groups) that the issue would be studied further and then revisited. The Commission on Marihuana (also known as the Shafer Commission) was to be the group responsible for making recommendations for the final decision on the scheduling of marijuana. (Bonnie and Whitebread 1999; Booth 2003; Gerber 2004; Himmelstein 1983; Lee 2012; Sloman 1998[1979]; Werner 2011).

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[4] Schedule I drugs are completely prohibited because of significant dangers posed from use and the likelihood of abuse. Schedule II drugs are recognized as being those drugs that can have medical use, however only under extreme restrictions. Morphine, cocaine, and methadone are a few examples of Schedule II drugs. Schedules III-V pose increasingly less risk and are less regulated.

[5] Under the new federal structure of agencies, being under HEW, the BNDD, now the DEA, would come to be the agency responsible for scheduling drugs.

Appointing each member on the Shafer Commission, Nixon had formed the committee in order to put an end, once and for all, to the "soft" take on marijuana. (Anderson 1981; Bonnie and Whitebread 1999; Gerber 2004; Lee 2012; Sloman 1998[1979]; Werner 2011). He put together a group of scientists, doctors, politicians, and experts who, he thought, would find unconditionally that marijuana is both morally and scientifically dangerous.

> Nixon handpicked most of the commission members, including Michael Sonnenreich, ex-deputy chief counsel of the BNDD. Stacked with drug-war hawks and chaired by former Pennsylvania Governor Raymond Shafer, a law-and-order Republican, the blue ribbon commission nevertheless took its work very seriously. (Lee 2012: 121).

To Nixon's, and some of its own members' surprise, the commission's findings suggested that marijuana caused little damage and, in fact, could have some, perhaps limited, medical benefits. While emphasizing the need to discourage use, the commission's findings came close to recommending full legalization. In the First Report of the National Commission on Marihuana and Drug Abuse, in 1972, the committee stated:

> Considering the range of social concerns in contemporary America, marihuana does not, in our considered judgment, rank very high. …The existing social and legal policy is out of proportion to the individual and social harm engendered by the use of the drug. (cited in Belenko 2000: 299).

As the commission was coming out with their conclusions, Nixon "denounced the commission's findings on personal grounds," (Gerber 2004: 24). Nixon rejected his own Commission's results stating "I oppose the legalization of marijuana…I do not believe you can have effective criminal justice based on a philosophy that something is half-legal and half-illegal," (quoted in Anderson 1981: 94-95).

Although the Commission's findings favored a more lenient stance toward marijuana, the commission did raise one concern about the impact the drug had on behavior. Their concern, that was supported by psychologists, some in the medical community, politicians, and others, was in direct opposition to the violent and aggressive behavior the drug was said to have caused in the earlier part of the 20th century.

> For the individual, harm resulting from abuse of cannabis may include inertia, lethargy, self-neglect, feeling of increased capability, with corresponding failure, and precipitation of psychotic episodes. … The harm to society derived from abuse of cannabis rests in economic consequences of the impairment of the individual's social functions and his enhanced proneness to asocial and antisocial behavior. (in Bonnie and Whitebread 1999: 228).

Termed the "amotivational syndrome", the dangers of marijuana lay in the fact that those who use marijuana would "drop out" of society and fail to become actively involved in contributing to America as a moral, hard-working, success-seeking nation. Ideology moved from a public safety perspective (keep our children safe from the dangerous and villainous users) to a public health perspective (protect our children who are using from succumbing to the lethargy-creating and success-sucking drug that is marijuana). "[T]he amotivational syndrome did dominate judicial deliberations, congressional hearings, and federal reports on marijuana," (Himmelstein 1983: 126). Although marijuana was said to have made its users turn their backs on their own ambition and, therefore, their ability to contribute to society, it simultaneously became a clear symbol of anti-government sentiment. The drug became linked to youth culture generally, but the anti-Vietnam war movement more specifically. (Anderson 1981; Bertram, Blachman, Sharpe, and Andreas 1996; Bonnie and Whitebread 1999; Booth 2003; Gerber 2004; Himmelstein 1983; Lee 2012; Sloman 1998[1979]; Werner 2011). Nixon and his supporters took full advantage of this connection, pointing out that not

only was the *drug* a danger to society, but those who chose the lifestyle associated with marijuana use were, therefore, enemies to America and must be dealt with accordingly.

The Fight to Reschedule Marijuana

Although the Shafer commission of the early 1970s recommended that states loosen up their tight marijuana policies, few would take on the strong and vociferous anti-marijuana stance of the Nixon Whitehouse, the BNDD, and the FBI. When Nixon left the White House in 1974, it seemed as if the political climate were right to hear other voices who were more sympathetic to the calls for leniency toward marijuana. Ford began, very gently, to step away from Nixon's strict anti-marijuana stance. Carter came on much stronger. He was vocal about his belief that the penalties for using marijuana hurt the user more than the drug did. With a new leader willing to offer new rhetoric regarding other ways to think about how to cope with marijuana, states began to follow his lead.

> By 1978, eleven states with over one-third of the nation's population (Oregon, Alaska, Maine, Colorado, California, Ohio, Minnesota, Mississippi, Nebraska, New York, and North Carolina) had decriminalized marihuana, and a similar change had been formally advocated by President Jimmy Carter on the federal level. (Himmelstein 1983: 104).

In 1977, with support from many state governments, and an energetic, although arguably not politically minded, drug advisor, Peter Bourne, Carter proposed that the federal government "eliminate all federal criminal penalties for the possession of up to one ounce of marijuana," (Gerber 2004: 28). The reaction to such a lenient stance was forceful and vigorous. Law enforcement saw this proposal as a threat to its budget to conduct the drug war, and used its political influence to ensure Congress would not support a strategy that, they contended, would weaken law enforcement in the United

States. Fighting on another front, conservative and well-funded parents' groups such as Families in Action and Parents' Resource Institute for Drug Education (PRIDE) used Bourne's politically naïve and unwise strategy of neither tempering nor mincing words as a way to garner public opinion and lobby Congress for their support. Worried about his political career, Carter backed down and marijuana policy fell off his agenda for the rest of his Presidency. (Anderson 1981; Belenko 2000; Bonnie and Whitebread 1999; Booth 2003; Gerber 2004; Meier 1994; Sloman 1998[1979]).

During the time when the nation was struggling to find a consensual view about how the federal government should treat marijuana, another battle was being waged. Two years after the CSA passed, during the Nixon administration, the newly formed group NORML (National Organization for the Reform of Marijuana Laws) petitioned Congress to re-categorize marijuana from a Schedule I to a Schedule II drug so that doctors could choose to prescribe the drug for patients they deemed would benefit from marijuana. After more than a decade of political and legal wrangling and testimony, and four Presidents later, hearings to reclassify marijuana finally began in 1986 and lasted two more years. Finally, in 1988, after testimony from a number of patients, physicians, scientists, and other groups, Judge Francis J. Young

> said that the approval by a 'significant minority' of physicians was enough to meet the standard of 'currently accepted medical use in treatment in the United States.' He added that 'marijuana, in its natural form, is one of the safest therapeutically active substances known to man…One must reasonably conclude that there is accepted safety for use of marijuana under medical supervision. To conclude otherwise, on the record, would be unreasonable, arbitrary, and capricious,'. (Grinspoon and Bakalar 1993: 15).

Finding fault in Judge Young's words "significant *minority"*, the DEA rejected the findings of its own appointed judge, and refused to reschedule the drug. Although

NORML and other groups tried to fight the DEA's decision, the final word on the subject of reclassification was made firm in March of 1992. (Gerber 2004; Grinspoon and Bakalar 1993; Herer 2010; Himmelstein 1983; Lee 2012; Meier 1994; Werner 2011). Marijuana would stay, as it is today, classified as one of the most dangerous drugs with a high likelihood of abuse, harm, and no medical benefit.

HIDDEN SIMILARITIES: THE *PROCESS* OF POLICY FORMATION

These histories of the two keystone marijuana policies in the United States may lead to the conclusion that, with the exception of both periods ending with moral arguments trumping science in order to establish anti-marijuana policies, there is nothing else in common about these two time periods. By focusing on the chronological telling of the stories and looking at each segment of each story only as it is embedded within its historical and political context, the similarities of the *process* become hidden. In fact, I argue that once the stories are broken down into the lowest common denominators, the similarities of the path to policy adoption, the *processes,* are striking. More specifically, I will show that four mini-battles were waged in order for these policies, in two very different time periods, to have been successfully passed, constructing marijuana as a formidable foe in the war on drugs. The rest of the chapter will be dedicated to showing evidence to support the following four mini-battles.

1. In each of the two time periods of policy construction and debate, there has been a push-pull struggle for control over marijuana between state and federal governments. In order to construct and maintain a consistent view of marijuana as both physically damaging and morally repugnant, states were the first to act, with the federal

government following their lead. Once the control over the drug became centralized in the federal government, there became a standardized understanding of the drug that could withstand pockets of contention. 2. There are a number of prominent actors within the political saga of marijuana legislation who were passionate entrepreneurs, looking to shape the nation's understanding of and reactions to marijuana. But in order to be successful, this individual or group needed to have the backing of powerful bureaucratic organizations linked to the federal government. 3. In the quest to maintain control over the image of the drug, there is a corresponding construction of the user as harmful to the nation. In the two time periods during which the policy battles were waged, there was a swell of new classifications and understanding of the types of people who would use the drug. Whether based in statistical reality or not, rhetoric was constructed that portrayed users as anti-American villains, and *potential* users as innocent victims that the country must rally to protect. 4. Finally, and perhaps most important to understanding why there has been such a struggle for acceptance of medical marijuana today, there has been a consistent silencing of science by arguments that are based within a moral realm.

It is necessary to highlight the similarities in the *process* of medical marijuana legislation by looking at the history not based on chronology, but instead, based in similar battles fought.

State vs. Federal Control

The first of the four battle sites where marijuana policy is waged lies in the process of passing the torch from state and local control to federal control. On the road to federal jurisdiction, the processes of these two very distinctive time periods followed very similar paths. Initially, there existed some movement within a few states that was

idiosyncratic to the states' own circumstances. As attention to the issue begins to grow and the drug takes on particular constructed meanings within the states, there is a diffusion at the state level of related, but inconsistent, policies. Finally, when the trickle of change at the level of state policy turns into a flood, and when the inconsistencies are perceived as being too great, a sense is developed that the issue is one of national scope. The federal government takes final control over the ability to have a singular definition regarding how the nation should respond. Although states have input in the development of policy, the federal government, in the case of marijuana policy, has always had the final say.

As the stories of each of the major time periods of marijuana legislation begin, states in the 1930s and states in the 1960s had very idiosyncratic ways with which to cope with the drug. Only states with an influx of Mexican immigrants had had to respond to marijuana in the 1930s (Bonnie and Whitebread 1999; Booth 2003; Fox, Armentano, and Tvert 2009; Herer 2010; Meier 1994; Sloman 1998[1979]). "Sixteen of the 22 western states, all with some Hispanic population, banned sale or possession of marijuana before 1930," (Meier 1994: 33). These 16 states each had its own distinct marijuana law, relatively unknown to the general public. In the 1960s, as states were coping with increased use by otherwise "respectable" youth, "sentences [for marijuana use and/or possession] could vary greatly, depending on which judge was trying the case," (Sloman 1998[1979]: 231). Although federal policy at the time suggested harsh penalties, some states began to reconstruct the issue as a health concern instead of a criminal one and dealt with marijuana charges on a case by case basis. (See, for instance, Booth 2003;

Herer 2010; Lee 2012). There was an inconsistency, not only across states, but sometimes within states, in reactions to breaking federal law against marijuana.

Although the federal policy in the 1960s remained strict, particularly from enforcement agencies like the FBN (later the BNDD), states began to find creative ways to exercise control over what their citizens perceived to be overly harsh federal penalties. Judges in court cases in Massachusetts and Colorado flouted federal sentencing standards, opting for more lenient treatment, the Governor of Virginia pardoned a local college student from his 25 year sentence for marijuana possession, reducing his sentence to 5 years of probation, and many state judges, enforcement officials, and politicians turned a blind eye to federal policy. (Belenko 2000; Bonnie and Whitebread 1999: 232-239; Earleywine 2002; Gerber 2004; Sloman 1998[1979]).

> While law enforcement authorities were molding their own procedures to the realities of widespread marihuana use, particularly in large cities, the [local] courts had begun by 1969 to take a new view of the propriety of harsh sentences in those marihuana cases which reached the courts. Some judges publicly questioned the prudence of the existing law and pleaded for legislative relief. By 1971 only 13 percent of the judges responding in an opinion survey indicated that they would incarcerate an adult for possession of marihuana; only 4 percent said they would jail a minor. (Bonnie and Whitebread 1999: 239).

While individual states in the 1930s were left to disseminate information about the presence of this "new" drug and figure out how to find the resources to cope with the perceived threat to its citizenry, states in the 1960s were left to manage their own citizens' outcry for more leniency toward marijuana in the face of a federal policy that seemed to be growing increasingly out of date and out of touch. Discussing the inconsistent state laws regarding opium in the early 1900s in America, Duster notes "as with many other problems of this kind, the lack of uniform state laws meant that control was virtually impossible," (1970: 13). And, in fact, in both cases, there was a period of

confusion and unrest during which states grasped for a new standard by which all states could respond to these threats. As inconsistencies in policy mounted, the marijuana problem began to make a move from a local to a national problem.

As early as 1920, the head of the Board of Health in Louisiana wrote a letter to the Surgeon General of the United States chronicling some of the problems of marijuana and saying firmly, "It seems to me it is imperative that the Federal Government take some action to enforce strict supervision of all drugs coming into this country," (Sloman 1998[1979]: 30). Throughout the '20s, politicians from Texas, New Mexico, Arizona, and Louisiana, particularly, would try to bring national attention to what, at that point, was a relatively unknown local issue. (Bonnie and Whitebread 1999; Booth 2003; Fox, Armentano, and Tvert 2009; Himmelstein 1983; Sloman 1998[1979]). Anslinger did not want the marijuana problem under his purview initially (for reasons that will be discussed later in this chapter), so, instead, he tried to answer the calls for consistent policy by pushing for (and passing) the Unified Narcotics Drug Control Act. His goal was to raise awareness within states so that they could model a policy based on this federal recommendation. Thus began Anslinger's now infamous campaign against the "marihuana menace", to arouse public sentiment and rally state-level action. And citizens and local politicians listened. Anslinger was so successful at convincing states that marijuana was a problem, it became irrational NOT to have the drug under federal control. The MTA of 1937, then, was a response to pleas for a truly unified and federally controlled national policy for marijuana.

While state policy in the 1960s and 70s became increasingly liberal, federal responses to marijuana, both before and after the CSA was passed, grew increasingly

polarized and muddied. Similar to the context in which the MTA was passed, it was the growing inconsistency and lack of clarity about how to cope with the problem that was at the heart of the final scheduling of marijuana as a Schedule I dangerous drug in the eyes of federal law. The Kennedy and Carter administrations, at least initially, were vocal about their fears that federal penalties for marijuana were disproportionate to the harms caused by the use of the drug. In 1961, host John Crosby aired an episode of his talk show that called for the legalization of marijuana. Even in times of more acceptance, Anslinger, still the head of the FBN, was outraged that such a perspective was voiced on such a public stage. He demanded equal time to present anti-marijuana arguments. He was granted his request by the network. (Sloman 1998[1979]).

As the decade wore on, and as more states blatantly ignored and stood in opposition to the still strict federal policy, the BNDD and Hoover's FBI grew in their resolve to protect the nation from what they saw as a harmful and dangerous substance. These federal enforcement agencies argued that, at the very least, any movement by the federal government toward acceptance would show implicit acceptance of marijuana use, and, at the most, would cause irrevocable harm to the nation. (Anderson 1981; Belenko 2000; Bonnie and Whitebread 1999; Booth 2003; Herer 2010; Himmelstein 1983). As a whole, the federal government's stance toward marijuana was mixed, fickle, and ever-shifting. This lack of a clear message to guide policy is what led to the status quo being upheld when the CSA was passed in 1970.

> Uncertainty and conflict still characterized discussion among experts about the effects of marijuana. Accordingly, the administration chose to perpetuate the classification of marihuana with drugs that were recognized to be more dangerous…Congress meekly deferred to this judgment, but all of the participants seem to have anticipated a change after 'the facts were in'. (Bonnie and Whitebread 1999: 246).

This "after the fact" change was attempted. Since the control of the problem was now squarely in the hands of the federal government, however, it was unsuccessful. Each attempt to reclassify marijuana has been marked by uncertainty, conflict, and inconsistency. States still attempted to pull the reigns of control out of the hands of the federal government. Nixon's Shafer Commission, which was put together in the hopes of silencing any remaining dissenting voices, cementing the federal position on the drug, only added to the nebulous position of marijuana. States slowly began to respond to the Commission's recommendations to relax penalties for marijuana, and in 1973, Oregon became the first state, of many that would follow, to move in the direction of decriminalization. (Bonnie and Whitebread 1999; Sloman 1998[1979]). Vice-President Agnew, the BNDD, and other enforcement agencies were dismayed at the Commission's recommendations and the state-level flight away from federal policy. No one, however, was more vocal in his condemnation of this new, more lenient stance toward marijuana than President Nixon. His determination to uphold the current federal stance to the drug, and the strength of the agencies backing him up, ensured that, as long as there was a strong federal voice, state-level policies would not hold up to the power of the federal government. State laws would come and go, NORML would bring a two-decade long law suit to try to reschedule marijuana, but once the federal government has jurisdiction over the issue, the lack of unity between states is no match for the singular, federal level definition of the marijuana problem and what are constructed to be appropriate responses.

Strengthening Bureaucratic Power

The battle for control over marijuana policy, and therefore the ability to construct the definition of the marijuana issue, extends beyond just the bounds of state vs. federal

political power. Drug policy has the interesting position of falling between different actors and groups who have what they perceive to be a legitimate claim for control. Politicians, law enforcement agencies, scientists and researchers, the medical community, certain industries (hemp and pharmaceuticals, for instance), parents' groups, and other interested citizens all may have a stake in the outcome of marijuana legislation and, therefore, have a reason to vie for power. This overlap in jurisdictional claims can lead to disagreements, power-plays, odd partnerships, and, what can only be described as "turf battles." (Booth 2003; Conrad and Schneider 1992; Dumont 1977; Fox, Armentano, and Tvert 2009; Herer 2010; Mizrachi and Shuval 2005; Room 2005; Werner 2011). In both of the major time periods on the path to federal control, there were actors from many of the groups listed above who felt very strongly about marijuana policy on *both* sides of the issue. There were many passionate, sometimes well informed, and committed groups and individuals who played a role in the marijuana policy construction story. These policy entrepreneurs took the initiative to enter into the debate to try to bring about (or prevent) actual change. But, passion, dedication, and reliable information are not enough to bring support to an issue or gain control over it. Only those actors, entrepreneurs, who felt invested in the cause who had *access to bureaucratic power* at the highest levels of government were able to impact the outcome in the MTA and CSA sagas.

In the battle to control the construction of marijuana policy, there was one group who, as discussed above, had default authority over the drug policy debate and outcomes: powerful federal government agencies. Another commonality between the passage of the MTA and the passage of the CSA (and its eventual scheduling outcome) is the use of marijuana policy as a pawn in order to replicate and/or strengthen the bureaucratic power

structure at the federal level. Anslinger, Nixon, Carter, and others manipulated and used marijuana policy for reasons that were really unrelated to the policy itself: to keep, maintain, strengthen their own bureaucratic power. Lee (2012), Booth (2003), Bonnie and Whitebread (1999), Himmelstein (1983), Becker (1977), and others have argued that the only reason Anslinger became involved in the issue of marijuana in the first place was to solidify the FBN's standing (and budget). Initially, relatively new to the newly formed bureau, Anslinger was reticent about dealing with this "new" drug, even when Southwestern politicians called for help. He was concerned about both his budget as well as the ability to successfully manage such an issue. (See, for instance, Becker 1977; Bonnie and Whitebread 1999; Booth 2003; Himmelstein 1983; Lee 2012; Meier 1994; Sloman 1998[1979]). Were he to focus on the drug and not able to gain control, he would weaken the waning support for his bureau. As Sloman (1998[1979]) points out, "early in his first year in office it was clear that Anslinger did not desire to burden his small staff with the additional responsibility of regulating traffic in a weed that was so widely available," (43). Putting control for this drug in the hands of the federal government was a risk Anslinger was not willing to take.

It was not until the marijuana issue became *useful* to the bureau did Anslinger find a reason to take control. His campaign, aimed at both the general population and local politicians, to encourage states to pass their own policies based on the Unified Narcotics Drug Act was so successful it forced Anslinger's hand. Although the problem of the drug had not grown, the *perception* that it was a problem added pressure to the federal government to step in. This posed a challenge for Anslinger. "Because the marijuana crisis was manufactured by the bureau, action had to be taken so that the bureau would

not be blamed for the policy's failure," (Meier 1994: 36). He turned this potential problem, however, into a way by which to grow the bureau, its reputation, and its budget.

> Within two years of the establishment of the FBN, it was in trouble. The Depression caused a considerable fall in tax revenue and government spending plummeted. The FBN budget was substantially cut. In order to boost his organization, Anslinger had to find a new target – a new drug menace – upon which to peg a budget increase. (Booth 2003: 180).

Instead of being a burden on the bureau, solving the marijuana "problem" (that the bureau created by raising awareness) became the dominant justification for its very existence.

Marijuana, however, had not used up all of its bureaucratic usefulness. In the era of the CSA, marijuana policy was similarly used to be beneficial to the bureaucrat constructed as being "in charge". During his run for the Presidency, in order to bolster his position, Nixon made no apologies for using the drug issue as a representative for much more. "He [Nixon] saw drugs as the *showcase* in the fight against crime, shaping the campaign squarely for the first time on the assumed effects of drug use on national cohesion," (Gerber 2004: 20, *emphasis added*). Nixon was trying to find ways to de-legitimize youthful rebellion that was beginning to stir the nation up in a way that would take away his ability to set the agenda. As will be demonstrated further in the following section, linking marijuana to these protesters as anti-American was a way for him to discredit this agitating segment of the population. *They* were anti-American, *they* were rabble-rousers, and *they* were the marijuana users against whom the nation would be wise to do battle. *He* would use this issue to be the hero, and save the nation from this threat. Nixon was able to align himself with the BNDD and FBI, and use this (faux) unified and harsh stance against marijuana as a tool in his arsenal in order to discredit youthful

"rebels" in the 60s and, later in his presidency, anti-Vietnam war protesters in the 70s. He linked their behavior to something that he regularly reminded the nation was against federal law and, more powerfully, immoral. The marijuana issue helped him fortify his position to be "rightly" against the protesters.

Nixon embraced his strict and unwavering stance against marijuana, and clung to the issue in order to add weight to his power. Carter, on the other hand, had to distance himself from the issue in order *not* to lose bureaucratic power. Early in his Presidency, Carter made very public claims that he was concerned that the punishments for marijuana use were disproportionate to the drug's harm. (See, for instance, Anderson 1981; Belenko 2000; Booth 2003; Earleywine 2002; Gerber 2004; Herer 2010; Meier 1994). He appointed a drug advisor, Peter Bourne, who felt similarly about the issue. Both men shot right out of the gate and tried with, some argue, little political tact, to change federal response to marijuana use 180^{o}. Without full regard for the connection between marijuana policy and the power structure of other federal agencies, Bourne has been accused of having "a trusting naiveté regarding drug politics and the traps in its political minefields," (Gerber 2004: 28). The political climate was such that, at this time, it was not the office of the presidency that held the federal bureaucratic power over drugs, but the offices of strongly aligned law enforcement agencies who were afraid such a dramatic change would threaten their budgets and spheres of control. In addition to a strong opposition from law enforcement agencies, organized and well-funded parents' groups began to pressure Carter to stand back. Although he felt passionately about his cause, it would have been political suicide for him to stand up to these forces. In this case, he upheld the standing current federal policy on marijuana in order to reassure these strong

parties that he was fit for the power that comes with the office of the Presidency. (Anderson 1981; Bonnie and Whitebread 1999; Booth 2003; Gerber 2004; Sloman 1998[1979]).

Entrepreneurial Wrangling for Bureaucratic Power

In the cases above, marijuana policy was used as a tool to strengthen power. In other cases, however, power is used to bolster competing claims of jurisdiction over marijuana. As Conrad and Schneider (1992) note, "the success of [defining behavior as deviant] is decided by who has the power to legitimate their definitions," (20). Both time periods saw the medical and scientific communities, industries, citizens' groups, and politicians and law enforcement as players on the battle field. There was a consistent winner. Power. No matter what the group, no matter what the group's stance, the group or policy entrepreneur(s) with the strongest ties to bureaucratic power at the level of the federal government "won". Without power, an adversary is (more) easily silenced.

Throughout the decades there have been a number of investigations looking into the medical benefits and biological and social harms caused by the use of marijuana (as was discussed in Chapter 2). Even when couched in science, experts' opinions are easily brushed aside and discredited without the support of a powerful bureaucracy backing them up. The tension between the federal government representing an interest in controlling the drug and the medical and scientific communities with an interest in keeping the option of marijuana as a medicine available, at the very least, to study, began early in marijuana's policy struggles. Dr. W.C. Woodward, a physician and lawyer who would serve as the legislative counsel for the American Medical Association (AMA), had done extensive research on marijuana. Although he was tangentially involved with the

bureau and drafting the UNDA, it was his testimony at the hearings of the MTA that gave the bureau reason to construct him as an enemy. The only witness arguing against the MTA, fearing that it would be too restrictive on a drug that had medical benefits, Woodward's testimony was ill-received, gaining hostile and dismissive reactions from members of the Congress. He was silenced at the end of his testimony being told, "You are not cooperative in this. If you want to advise us on legislation you ought to come here with some constructive proposals rather than criticism, rather than trying to throw obstacles in the way of something that the Federal Government is trying to do," (quoted in Grinspoon and Bakalar 1993: 11). (For more of the Dr. Woodward story, see also, Bonnie and Whitebread 1999; Booth 2003; Fox, Armentano, and Tvert 2009; Gerber 2004; Gusfield 1972; Herer 2010; Isralowitz 2002; Sloman 1998[1979]).

The AMA and others representing the medical field have felt the competing and antagonistic pull between the federal government and science throughout the years. After initially supporting a scientific study published in the Journal of the American Medical Association in the 1930s that suggested that marijuana did *not* cause violent tendencies as the federal government was claiming, the AMA received significant pressure from federal forces, including Anslinger's bureau, and eventually rescinded their support. (Bonnie and Whitebread 1999; Grinspoon and Bakalar 1993; Herer 2010; Sloman 1998[1979]). After the passage of the MTA, New York City Mayor Fiorello LaGuardia put together a group composed of scientists, law enforcement, and city officials, to investigate the currently constructed conception of marijuana as being harmful and dangerous. The commission found no support for these claims, but instead suggested that it was not a very harmful substance. Initially accepted by the medical community,

Anslinger went on a campaign to silence the doctors who were the spokesmen for the findings. Once again, the Journal of the American Medical Association, which had originally published and supported the work, backtracked and, under pressure from the federal government, withdrew their support from the study.

In the 1960s, in an attempt to gain control over marijuana, Dr. John Goddard, head of the FDA attempted to take advantage of the resources made available to him as head of a federal agency, and conducted a series of investigations into marijuana. He made persistent and vocal claims that marijuana does little to no harm and users should not be criminalized. He was no match for the combined forces of the FBN and HEW, however. Commissioner Giordano, Anslinger's replacement, vilified Goddard who eventually, under pressure, resigned from his position. (Bonnie and Whitebread 1999; Himmelstein 1983). In discussions leading up to the classification of marijuana just prior to the passage of the CSA, Dr. Yolles, Director of the National Institute of Mental Health also attempted to get the voice of science and medicine heard. He presented Congress with "myths" and "facts" about marijuana and became a very outspoken spokesman for a softer response to marijuana use. Not long after his testimony in front of Congress, he was dismissed from his position. (Bonnie and Whitebread 1999). In each of these cases, the power of scientific findings found no bureaucratic support and were summarily delegitimized and dismissed.

Even community-based groups were only heard if their fight was on the "right" side, the side with power. Early in the campaign against marijuana, the Women's Christian Temperance Union (W.C.T.U.) "carried on [an anti-marijuana] campaign – including propaganda, attacks on its critics, and legislative lobbying," (Dickson 1977:

37). Helping Anslinger in his call for attention to the drug, the W.C.T.U. published pamphlets and disseminated information about the sins of the "reefers". (Bonnie and Whitebread 1999; Booth 2003; Dickson 1977). A similar group was successful in aligning with the federal cause against marijuana in the 70s. Although Carter was proposing a pro-marijuana campaign, powerful federal agencies stood up to him at every turn. Recognizing their natural ally with law enforcement, concerned parents formed "Families in Action" and PRIDE ("Parents' Resource Institute for Drug Education"). As policy entrepreneurs, these parents' groups used the bureaucratic power of the BNDD and the FBI and are credited not only for halting progress of the pro-legalization movement, but also for getting Bourne to resign. (Belenko 2000; Bonnie and Whitebread 1999; Booth 2003; Gerber 2004; Meier 1994; Sloman 1998[1979]; Werner 2011). Although NORML had its own highly functioning bureaucratic agency that had access to vast amounts of resources, enough to wage a two-decade long law suit against the government in an attempt to reschedule marijuana, the group struggled to find an ally in the federal government. (Bertram, Blachman, Sharpe, and Andreas 1996; Booth 2003; Gerber 2004; Grinspoon and Bakalar 1993; Herer 2010; Sloman 1998[1979]; Werner 2011). No amount of resources, research, evidence, or lawyers, would be able to counterbalance the weight of the DEA, Presidential offices, and other federal groups standing in the way of their plight. Power won.

Money does matter, however, when it comes in the form of industries tied to political groups. Yet another reason that Anslinger initially did not want to take on the issue of marijuana at a federal level lay in the support he would lose from the pharmaceutical and hemp industries (Booth 2003; Herer 2010; Lee 2012). In the 1930s,

the hemp industry was a lucrative business, and doctors were still allowed to prescribe marijuana as a medicine (although few did), giving profits to the pharmaceutical industry. Making an enemy of these industries would be unwise. By 1937, the bureau had found a new and just as lucrative ally in another related industry. Some have suggested that the "Marijuana Tax Act of 1937 was passed at the urging of distillers and brewers in order to eliminate marijuana as a competitive intoxicant," (Meier 1992: 44). There was no lucrative industry that could claim the profits of marijuana. Although synthetic THC was rescheduled as a Schedule II drug in 1985, with pharmaceuticals in the corner of the drug, the natural form of marijuana did not garner industry support (Booth 2003; Fox, Armentano, and Tvert 2009; Werner 2011). Telling of his testimony at the BNDD during the attempt to reschedule marijuana after the passage of the CSA, Dr. Grinspoon recalls that another drug, pentazocine, was downgraded to a Schedule IV drug even though "testimony indicated several hundred cases of addiction, a number of deaths from overdose, and considerable evidence of abuse," (Grinspoon and Bakalar 1993: 14). Following the success of that drug, marijuana had no cases of overdose or medical claims of addiction, but marijuana was kept as the most severe Schedule I drug. The author reflects, "might the outcome have been different if a large drug company with enormous financial resources had a commercial interest in cannabis?" (ibid).

The success of the MTA and the CSA rested on the shoulders of power. Whether being used as a tool to keep and/or strengthen power, or whether groups struggle to find someone who will stand in their corner who has power, without a connection to a powerful federal bureaucratic agency, one's entrepreneurial commitment to an issue may go unheard.

Anti-American Users

It is not enough for those in power merely to *silence* their adversary. While relationships were being negotiated and groups were vying for power, entrepreneurial claims-makers needed to manage the image of the *user*. In his book looking at the Temperance Movement of the 1920s, Gusfield explains that "gestures of differentiation" are a way by which those in power can distance themselves and "society-at-large" from those they deem to be dangerous or immoral.

> Such gestures of differentiation are often crucial to the support or opposition of a government because they state the character of an administration in moralistic terms. They indicate the kinds of persons, the tastes, the moralities, and the general life styles toward which government is sympathetic or censorious. They indicate whether or not a set of officials are 'for people like us' or 'against people like us.' It is through this mechanism of symbolic character that a government affects the status order. (Gusfield 1972: 172).

Although the details regarding the constructions of the user were vastly different in the 1930s and the 1960s/70s, in both time periods marijuana users were constructed as being a threat to the American way of life. By vilifying the drug's users, and its associated proponents, the group in power can symbolically and more powerfully demean the status of those groups, effectively vilifying the drug itself.

The differences between the constructed users of the 1930s and the 1960s/70s are abundant and apparent. The demographic differences alone may lead one to conclude that there would be no way by which to compare the treatment of the users in these two time periods. Mexicans coming across the border in the early part of the 20th century were lower class, not well educated, and had limited English skills. This group was already marginalized and seen as an unwelcome, although hard-working, part of the labor force. They were assumed to be a violent and criminal element that was infiltrating

American society, although modern analyses of the data do not support these claims made then. (See, for instance, Bonnie and Whitebread 1999; Gerber 2004; Grinspoon and Bakalar 1993; Herer 2010; Himmelstein 1983; Isralowitz 2002; Lee 2012; Meier 1994). In 1929, President Hoover appointed a commission that became known as the "Wickersham Commission" to study crime in the United States. In the final report, a significant amount of attention was given to "Crime and the Foreign Born", focused primarily on the (alleged) dangers of Mexicans.

> Much of this volume ["Report on Crime and the Foreign Born"], in turn, was devoted to an examination of the incidence of criminality among Mexicans. Anti-Mexican feeling was running high; and the Wickersham research was undoubtedly triggered by a widely shared belief that Mexican laborers were responsible for a disproportionate number of violent crimes. (Bonnie and Whitebread 1999: 71).

On the other hand, those to whom the drug was attached in the middle to late part of the 20th century were middle-upper class and highly educated. Marijuana was seen as the drug of college campuses, linking the drug to a class of youthful users who had access to political power and had the numbers and resources to make a difference in policy. Unlike the image of Mexican migrant workers "taking" jobs from good Americans, users in the 60s and 70s were seen as problematic because they were *not* contributing to the labor force in a meaningful way. In direct contrast to the violent imagery of Mexican users, the subculture linked to marijuana around the time of the passage of the CSA was seen as non-violent, apathetic, and lazy. The medical community began referring to the "amotivational syndrome" as the effect of marijuana on an individual that leads to "a condition of wakeful sleep," (Gerber 2004: 80). Begun by two Philadelphia psychologists, the amotivational syndrome became accepted as a diagnosis for this group of drug users. (See, for instance, Booth 2003; Gerber 2004; Himmelstein 1983;

Isralowitz 2002; Meier 1994; Sloman 1998[1979]). As the war in Vietnam got underway and continued, these apathetic and "drop-out" users were given more agency. Already conflated with the "hippie" culture, now marijuana using hippies were not just "dropping-out", but were becoming a cancer to the administration. "Pot and political protest went hand in hand in the cacophonous Sixties," (Lee 2012: 93).

> Many such conservatives identified marijuana with threats to patriotism and American security. It was no coincidence, they believed, that many of the people who were protesting the Vietnam War were also using and promoting marijuana: at the root of both was a fundamental contempt for traditional American values. (Bertram, Blachman, Sharpe, and Andreas 1996: 98).

Marijuana became a powerful symbol that was used as a tool to discredit its users, their lifestyle choices, and their political stances. In doing so, marijuana as a drug became discredited as well. Even when the stories of these two decades are told as two very different chapters in the book of marijuana policy legislation, claims of marijuana as a symbol to solidify one group's control over another are recurrent themes in the literature. The details vary dramatically, but the story remains the same.

> The official war on pot shows repugnance at the cultural by-products of its users: long hair, hippie lifestyles, jazz, pacifism, and a closet full of other antiestablishment discomforts annoying the religious and cultural right. For Commissioner Anslinger, the worst of pot's threats resided not in its medical harm but in its assumed incentive to the violence, jazz, and sexual misconduct he generously ascribed to pot-using minorities, especially Hispanics, blacks, and other "foreigners". His greatest fear, it turns out, resided not in marijuana but in "The Other." (Gerber 2004: 139).

The passage above can be applied to either decade. Constructing an enemy of an "other" is a tangible way by which to rally public opinion against threats to a more civilized society, and ensure that not only is the drug perceived as harmful, but the people attached to the drug are as well. In order to ensure these groups were constructed as such, and to wage a battle against the drug and warrant the passage of anti-marijuana

legislation, media campaigns were organized to demonize Mexicans and jazz musicians in the 1920s and 30s and the counterculture of youthful rebels in the 1960s and 70s. In a study looking at the media coverage of marijuana issues across the decades, Himmelstein (1983) finds that 85% of all articles about marijuana between 1935 and 1940 make claims that marijuana is associated with violence. Although violence claims were only mentioned in 2% of articles on marijuana between 1964 and 1976, "the danger most commonly attributed to marihuana in the 1964-1976 period, however, was the 'amotivational syndrome'," (ibid: 125). The actual behavior that was attributed to the user did not matter. Instead, "criminal laws prohibiting drug use emerged at various points in history precisely when demographic shifts encouraged policies designed to control populations perceived to be threatening," (Jenness 2004: 152). As long as the administration, law enforcement, media, parents' groups and others propagate the perception that a group of user was threatening to the nation, a group's potential power was undermined, adding weight to the position of those in power. By doing so, the image of the drug, its users, and its wider meaning to society could be controlled and managed by drug policy entrepreneurs who were backed by bureaucratic power. Stigmatizing and marginalizing a group in a way that made contextual and political sense, delegitimized the stance of the opponent and put them on the defensive as a newly constructed enemy to the American way.

> At times of social conflict or stress, the drug use of a socially subordinate group may become a symbol of the threat that this group poses to a relatively dominant social group or to the dominant social order. Legislation against drug use thus may become a way of reasserting the legitimacy of the existing social hierarchy and the hegemony of dominant social groups by symbolically condemning those groups that threaten that hierarchy and hegemony. (Himmelstein 1983: 15).

The Battle between Science and Morality

As entrepreneurial bureaucrats compete for power to construct the drug user and by relational proximity their opposition as a threat to the social order, a battle for control over the ideological paradigm is also underway. Just as there are many groups fighting for control over the drug, and therefore policy outcomes, each of these groups uses a different rhetoric set by which to frame the social issue. As has been demonstrated in Chapter 2 and the history of marijuana policy above, there were many points along the path to marijuana legislation that, if policy were merely a reflection of scientific inquiry, the prohibition of the drug would have been lifted on more than one occasion. The voice of science was silenced consistently throughout the years. By controlling the realm of rhetoric, the policy has been managed and controlled.

Early in the battle for marijuana legislation, in the June 1937 edition of the Journal of the American Medical Association, the AMA published their opinion that

> there is positively no evidence to indicate the abuse of cannabis as a medicinal agent or to show that its medicinal use is leading to the development of cannabis addiction. Cannabis at the present time is slightly used for medicinal purposes, but it would seem worth while [*sic*] to maintain its status as a medicinal agent for such purposes as it has now. There is a possibility that a restudy of the drug by modern means may show other advantages to be derived from its medicinal use. (*Quoted in* Belenko 2000: 151).

In response to Dr. Woodward's testimony, the legislative counsel for the AMA and the only expert testifying in support of medicinal use of the drug at the hearings for the MTA, Representative John Dingell chided Woodward at one point saying, "the medical profession should be doing its utmost to aid in the suppression of this curse that is eating the very vitals of the Nation," (Grinspoon and Bakalar 1993: 10). Answering calls for more scientific inquiry into the harms (and possible medical benefits) of

marijuana, the LaGuardia Commission of 1944, the Kennedy Commission in the 1960s, the Shafer Commission of the 1970s, and other studies performed by the medical and scientific communities all reached similar conclusions. Marijuana has not been found to be addictive. Marijuana does little to no biological harm to the body. The link between marijuana and crime is complicated by the criminality of the drug. In short, the punitive stance toward marijuana is *scientifically* unjustifiable. Even in Judge Young's recommendation to reschedule marijuana under a lesser schedule, he referred to scientific and medical opinions as a way to support his conclusion. (See, for instance, Bonnie and Whitebread 1999; Booth 2003; Dumont 1977; Gerber 2004; Grinspoon and Bakalar 1993; Herer 2010; Himmelstein 1983; Lee 2012; Meier 1994; Sloman 1998[1979]; Werner 2011).

Through political pressure from the FBN, with Anslinger at the helm, the AMA quickly backed off of its support for medical marijuana in the mid-late 1930s, later publishing opinions that were more consistent with the bureau's: that the harms caused by marijuana were related to its breakdown of society. The AMA stepped away from science. As each of the major scientific studies went public with their research, there was an immediate and robust response to the findings. These responses, however, were not meant to counter the science, or even to call into question the methods of the science. Instead, the science was easily dismissed through the use of moral arguments. In the 1930s and 40s, the bureau countered growing scientific claims that marijuana does little harm by increasing its propaganda machine touting the connection between use of the drug and crime, despite a lack of evidence to support it. In anticipation of the Commission's "surprising" findings and conclusions, Nixon pre-empted their publication

stating "I can see no social or moral justification whatever for legalizing marihuana. I think it would be exactly the wrong step. It would simply encourage more and more of our young people to start down the long, dismal road that leads to hard drugs and eventually self-destruction," (Bonnie and Whitebread 1999: 256). By linking marijuana to behavior that is perceived as *wrong*, whether it is violence, crime, apathy, or protesting against one's own government, the science is left irrelevant. Grinspoon and Bakalar (1993) point out that harsh legal penalties against marijuana are set in place in order to "[contain] what is believed to be a threat to the social fabric and moral order," (164). Who would choose the side of science when that side is perceived as being anti-American and immoral?

Constructing marijuana as an issue of morality, instead of just an objective focus for scientific inquiry has been instrumental in the path to marijuana legislation. Although there may be different justifiable sides in a scientific debate, no one is in favor of violence or the disintegration of American youth. The groups who have had the power to construct the rhetoric have, in both time periods, constructed an issue of consensual morality. "And consensus morality policy is especially amenable to entrepreneurial activity because of the lack of risk to the entrepreneur of significant opposition and the ease of demonizing the target of the policy," (Mooney and Lee 2000: 226). A bureaucratically powerful entrepreneur using consensual morality as a tool instead of science, therefore, is more easily able to marginalize and wield power against the marijuana user and other political opponents, helping to ensure that marijuana legislation falls on the "right" side of morality.

MOVING FROM HISTORY TO THE PRESENT

Taken together, marijuana policy was only successful when these four battles were waged at the same time. With these four forces conjoining, the path to the policy process was set. Even in two vastly disparate time periods that seem incompatible, the *processes* took the same shape. No matter the political or social climate, no matter the construction of the drug, federal agencies gained control, policy advocates aligned with bureaucratic power, users were constructed as enemies of the nation, and moral rhetoric was at the forefront of the policy debates. As attention is moved back into the current battles for marijuana as medicine, understanding this *process* of four converging battles will be a useful tool in analyzing today's policy debates and outcomes.

Chapter 4:
Quantifying Morality

LAYING THE GROUNDWORK

A Shifting Foundation

Until the mid-late 1990s, the historical context that was outlined in the previous chapter provided a solid and seemingly unmovable foundation for marijuana policy. Marijuana held its status as enemy drug from the CSA of the 1970s, and, in many cases, penalties for marijuana use, possession, and distribution increased in the 1980s and beyond. The Reagan and Bush years brought with them increased spending and laser-sharp aim in the war on drugs, marijuana constructed as one of the most insipid enemies. (Bertram, Blachman, Sharpe, and Andreas 1996: 43; Fine 2012; Fox, Armentano, and Tvert 2009; Gerber 2004; Lee 2012; Werner 2011).

> In order to justify the increased expenditures and expanding militaristic incursions into the lives of otherwise law-abiding citizens, Reagan…poured hundreds of millions of dollars into…expanding law enforcement's power to persecute marijuana users, growers, importers, and vendors. (Werner 2011: 84).

Beginning with Nancy Reagan's "Just Say No" campaign, and continuing into the Clinton administration, during which "funding for the military's drug-enforcement activities increased from $357 million in 1989 to more than $1 billion in 1992," (Bertram, Blachman, Sharpe, and Andreas 1996: 115) the war against marijuana continued to be a war of morality. As President Clinton was heading into his re-election campaign in 1995, he began a $1 billion dollar public relations campaign against drugs, depicting lethargic, irresponsible, and, in some cases, almost evil users of marijuana in the ad campaigns run against marijuana (Gerber 2004: 52).

> In 1998, federal legislators enacted the Drug-Free Media Campaign Act, creating what would eventually become the National Youth Anti-Drug Media Campaign. Improving upon the initial $175 million annual funding request from PDFA [Partnership for a Drug-Free America], the Act authorized $195 million a year for five years. (Congress eventually provided the drug czar with $930 million of that potential $975 million amount.) In the six years that followed, Congress allocated some $600 million more in funding. The vast majority of this money was used to produce and air public-service announcements demonizing marijuana use. (Fox, Armentano, and Tvert 2009: 86).

Law enforcement also continued to be on the prowl in the 1990s. During the Clinton administration, even while the President appeared to take a softer ideological stance toward marijuana than his two predecessors, "there were more arrests for pot use in 1998 than for murder, rape, robbery, or aggravated assault combined, costing in 1996 alone some $13 billion just for pot arrests, approximately $21,400 for each one," (Gerber 2004: 55).

As drug war spending was reaching historical heights during this time period and the climate for marijuana seemed increasingly hostile, a new trajectory began to stir, taking the form of some states' acceptance of marijuana as a medicine. In 1996, as President Clinton's anti-drug ad campaign was picking up speed, California became the first state to pass legislation favoring medical marijuana. Proposition 215, the Compassionate Use Act, passed as a state wide voter initiative with 55.6% favoring the legislation and 44.4% voting no. Since that landmark vote, 20 other states plus Washington, DC have passed laws favorable to medical marijuana (one of which, Minnesota, was vetoed by the state governor), and many more heard state wide debates and have had a bill find its way, although unsuccessfully, to the legislative floor.

Taking the seemingly inhospitable federal level climate into account, why has there been such a push for some states to allow for the legal use of marijuana for medicinal purposes? By taking a statistical glance at the differences between states that have passed

medical marijuana legislation and those that have not, patterns of adoption will be uncovered, adding insight not only to the picture of medical marijuana today, but also to the morality policy literature.

QUANTITATIVE VIEWS IN THE LITERATURE

Intrastate and Interstate Policy Adoption Forces

Many policy scholars use quantitative analyses either to predict the likelihood that states with particular characteristics will pass a piece of legislation or, more commonly, to determine the force(s) that have (had) the most significant effect in influencing the outcome of legislation. Researchers are most likely to take a retrospective glance at the policy adoption/innovation process, explained by statistical descriptions of quantitative characteristics. Much of the policy literature looking at innovative public policy adoption distinguishes between two types of data analyses as predictive or illustrative models: diffusion of the policy *across* states (interstate diffusion) (for instance, Boehmke and Witmer 2004; Greenberg 1977; Hays 1996; Karch 2007; Renzulli and Roscigno 2005; Shipan and Volden 2006; Shipan and Volden 2008; Volden, Ting, and Carpenter 2008) and *intra*state[1] demographic characteristics (such as, Berry and Berry 1990; Daley 2007; Daley and Garand 2005; Hays and Glick 1997; Meier 1994; Mooney and Lee 1995; Soule and Earl 2001). Often treated as separate bodies of literature, some scholars have highlighted the complimentary function of thinking about policy innovation as it is prompted both by internal characteristics as well as diffusion across states (Berry and Berry 1990; Renzulli and Roscigno 2005; Soule and Earl 2001). Because of the nature of the data in this analysis, I

[1] Also referred to as internal determinants, the term "intrastate" is "a term borrowed from the policy literature" (Soule and Earl 2001: 282) that focuses on a state's individual demographic and quantitative characteristics as an important indicator of policy adoption.

will focus primarily on the impact of state level characteristics on the likelihood of medical marijuana legislation passage. I will also, though, take a descriptive and preliminary glance at the geographic diffusion of the policy.

Perhaps one of the most common quantitative approaches to studying public policy adoption (particularly for sociologists), is to determine which factors *within* a particular region (usually state-wide) are the most significant in explaining policy variability across states. These studies examine the degree to which certain demographic, socioeconomic, and/or political variables influence the likelihood that a state will pass (or not) a particular piece of legislation. Simply stated, "*internal determinants* models posit that the factors leading a state government to innovate are political, economic, and social characteristics internal to the state," (Berry and Berry 1990: 395-396, original emphasis). Some common variables used as internal determinants include urbanism, education levels, economic conditions, racial demographics, crime rates, spending on issues, and political ideology of the state legislature and its citizens, (Galea, Rudenstine, and Vlahov 2005; Hays and Glick 1997; Meier 1992; Mooney and Lee 1995; Shepard and Blackley 2004; Soule and Earl 2001). Mooney and Lee explain that looking at the internal characteristics that are present in states that pass a particular policy allows for a glimpse into the "factors that enhance demand for a given policy, factors that enhance the resources of those advocates or opponents of the policy, and constraints on a state's adoption of the policy," (1995: 611).

Testing the likelihood that a state will pass medical marijuana based on internal characteristics is an important piece in understanding the national context of marijuana policy, and one that will be the focus of this research, however as Berry and Berry (1990) point out, it is "implausible to presume that states are totally insulated from influence by

neighboring states, given the context of federalism, active national associations of state officials, and media attention on state innovations," (396). More recently, scholars have begun to see the benefits of understanding the relationship between what is going on within a state, in other words internal determinants, and the *contextual* nature of policy adoption and innovation.

Harkening back to the early and influential work of Walker (1969), much of the research looking at policy adoption and innovation emphasizes the "social learning" element of policy diffusion. (See, for instance, Berry and Berry 1990; Boehmke and Witmer 2004; Greenberg 1977; Hays 1996; Karch 2007; Mooney and Lee 1995; Nicholson-Crotty 2009; Renzulli and Roscigno 2005; Shipan and Volden 2006; Shipan and Volden 2008; Soule and Earl 2001; Volden, Ting, and Carpenter 2008). This theoretical approach suggests that "state officials tend to draw on the experience of nearby states when considering whether they should adopt a policy," (Boehmke and Witmer 2004: 39). As neighboring states pass particular pieces of legislation, related information (and perhaps moral acceptance of these policy ideologies) may spread into neighboring states. This allows for a construction of political legitimacy, creating momentum, and perhaps political pressure, for the policy process in states that have not yet adopted the policy. (Baybeck, Berry, and Siegel 2011; Boehmke and Witmer 2004; Hays 1996; Karch 2007; Mooney and Lee 1995; Renzulli and Roscigno 2005; Volden, Ting, and Carpenter 2008). Although this research will not focus explicitly on the diffusion of medical marijuana policy, I will sneak a brief peak to see if there are potential patterns of policy diffusion.

State-Level Morality

One other segment of the policy analysis literature that is important to take into account, and consistent with both the internal determinants model and interstate diffusion, pertains to morality policy. When thinking about which characteristics will be important to consider in this quantitative analysis, special attention must be paid to the role morality plays in establishing medical marijuana policy. A case was made in earlier chapters that when morality is pitted against science, morality has, in the case of marijuana policy, always won. Scholars suggest that morality policy is guided by a sense of what particular groups in power consider to be "right" and "wrong". Instead of being governed by rational and more traditional cost-benefit analyses, morality policy is governed by an overarching set of values held by a large group within a society. Sharp (2003) defines morality policy "as including all issues in which the primary stakes, for at least one if not all sides on the issue, are matters of fundamental religious value or deep-seated belief about the propriety of a behavior or activity," (862). (For other dicussions of and definitions of morality policy see, for instance, Duster 1970; Gusfield 1972; Meier 1994; Mooney 2001; Mooney and Lee 1995; Oldmixon 2002; Roh and Haider-Markel 2003; Stabile 2007).

One of the major themes of research done in the area of morality policy suggests that individual, government, and state values are more important in shaping morality policy than any other demographic characteristics that usually predominate more quantitative analyses (Fairbanks 1977; Haider-Markel and Meier 1996; Meier and McFarlane 1992; Mooney and Lee 1995; Roh and Berry 2008; Sharp 2002). Mooney and Lee (1995), for instance, found that variables indicative of a state's citizens' values (such as religious affiliation) were more important when determining whether or not a state would adopt abortion regulation reform

than the more traditional variables of a state's economic climate. Looking at the legislative regulation of pornography and other "sexually explicit materials," Smith (2001) concludes that "value redistribution" is a major determinant in the "politics of porn," (197), for another example. Quantitative analyses of the adoption process of morality legislation have focused on a few major policy arenas, with some of the more popular topics including: abortion policy (Meier and McFarlane 1992; Mooney and Lee 1995; Norrander and Wilcox 2001; Roh and Berry 2008), gay and lesbian rights (Haider-Markel 2001; Haider-Markel and Meier 1996; Miceli 2005), hate crimes (Grattet and Jenness 2001; Soule and Earl 2001), death penalty, (Mooney and Lee 2000; Mooney and Lee 2001; Norrander 2000), health care and education (Renzulli and Roscigno 2005; Wald, Button, and Rienzo 2001), physician-assisted suicides (Glick and Hutchinson 2001), pornography (Smith 2001), and human cloning (Stabile 2007).

Research Quantifying Marijuana Policy

Although, as I have shown in previous chapters, there have been some very important works on the relationship between morality and drug policy (see, for instance, Duster 1970; Gusfield 1972; Meier 1992; Meier 1994), these studies tend to be historical analyses, focusing more on the many contextual and narrative details that have led to the adoption of particular pieces of legislation than on a way to look at the adoption of these policies quantitatively. There are surprisingly few quantitative studies that focus on the *adoption* of marijuana policies. One of which, published in 1983, is primarily an historical and narrative exploration into the evolution of the key marijuana policies. In order to explore the ways by which the meaning of marijuana and the drug's rhetoric gave shape to

the policy environment, the author coded and quantified themes in periodical articles about marijuana. (Himmelstein 1983). (See chapter 5 for a similar, current analysis.)

More specific to the process of policy adoption, Meier (1992) investigated the environmental, political, interest group, and bureaucratic forces within a state that led to the adoption of more liberal drug policies. Looking at the extent to which a state was likely to adopt more liberal marijuana policies specifically, he found that bureaucratic forces (conceptualized as legislative enforcement of drug laws) had the strongest influence on the adoption of more liberal marijuana policies. States with higher rates of marijuana use were less likely to pass liberal marijuana policies. Political party affiliation of legislators and a state's citizens was also found to be indicative of a state's marijuana policies, however in a limited fashion. (ibid).

A significant portion of this same study was focused on the *implementation* of drug related policies. In fact, when thinking about medical marijuana policy specifically, the recent literature exploring the new surge of state-level legislative acceptance of marijuana as a recognized medicinal treatment focus not on the process of policy passage, but instead, on the consequences of implementing these new policies. Recent literature, primarily in health related fields and, to a limited extent, public policy research, has investigated the attitudes toward medical marijuana policies (Garland, Bumphus, and Knox 2012; Mendes 2010), the relationship between the presence of medical marijuana dispensaries and crime (Jacobson, Chang, Anderson, MacDonald, Bluthenthal, and Ashwood 2011; Kepple and Freisthler 2012), as well as the potential impact on drug use and harm to "innocent" citizens as a result of the increased availability of the drug (Boyd and Carter 2012; Kleber and DuPont 2012;

Salomonsen-Sautel, Sakai, Thurstone, Corley, and Hopfer 2012; Wall, Poh, Cerda, Keyes, Galea, and Hasin 2011).[2]

While the quantitative morality policy literature discussed in the previous section has focused primarily on the adoption of particular policies, and the interplay between interstate and intrastate forces that determine a policy's likely success, the quantitative approaches to understanding drug policy has been more focused on the consequences of policy adoption. This chapter places the focus squarely on medical marijuana policy *adoption.* I will explore the statistical differences between those states that have adopted medical marijuana policy and those that have not. The investigation into the quantitative characteristics that are indicative of (and perhaps predictive of) a state's likelihood to pass medical marijuana legislation will allow quantitative methodological approaches from morality policy research (looking at intrastate characteristics and, to a more limited extent, interstate diffusion) to be brought together with the drug policy literature, specifically medical marijuana. In doing so, understanding the mechanisms at work in adopting morality policies will be augmented with another tangible example. In addition, and perhaps more importantly, another vantage point can be added to conversation of drug policy adoption in general, and medical marijuana explicitly.

[2] A relatively new area for investigation, the results of these studies vary widely. A number of scathing public responses, commentaries, and editorials critiquing the array of conclusions reached suggest that there is no clear consensus regarding the extent of harm caused by the presence of medical marijuana availability. As more states pass medical marijuana legislation, the consequences of the availability of marijuana as a medicine are important avenues to be explored in depth, but this particular focus is beyond the purview of this research.

METHODS

Dividing States by Medical Marijuana Legislation

The dependent variable in this analysis is a simple, dichotomous variable: states that have passed legislation favorable to medical marijuana and those states that have not as of November 7, 2012. Currently 19 states plus Washington, DC have passed laws favoring medical marijuana. These 20 states (which includes Washington, DC), comprise the "yes" category of the dependent variable.[3] There are 27 states, categorized as "no", those that do not currently have laws favoring medical marijuana policy.[4] Four states were excluded from the analysis (NY, IL, OH, and PA) because they currently have legislation pending. These four states show that there is a climate that *could* be hospitable to medical marijuana policy since there has been enough momentum for a bill to be proposed, but since the outcome is not yet determined, it would seem as if the tenuous nature of these states would serve only to complicate the data. Table 4.1 lists each state according to the categories of laws favorable to medical marijuana policy ("yes"), and those (included in this analysis) that do not currently have laws favoring medical marijuana policy ("no"). (States excluded from the analysis are listed below the table.)

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[3] There are varying degrees of implementation of medical marijuana policy. For some, there has been little done since the seemingly symbolic vote. For others, including CA, OR, and AK, there are complex systems set in place with a business economy created around medical marijuana distribution. States such as MD have only passed laws that allow for a "medical marijuana" defense for a marijuana possession charge, still operationalized as legislation favoring medical marijuana. The differences in implementation will not be focused on.

[4] Although there are a number of reasons why states have <u>not</u> passed medical marijuana, including either never having voted or having voted unsuccessfully, the "no" category of the dependent variable does not take these reasons into account. While breaking the "no" category down into categorical groupings based on whether or not a vote has ever been taken may add more nuance to the findings, the "N" for these groups would be too small for a proper analysis. The goal of this research is to look for patterns of *adoption*; splitting up the "no" category may also serve to mask these patterns.

Table 4.1 Medical Marijuana Policy: Categories of the Dependent Variable

States with Laws Favoring Medical Marijuana Policy	*States included in the Analysis with No Medical Marijuana Policy*
Alaska	Alabama
Arizona	Arkansas
California	Florida
Colorado	Georgia
Connecticut	Idaho
Delaware	Indiana
District of Columbia	Iowa
Hawaii	Kansas
Maine	Kentucky
Maryland	Louisiana
Massachusetts	Minnesota
Michigan	Mississippi
Montana	Missouri
Nevada	Nebraska
New Jersey	New Hampshire
New Mexico	North Carolina
Oregon	North Dakota
Rhode Island	Oklahoma
Vermont	South Carolina
Washington	South Dakota
	Tennessee
	Texas
	Utah
	Virginia
	West Virginia
	Wisconsin
	Wyoming
(20)	(27)

States excluded from the analysis: IL, NY, OH, PA

MEASURING INTERNAL DETERMINANTS: MINI-BATTLES AND PREVIOUS RESEARCH

Using previous research as a guide, and in order to determine the internal variables that are associated with the likelihood that a state will vote in favor of medical marijuana, four initial categorical groupings of variables were used as the independent variables: intrastate morality measures, drug use trends, crime data, and finally, demographic variables. (These categories are later tested through factor analysis.) As will be discussed in

detail below, these categories are grounded in previous quantitative morality policy studies as well as in the four battle fronts discussed in Chapter 3 (state and federal governments vying for power, the necessity of an entrepreneur with bureaucratic power, the construction of the user, and science vs. morality). (Table 4.2 lists the four major groupings of independent variables, the specific independent variables, and the corresponding mini-battle(s), if there is one associated.)

Intrastate Morality Measures

As has been established thus far, medical marijuana is a morality policy. It will be necessary, therefore, to find a way to quantitatively capture (at least a part of) each state's moral and ideological leanings. The first grouping of variables responds directly to the construction of medical marijuana legislation as a morality policy. Morality policy scholarship has found that value and belief systems are salient indicators of the acceptance or rejection of a morality policy within a population. "Indicators of citizens' values, such as aggregate measures of religious affiliation and public opinion, have been used frequently in empirical models of state morality policy adoption," (Mooney 2001: 10). Explained in detail below, there are four indicators of a state's collective value systems: percent of a state's population who state that religion is important, percent of a state's upper house (State Senators) that is democratic, percent of a state's lower house (State Representatives) that is democratic, and percent of the population that identify/lean democratic.

A case was made in Chapters 1 and 3 that, although an individual entrepreneur may come from either "side of the aisle" touting drug policy change, when looking at patterns of support, Democratic ideology tends to lean more toward a liberal set of drug policies while the Republican perspective is more likely to rely on historically embedded constructions of

punitive drug policies. Most public policy research includes variables to measure the role of legislative bodies and voting patterns of the public as indicators of policy development and success. (Benoit 2003; Flanagan, Cohen, and Brennan 1993; Harkreader and Imershein 1999; Meier and McFarlane 1992; See, for instance, Oldmixon 2002; Sharp 2002). In his work looking at drug policy adoption, Meier clearly explains the distinction between the two major American parties' stances toward drug policy specifically.

> Despite bipartisan support for the current drug war, the major political parties have staked out two different approaches to the problem. The Republican party is more closely associated with law enforcement approaches to drug abuse than is the Democratic party. … The Democratic preference for treatment rather than law enforcement can be tied to their more liberal orientation. (Meier 1992: 43).

Correspondingly, about 20% more citizens who identify as Democrat favor legalizing marijuana for medicinal purposes compared to those who identify as Republican (at 80% and 61% respectively) (Mendes 2010). One would expect, therefore, that the more a state's two houses lean democratic, and the more citizens who identify with the Democratic party, the more likely that state will be to implement medical marijuana policies. The two variables measuring the percent of a state's Senators and Representatives who are Democratic were gathered from the 2011 U.S. Census Bureau's Statistical Abstract of the United States (derived from 2010 Census data) (Census 2011). Also from the year 2010, I used data gathered from a Gallup poll to measure the percent of a population who say that they either identify or lean democratic (Newport 2010) .

The final variable measuring intrastate level morality, taken from a 2008 Gallup poll, is the degree to which citizens identify as being religious (Newport 2009). As has been discussed, morality policy scholars have found that religious affiliation, used as an indicator of a state's citizens' values, can be significant indicators of whether or not a state would

adopt a particular morality policy than the more traditional variables of a state's economic climate. (See, for instance, Berry and Berry 1990; Grattet and Jenness 2001; Haider-Markel 2001; Mooney 2001; Mooney and Lee 1995; Norrander and Wilcox 2001; Soule and Earl 2001; Stabile 2007). I would expect that the more citizens in a state who say that religion is important, the less likely that state will have passed medical marijuana policy.

While all four of these measures represent an empirical way to study the science vs. morality battle laid out in the historical analysis of this work, the upper and lower house party affiliation is a way to take a quantitative look at the relationship between entrepreneurial activity and bureaucratic power. Because state Senators and Representative are, by nature of being in office, tied to a powerful bureaucratic agency, the federal government, these two variables may be an indicator of the extent to which an entrepreneur with a particular party affiliation has had pull in shaping a state's medical marijuana policy.

Measuring Drug Use Trends

The next grouping of variables deals with marijuana use in each state. Two of the variables, marijuana use in the past year and non-traditional pain relief use, are 2008-2009 data from the National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Service Administration (SAMHSA 2011). Connected to SAMHSA, the Treatment Episode Data Sets (TEDS) "includes records for some 1.5 million substance abuse treatment admissions annually," (SAMHSA). The third drug use variable, from the 2010 data set, measures the percentage of all treatment admissions that listed as marijuana being the "primary substance of abuse," (SAMHSA 2010). Because the visibility of drug use in a state may impact attitudes toward drug policy, these variables all capture a piece of the battles constructing the marijuana user.

A higher percentage of marijuana use in a state may indicate more acceptance of the drug. If, however, use is perceived by others as a problem, it may negatively impact the likely success of medicinal marijuana policy. As Meier indicates, "as visible drug use increases in a state, that state will be more likely to pass strong drug control policies and more likely to support aggressive implementation of those policies," (1992: 42). Taking into account the negative constructions of users discussed in the previous chapter, if use is wide-spread, visible, and perceived by others as a threat to a community, one would expect that a state would be less likely to pass medical marijuana. Similarly, the percentage of all treatment admissions that are for marijuana, as opposed to other drugs, may indicate a state's stance toward the drug. A higher percentage of treatment admissions that are for marijuana as the primary substance of abuse may be an indicator that the drug is seen as a problem, something that needs to be treated. The advantages of treatment may be perceived as reducing health costs, addictions, overdoses, and other drug related problems; if that treatment were to be replaced with accessibility, in the form of medical marijuana, the detriments may be seen as outweighing the benefits of treatment (Shepard and Blackley 2004).

The final variable in this grouping, the percentage of individuals who have reported using non-medicinal pain relief, is an indirect measure of the perceived acceptance of non-traditional medicine. Although this variable measures only one aspect of the acceptance of non-traditional medical treatments, it may be an indicator of a likelihood to look outside of standard medicine for alternative medical treatments. One might expect that states with a higher percentage of the population more accepting of these non-traditional treatments may be more likely to embrace marijuana as a medical treatment.

Crime Data

The third independent variable grouping is related to the idea of the construction of user and visibility of the drug. There is often a link made between drug use and crime. As Meier suggests, "drug control laws are frequently justified by the relationship between drug use and street crime," (1992: 63). Whether or not there is evidence to back up that claim, the fact remains that there is often an assumption made by the public that the more liberal the drug laws, the more likely crime will increase. Therefore, one may reasonably expect that in areas with high levels of crime, there would be a corresponding reticence to allow for more liberal marijuana policies. Similarly, the number of arrests made for drug offenses may be another indicator of the state's construction of marijuana and its users. If there are a high number of drug related arrests in a state, one could reasonably conclude that drug problems are not only linked to criminality, but are also more visible.

All of the crime data were collected from the FBI Uniform Crime Reports for 2010 (UCR 2010b). Violent crime (which includes murder, manslaughter, rape, robbery, and aggravated assault) and property crime (defined as burglary, larceny-theft, motor vehicle theft, and arson) are rates per 100,000 of the population. The drug arrest data, also from the FBI Uniform Crime Reports (UCR 2010a), are the number of drug arrests within a state per 1,000 of the population.[5]

Demographic/Economic Indicators

Consistent with internal determinants model of policy analysis, the final grouping of independent variables are demographic/economic in nature: percent non-white, percent of a population over 65, percent with a Bachelor's degree or more, and median income. All of

[5] Although these data are not limited to marijuana arrests, drug arrest rates are an indication of the ideology toward and likelihood to enforce drug policies.

these variables were gathered from the Census 2010 "State and County QuickFacts" (Census 2010).

Previous research has suggested that states with higher levels of socioeconomic development are more likely to develop (and pass) innovative public policies. (Hays and Glick 1997; Mooney and Lee 1995; Walker 1969). Two of these variables, percent of the population with a bachelor's degree and median income are indicators of the socioeconomic level of a state. One might expect that states with higher median incomes and a higher percentage of citizens with bachelor's degrees, the more likely that state is to pass medical marijuana policy.

The other two variables, the percent of a state's population that is over 65 and the percent of a state that is non-white are attempts to, broadly, capture the demographic make-up of a state. Younger generations appear to be more likely to support more lenient drug laws, and less likely to have been impacted by the historical constructions of marijuana discussed in Chapter 3 (and further developed in Chapter 5). As also previously noted, the historical constructions linking drug use to racial and ethnic minorities is still embedded in drug policy. "The historical evidence as well as the current arrest data…suggest that states with larger minority populations will pass stronger drug control laws," (Meier 1992: 43). By extension, I propose the older a state demographically and the lower the proportion of the population that is non-white, the less likely the state will have passed medical marijuana.

Taken together, these four groupings of independent variables are meant to cover a wide-range of intrastate characteristics as well as to empirically measure some the marijuana policy battles that were outlined in the previous chapter.[6] Table 4.2 lists the four major

[6] Although this analysis is, in part, an attempt to empirically analyze the four battles discussed in Chapter 3, there is not a 1-to-1 relationship between the four mini-battles and the groupings of independent variables.

groupings of independent variables, the specific independent variables, and the corresponding mini-battle(s), if there is one associated.

Table 4.2 Independent Variables: Categorical Groupings and Mini-Battles

Independent Variable Groupings	Specific Independent Variables	Corresponding Mini-Battle
Intrastate Morality	% Upper House Democratic (State Senators)	Science vs. Morality (Entrepreneur with Bureaucratic Power)
	% Lower House Democratic (State Representatives)	Science vs. Morality (Entrepreneur with Bureaucratic Power)
	% Population Identify/Lean Democratic	Science vs. Morality
	% Who Say Religion Is Important	Science vs. Morality
Drug Use	% Reporting Past Year Marijuana Use	Construction of User
	% Reporting Non-Medical Pain Relief Use	Construction of User
	% Treatment Admissions for Marijuana	Construction of User
Crime Data	Violent Crime Rate	Construction of User
	Property Crime Rate	Construction of User
	Drug Arrest Rate	Construction of User
Demographic/Economic Indicators	% Over 65	Construction of User
	% Non-white	Construction of User
	% with a Bachelor's Degree or More	Science vs. Morality
	Median Income	–

TESTING INTERNAL DETERMINANTS MODEL

In order to determine the extent to which the above independent variables are indicative of medical marijuana policy in a state, the data are analyzed in a multi-step

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There is not always a coherent way to quantitatively measure the issues raised by each of these sites of battle, and, when there is, the categories are not necessarily exclusive. Chapter 5 will revisit some of the battles that are not as easily measured quantitatively.

process. First, through means comparisons and simple biserial correlations[7], the independent variables will be examined to determine which appear to be related to medical marijuana policy passage. A factor analysis is then conducted in order to determine if groups of related variables can uncover some of the underlying dimensions of this relationship. Finally, using these factors and a few individual independent variables, a binary logistic regression is performed to look at the predictive power of particular state level characteristics on medical marijuana policy. By doing so, I will explore the statistical differences between those states that have adopted medical marijuana policy and those that have not. This broad analysis will help to uncover the patterns of medical marijuana legislation adoption across states.

An Initial Comparison: Comparing Means and Correlations

Table 4.3 presents a preliminary glance at the relationship between each independent variable and the likelihood of medical marijuana policy.[8] The first two columns of findings in the table show a comparison of the means across both categories of the dependent variable. The final column reports the biserial correlation coefficients indicating the strength of the relationship between that particular independent variable and the dependent medical marijuana policy.[9] (The complete correlation matrices are included in Appendix 2.)

[7] Because of the dichotomous nature of the dependent variable (medical marijuana policy or no policy), biserial correlations were the most appropriate correlation coefficients.

[8] In preliminary analyses of the univariate statistics, three of the independent variables demonstrated a significantly skewed distribution. These variables were transformed in order to normalize the skew. Appendix 1gives more details on these transformations. For interpretive purposes, the means and standard deviations compared the non-transformed values, while the correlations were calculated using the more normally transformed variables.

[9] Because of the dichotomous nature of the dependent variable, and the scaled nature of the independent variable, some of the more traditional analyses, such as ChiSquare, would not have been appropriate.

Table 4.3 Means Compared and Correlations by Medical Marijuana Legislation

Variable	Mean (S.D)		Point Biserial Correlation Coefficients
	Policy	No Policy	
Morality Measures			
Democratic Senate (%)	64.7	47.6	.526**
	(13.6)	(14.2)	
Democratic House (%)	64.4	47.5	.499**
	(15.1)	(14.7)	
Citizens Identify	47.3	39.7	.484**
Democrat (%)	(8.7)	(5.3)	
Religious Importance (%)	56.1	70.1	-.687**
	(6.2)	(8.4)	
Drug Use			
Past Year Marijuana Use (%)	12.9	9.7	.694**
	(1.9)	(1.5)	
Non-Medicinal Pain Use (%)	5.2	5.0	.106
	(0.9)	(0.9)	
Marijuana Treatment	16.1	20.3	-.305*
Admissions (%)	(6.6)	(6.8)	
Crime			
Violent Crime Rate	435.6	452.6	.151
(per 100,000/population)	(266.5)	(554.5)	
Property Crime Rate	2892.9	2932.5	-.031
(per 100,000/population)	(647.8)	(654.2)	
Drug Arrest Rate	4.5	5.0	-.164
(per 1000/population)	(2.0)	(1.4)	
Demographic/Economic Indicators			
% over 65	13.0	13.3	-.081
	(1.8)	(1.6)	
% Non-White	28.0	19.9	.221
	(17.6)	(10.9)	
% Bachelor Degree	30.5	24.7	.522**
or Higher	(5.9)	(4.0)	
Median Income	55904.6	46738.0	.527**
(in dollars)	(8780.3)	(6329.7)	

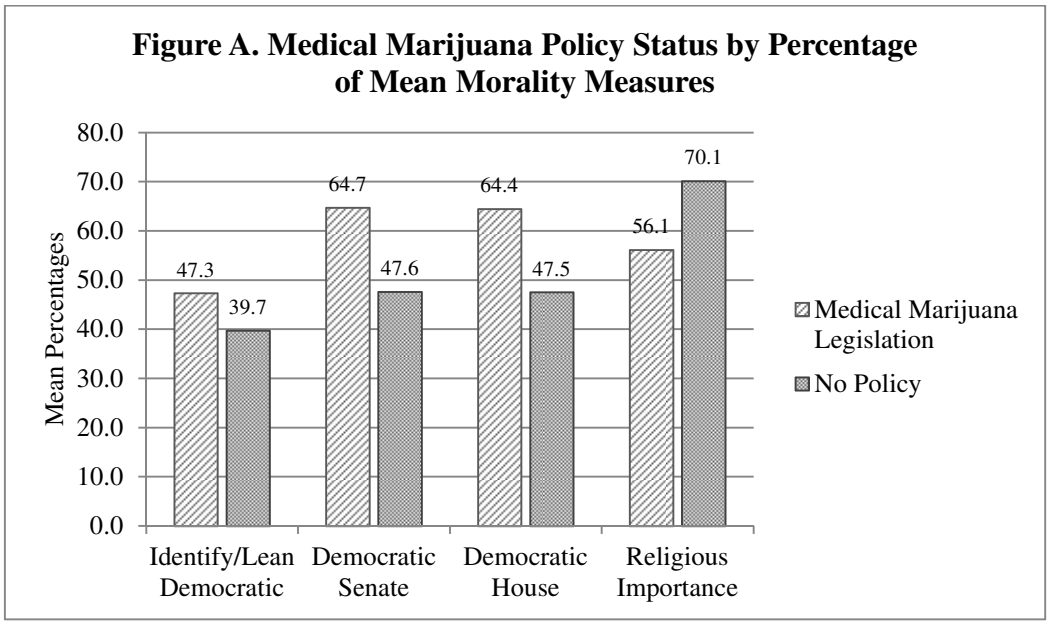
(T-tests performed for the means confirm the significance levels for the biserial correlation coefficients)

** Correlation is significant at the .01 level

* Correlation is significant at the .05 level

Morality Differences

In the preliminary analysis of intrastate morality measures, table 4.3 supports the notion that medical marijuana policy may, in fact, be an issue of morality. States that can be described as more heavily democratic, measured by the upper and lower houses and the percentage of the population who identify or lean Democratic, are more likely to have passed medical marijuana. Religion also appears to be an important indicator of medical marijuana policy; the mean percentage of citizens who find religion to be important is almost 15% lower in states that have passed medical marijuana policy as opposed to those who have not. The correlation coefficient (-.687) suggests that this is a strong, negative association. Figure A visualizes the strong relationship between morality measures and medical marijuana policy.



Mean Drug Use and Drug Policy

The second grouping of variables (see table 4.3), looking at the impact drug use trends may have on the likelihood that a state will have policies favorable to medical marijuana, told an interesting story. (For a graphic representation of this particular

relationship, between the means of the drug use independent variables and the dependent variable categories, see figure B below.) There was almost no difference between the mean percentage of citizens who report using non-medicinal pain relief across the two categories of the dependent variable. The lack of correlation suggests that the ways by which individuals make sense of how and what drugs are appropriate to use to help to ease pain may not be an important piece of the story.

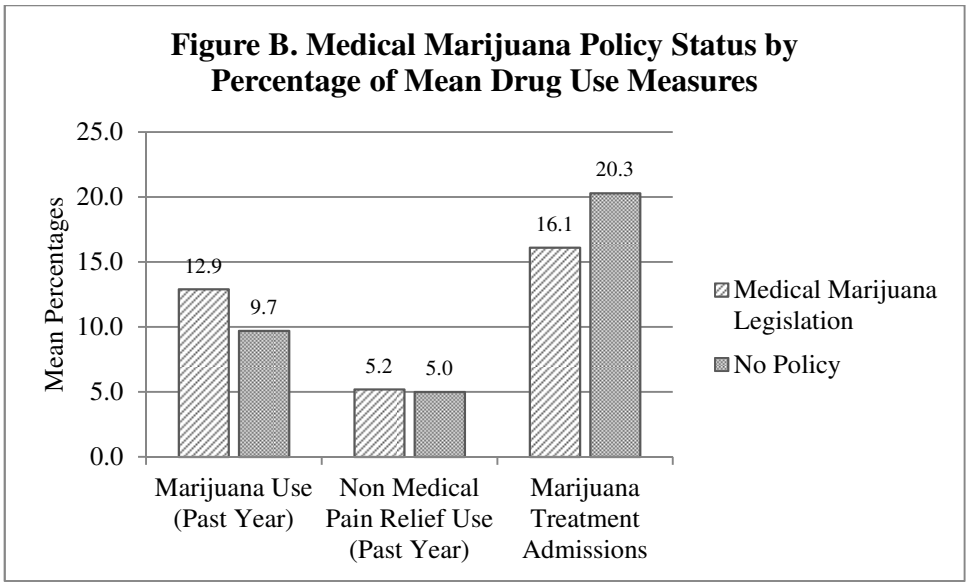
Medical marijuana policy was, however, strongly, positively associated with the percentage of a state's population who admitted to using marijuana in the past year; states with a medical marijuana policy on the books averaged 13% of citizens who admitted to using marijuana in the past year while states without medical marijuana policy averaged less than 10%. Said more simply, the higher the percentage of citizens who use marijuana, the more likely that state will have passed medical marijuana legislation. This seems to suggest that the greater number of users there are in a state, the more accepting these "users" will be of liberal marijuana policies like medical marijuana. It is important to note that the broad measurement of "percentage reporting past year marijuana use" does not allow for any generalization about the *type* of user. It is possible that, at least a small part of the positive association between marijuana use and medical marijuana policy may be a result of the policy itself. States that have passed medical marijuana would be likely to have a segment of their population who use the drug for medicinal purposes, which would be included in the usage rates. Considering the wide disparity of levels of implementation, although some states may have a comparatively high number of medical users, other states have not yet reached the implementation level of the policy. (The vote may either have been symbolic, with no further action taken to try to ensure patients have access to medical marijuana, or the

system may be so new that it may have had little if any impact on degree of use.) Medical marijuana use, therefore, can only account for part of the relationship between use and policy.

As was discussed earlier, visibility of use has been found to impact the level of acceptance of less punitive reactions to the drug (Galea, Rudenstine, and Vlahov 2005; Meier 1992). It may be that in the states with higher levels of marijuana use, the users may not only be seen as less threatening (or perhaps less visible altogether), but these users may, because of their connection to the drug, feel more of a vested interest in the policy, perhaps showing their support for the liberal policy by, at minimum, showing up to vote for marijuana legislation, and, at most, becoming voice in the state's corresponding discussions. It would appear that the construction of the user, discussed as an important mini-battle, is not supported by these data. Even if users in these states are constructed in a negative light, that does not impact the success of the policy. Perhaps more likely, states with a high degree of marijuana use may be either less likely to apply a stigma to users, or their use may be less visible. Either way, high use does not necessarily indicate a negative perception of user by state citizens.

The percentage of all treatment admissions that are for marijuana as opposed to other drugs is negatively correlated with medical marijuana policy, significant at the .05 level. Compared to states with medical marijuana policy, those with no policy averaged 4% greater drug abuse treatment admissions in which marijuana was listed as the primary substance of abuse. This finding gives weight to the notion that the construction of the actual drug itself may matter. If marijuana is seen as a problem that should be treated,

indicated by states with a higher percentage of marijuana treatment admissions, there would appear to be less acceptance of the medical utility of the drug.



Crime and Demographics

There was very little difference when the means of crime measures were compared between states with medical marijuana policy and those without. Table 4.3 shows no correlation between crime, drug arrests, and medical marijuana legislation. One might assume, as was discussed earlier, that areas with high crime may be less likely to pass medical marijuana legislation because of an assumed stricter stance toward the drug. The more visible crime and drug use, the more likely a state will enact harsh policies toward the drug, according to Meier (1992), however the data presented so far do not support the assumed relationship between high crime and harsh drug policy. Although there is an initial lack of relationship, these variables will be factored below in order to test to see if there is a relationship between drug use and crime when the crime variables are considered as one group (particularly when taking into account the cross-correlation among these three independent variables, as seen in Appendix table 2.3).

Finally, the demographic/economic model tells a bit more of a complicated story (see table 4.3). Neither of the two variables that capture some population characteristics, percent of the population over 65 and the "non-white" percent of a population, were found to be correlated with a state's medical marijuana policies. In fact, there was almost no difference between the mean percentage of citizens over 65 across the categories of the dependent variable, and less than a 10% difference in mean percentage non-white. The two variables measuring the socioeconomic status of a state did, in fact, demonstrate that the higher the median income and the more educated a population, the more likely a state will have adopted the liberal policy toward marijuana. This finding is consistent with the literature discussed previously.

The results from these preliminary means comparisons and biserial correlations suggest that, taken as a whole, the morality measures are most strongly correlated with medical marijuana policy, with all four independent variables showing a relationship with the dependent variable. Drug use also seems to be indicative of medical marijuana policy to some extent, with two of the three measures, marijuana use and treatment admissions for marijuana, showing statistically significant findings. This finding may begin to shed some light on the relationship between the construction of the marijuana user and the likely adoption of medical marijuana policy, although not necessarily in the expected direction. The other group of variables, crime data, also looking at the impact of the construction of the user on marijuana policy demonstrated no relationship with the dependent variable. The lack of relationship is, perhaps, surprising, particularly when considering past scholarship (Galea, Rudenstine, and Vlahov 2005; Meier 1992, for instance). Demographic/economic indicators were a mixed bag, with the two variables focusing on two specific demographic

characteristics across states, the percent of a population over 65 and the percent of a population that is "non-white", showing no relationship, and the two variables focusing more on socioeconomic indicators, median income and the percent of a population with at least a bachelor's degree, resulting in statistically significant correlations.

The data presented thus far, however, can only indicate if there are individual bivariate relationships and do not take into account the theoretical relationship among closely grouped independent variables. In order to test to see if these groupings hold up to statistical scrutiny, a factor analysis was performed.

Factors Underlying Medical Marijuana Policy

Although the independent variables have been discussed in theoretical groupings that were grounded in previous research and the mini-battles presented in the historical chapter in this work, they have been treated independently. Considering the high degree of cross-correlation within each categorical grouping (as seen in Appendix 2), and taking the ideological underpinnings of these groups into account, it is important to determine if any of these variables might have an impact on medical marijuana policy as a cohesive and interconnected group. In order to determine whether or not these categorical and, thus far, theoretical groupings might be more influential in determining policy outcomes than their individual values, the data were factored. With a maximum N of only 47 states, factor analysis also has the additional advantage of reducing the number of independent variables to be used in the (eventual) regression analysis.

To ensure a sound analysis, some of the variables were not included. Because of their lack of correlation with medical marijuana legislation, non-medicinal pain use, percent over 65, and percent non-white were left out of the factor analysis. The crime data, although

not individually significantly correlated, were kept. Considering the significant correlations across these three independent variables (as shown in Appendix table 2.3), it is possible that while crime data did not have a significant impact on the likelihood a state will pass medical marijuana legislation on an individual level, if grouped together, might have a larger impact on the policy adoption process.

After a number of exploratory factor analyses, it was determined that three of the variables found to be statistically correlated in the bivariate relationships were best left as individual variables and were not included in the final factored groupings. Because marijuana use had a positive association with medical marijuana policy, and treatment admissions had a negative association with medical marijuana policy, it made more sense to keep these two variables detached as opposed to factoring them together. Although both may be indicative of the construction of a marijuana user, they are testing for different aspects of that relationship. Religious importance was also kept as an individual, as opposed to a grouped, variable. The analysis thus far suggests that the religion variable may be an important indicator of medical marijuana policy. It does, however, appear to measure a different phenomenon than any other variable in the model.

With the remaining variables, a principle components factor analysis with an orthogonal varimax rotation was performed[10]. A three factor solution emerged. The first factor, termed "democratic", broadly measures a state's identification with the Democratic Party. Socioeconomic measures were loaded on the second factor, and include the measures of median income and the percent of a state's citizens with at least a bachelor's degree. The

[10] Because assumptions of linearity are necessary for factor analysis, the transformations of "bachelor's degree" and "violent crime" are used. (See Appendix 1 for details on transformations.)

final factor, crime, includes all three of the original crime variables. The three factors and their corresponding loadings are listed in table 4.4.

Table. 4.4 Factor Loadings for Morality Measures, Crime, and Socioeconomic Indicators

	Factor 1	Factor 2	Factor 3
Variables	*Democratic*	*Socioeconomics*	*Crime*
Democratic Senate	.938		
Democratic House	.911		
Citizens Identify Democratic	.843		
Violent Crime Rate			.871
Property Crime Rate			.641
Drug Arrest Rate			.805
Bachelor Degree or Higher		.868	
Median Income		.938	

(Note: factor loadings less than .4 were left out of the analysis)

The factor analysis strongly supports the notion that the previous theoretical groupings of variables is statistically sound. The three factors that emerged, democratic, socioeconomics, and crime, may highlight a larger underlying dimension to help explain medical marijuana policy adoption. New variables were then created from these factor loadings in order to determine the extent to which these new groupings may have a composite effect on marijuana policy.

In order to compare to the previous, individual correlations, a new biserial correlation matrix was composed. Focusing specifically on the relationship between the new independent variable groupings and medical marijuana policy, the correlation coefficients and their significance levels are reported below in table 4.5. Each of the relationships between the independent variables and medical marijuana policy were consistent with the findings earlier. The democratic variable, measuring a state's political ideology, is strongly positively correlated with medical marijuana policy, as is the grouped

variable measuring socioeconomics. The final variable grouping, crime, remains not statistically significant relative to medical marijuana policy adoption. These levels of correlation will be important to keep in mind when structuring the predictive model below.

Table 4.5 Point Biserial Correlations, Independent Variable Groupings by Medical Marijuana Policy

Variable	Correlation Coefficients (r)
Democratic	.541**
Religious Importance	-.687**
Past Year Marijuana Use	.694**
Marijuana Treatment Admissions	-.305*
Crime	-.141
Socioeconomics	.527**

** Correlation is significant at the .01 level
* Correlation is significant at the .05 level

Making Cautious Predictions: Logistic Regression

The data run above demonstrate that there are important factors to consider when thinking about the impact that state-level variables have on the likelihood of medical marijuana passage. Although many of these variables show a significant relationship to medical marijuana legislation, including the extent to which a state is Democratic, the level of importance placed on religion among state citizens, marijuana use, treatment admissions for marijuana as a primary substance of abuse, and socioeconomic measures, none of these findings can, yet, begin to make predictions about the degree to which certain independent variables cause a move toward (or away from) medical marijuana policy. Although related, these variables may not necessarily be *predictive* of medical marijuana legislation. With an

N of only 47, it is difficult to make predictions, however a logistic regression analysis was run in order to begin to get a clearer picture about the variables that may be more influential in the formation and adoption of this liberal drug policy.[11]

Crime, whether tested independently or as a categorical grouping, has shown no relationship with medical marijuana policy, so the data were left out of the regression model. (It is also important to limit the number of independent variables in the analysis because of the small N.) The democratic and socioeconomic factors were regressed along with the individual measures of religious importance, marijuana use, and marijuana treatment admissions. In the forward, step-wise, likelihood ratio model, only religious importance and the factored "democratic" variable were found to be able to significantly predict medical marijuana legislation (see table 4.6). (For the full regression model, please see Appendix 3.)

Table 4.6 Forward Stepwise Logistic Regression (Likelihood Ratio), Predictors of Medical Marijuana Legislation

	STEP 1: Odds Ratio, Exp(B) (S.E.)	STEP 2: Odds Ratio, Exp(B) (S.E.)
Religious Importance	.777** (.074)	.784** (.082)
Democratic		1.124* (.052)
Nagelkerke R^2	.623	.735

** $p < .01$; * $p < .05$

Variables not in the equation in last step: crime, marijuana use, marijuana treatment admissions

[11] Because the dependent variable is dichotomous, and the independent variables used in the regression model were continuous, logistic regression was the best method from which to choose.

Religious importance had the largest individual impact on *not passing* medical marijuana legislation (entered on step 1 of the model). The extent to which a state is affiliated with the Democratic party, included at step 2, was also found to be a significant predictor of medical marijuana legislation. In the final model, with an odds ratio of .784, for every one-point percentage decrease in religious importance, states were 21.6% more likely to have passed medical marijuana policy (0.777-1.000 = - 0.216). Although less predictive, but still significant, the extent to which a state is Democratic increases the likelihood by 12% that a state will have medical marijuana policy (1.124-1.000 = 0.124). When looking at the usefulness of the model, if no information was known about a particular state one would be able to predict the likelihood that a state had no medical marijuana policy correctly 57.4% of the time (states with no medical marijuana policy divided by all states in the sample). Once the full model is applied, considering the impact of both religious importance and democratic measures, one's ability to predict whether or not a state has medical marijuana policy increases to an 86.7% likelihood.

Although the marijuana use, marijuana treatment admissions, and socioeconomic variables were found to be correlated with medical marijuana policy (see tables 4.3 and 4.5), they did not have a statistically significant impact on the likelihood of adopting medical marijuana policy when taking religious importance and the political party affiliation of a state into account. Marijuana is, in fact, a morality policy. Whether or not a state is likely to support a more liberal perspective regarding medical marijuana policies rests in the political and ideological leanings of a state. Although pragmatic arguments may enter into the public debate (as will be discussed in the next chapter) – such as the impact medical marijuana policy may have on crime rates in an area, economic considerations of potentially unlocking

a new medical marijuana industry, scientific scrutiny of the evidence of the medicinal value of the drug – the intrastate determinants are driven not by concrete considerations that can be measured with drug usage rates, crime rates, and socioeconomic indicators, for instance, but by a state's value systems, conceptualized here as the extent to which a state identifies as a democratic state and the extent to which a state's citizens find religion to be important to them. Morality matters to the success or failure of medical marijuana policy.

THE SPREAD OF MEDICAL MARIJUANA POLICY

A Split Country

If one were to delve into the story of any one state's struggles with medical marijuana legislation, this research demonstrates that the state's value systems, conceptualized here by religious importance and political party affiliation of the state, would play leading roles with other variables such as marijuana use, marijuana treatment admissions, and socioeconomics as supporting characters. Just as the story of marijuana policy needed to have been grounded in its historical context, the story of any one state does not exist in isolation. Although the focus of this research is primarily on internal considerations, it will be useful to see if there are geographic patterns that may illuminate another piece of the medical marijuana saga[12].

Pulling together the processes of geographic and temporal diffusion, Mooney and Lee (1995) suggest that early policy adopters pave the way for other states to follow. They suggest that as policies move geographically, there is a parallel temporal pattern. In the

[12] While Event History Analysis could be another statistical way to explore the geographic and temporal diffusion of medical marijuana legislation, for purposes of this research, looking at the basic movement of the policy across time and region is meant to be painted with broad brush strokes, getting a general and descriptive sense of the movement of the path to policy adoption.

beginning phases of an innovative policy, early adopters will be viewed by geographically proximate (and demographically similar) states as leaders, opening the door for a larger, second wave of policy adoption. After this large group of adopters constructs the legitimacy of the policy (and perhaps applies political pressure to non-adopters), a third and smaller wave of adopters will follow. Researchers have suggested that the interplay between demographic proximity and temporal sequence fashions an S-shaped pattern. (Gray 1973; Mooney and Lee 1995; Soule and Earl 2001). As this process plays out, the policy does not stay stagnant, but instead, becomes reinvented and adapted to fit changing times and geographic regions (Hays 1996; Hays and Glick 1997; Mooney and Lee 1995). Because of this, scholars have pointed out the possibility that "with a morality policy the uncompromising and conflictual nature of the debate may keep some states from *ever* adopting it," (Mooney and Lee 1995: 606), leading to a truncated S-curve (Carmines and Stimson 1980a; Gray 1973; Hays and Glick 1997; Mooney and Lee 1995; Nicholson-Crotty 2009).

In order to take an exploratory look into the patterns of policy adoption across the United States, figure C shows the spread of medical marijuana legislation both geographically and temporally. (The states with no shading indicate the states that were not included in this analysis; they have medical marijuana legislation currently pending.) Only the years for which at least one state passed medical marijuana have an associated map.

Figure C. The Spread of Medical Marijuana Policy across the United States

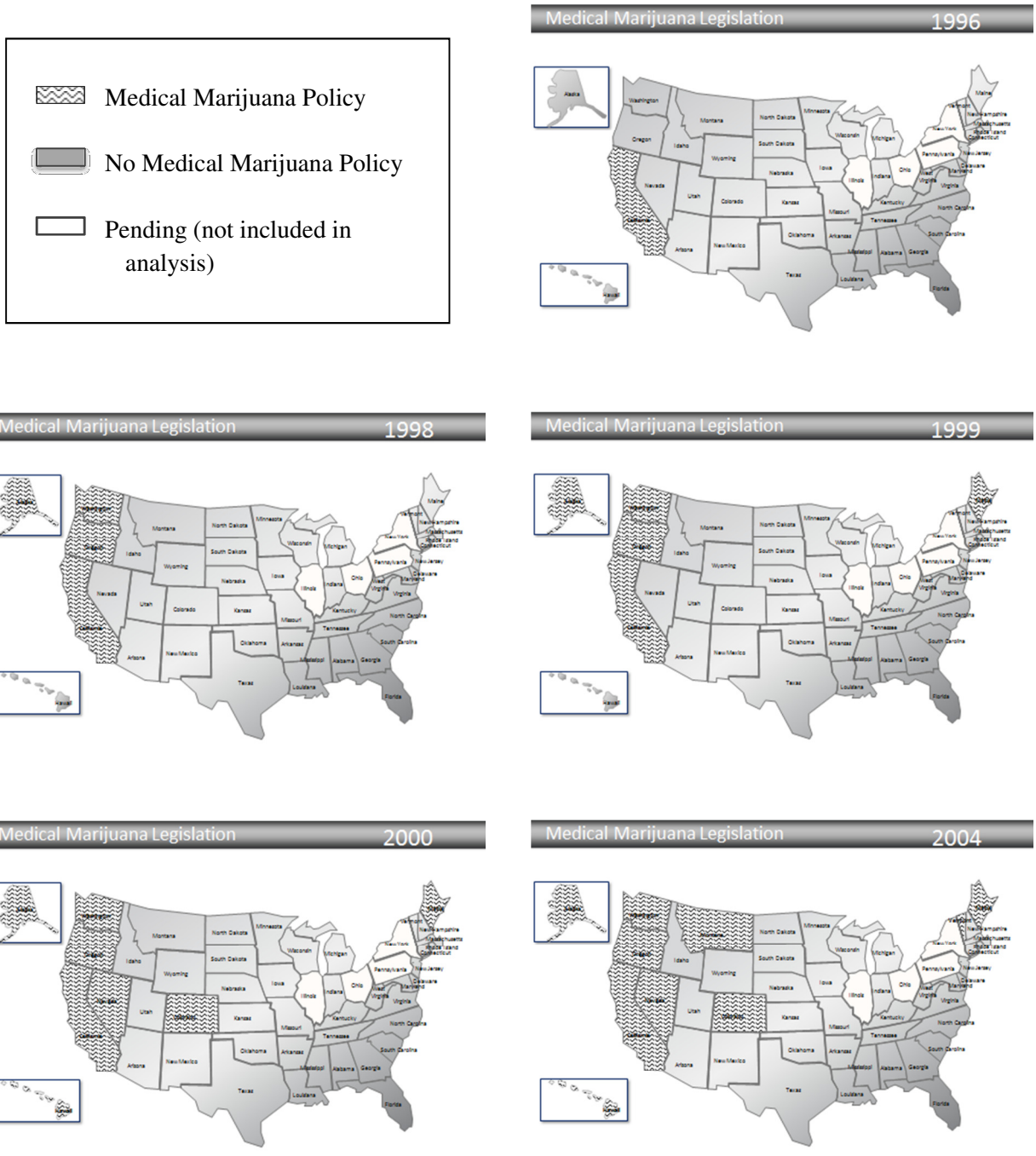


Figure C. (cont): The Spread of Medical Marijuana Policy across the United States

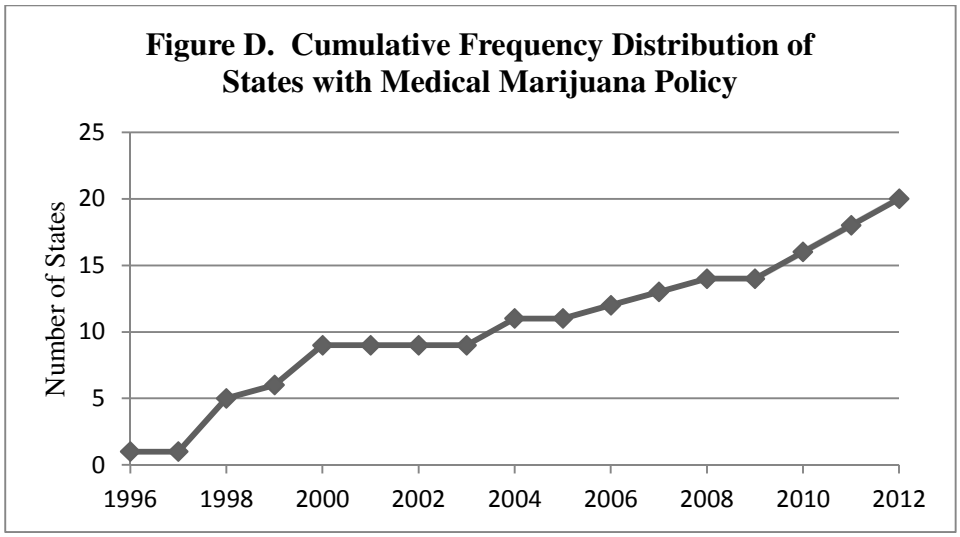
Looking at the geographic dispersion of medical marijuana policy over the years, two clear patterns emerge. First, it is evident when looking at the passage of policy over time, that most of the movement toward medical marijuana policy occurs in the Western part of the United States. Second, the northeast, although slower to gain acceptance, demonstrates another pattern of diffusion, although with less proliferation. There appears to be a clear geographic pattern to the diffusion of medical marijuana policy. The 2012 map is almost geographically split in two; the central and southeastern regions of the United States remain free of medical marijuana legislation. This is consistent with the ideological influence demonstrated by the intrastate characteristics above, but it also suggests that these democratically leaning states may be more likely to pass medical marijuana if there is a neighbor that has also taken the plunge into medical marijuana policy. In fact, when analyzing the pattern of policy adoption, at the time a state's medical marijuana policy passed, 40% (8 of the 20 with policies favoring medical marijuana) were bordered by a state that had already passed similar legislation.[13] Although this pattern of geographic diffusion cannot explain *why* this pattern exists, it does provide support that states are influenced by factors that may be external to their own state-wide politics and demographics. (Chapter 5 will explore this idea further by looking at the national discussions of medical marijuana.)

Rising Legislation

In order to determine whether or not the pattern of medical marijuana policy passage follows the expected S-curve discussed above (Carmines and Stimson 1980a;

[13] Because of they are somewhat geographic "outliers", Hawaii and Alaska were considered not to have been bordered by a state when they passed their medical marijuana policies. One might consider these states somewhat proximate to California and other west coast states that had already passed medical marijuana legislation. If Alaska and Hawaii are considered contiguous to medical marijuana states, then the percent of states with a medical marijuana neighbor increases to 50%.

Gray 1973; Hays and Glick 1997; Mooney and Lee 1995; Nicholson-Crotty 2009; Walker 1969), the cumulative frequency distribution of states that passed medical marijuana was analyzed. As seen in Figure D, there is a minimal S-curve associated with the adoption of medical marijuana policy. As expected, the chart shows an initial burst of adoption, a leveling off from 2000–2003, and a second wave of adoptions from 2004 until the present. It is interesting to note that the line has not been truncated, as was suggested could be the case for morality policy (Carmines and Stimson 1980b; Mooney and Lee 1995). This may indicate that the nation is still experiencing the second round of policy adopters. Supported by the research, as more information is spread about the success of previous adopters, regionally proximate states may be more willing, or perhaps feel pressured, to take the risk to adopt the innovative medical marijuana policy (Berry and Berry 1990; Boehmke and Witmer 2004; Hays 1996; Hays and Glick 1997; Mooney and Lee 1995). As the chart continues over the next few years, it is possible that it will level off, suggesting that the nation may be in the second phase of a double S-curve. With four more states with policies currently pending, and interest groups active in others, there may be continued upward movement, and the surge of adopters will continue. As more states begin to adopt medical marijuana policy, the likelihood of other states adopting this policy may, in fact, increase.



THE PATH TO CUMULATIVE MORALITY

This quantitative analysis establishing patterns of similarities across states with (and without) medical marijuana policy can help to add insight to this specific policy adoption process. Understanding particular state level characteristics is an important first step in revealing these patterns. The data uncovered some unexpected findings. Considering previous scholarship on the relationship between crime and drug policy (see, for instance, Galea, Rudenstine, and Vlahov 2005; Meier 1992) and the images that the war on drugs' rhetoric brings to mind, it was surprising that there was no relationship between crime rates and medical marijuana policy. Taken at face value, the lack of correlation may be a straight-forward finding that crime rates have nothing to do with the likelihood that a state will pass medical marijuana legislation. However, once the positive association between the percentage of marijuana users in a state and medical marijuana policy is also considered, these findings may begin to point to a more nuanced picture regarding the construction of the user. If marijuana use is now associated with less stigma than it has been in the past, or if this use is less visible, then perhaps the

negative imagery of the drug is waning, making more room for more liberal marijuana policies. Although the construction of the user cannot be explored through these quantitative data, it will be important to investigate in the next chapter.

Overall, though, the findings in this study point to the primacy of morality in establishing medical marijuana policy. This portrait paints state-level political ideology (percent Democrat) and religious identification as being the variables most predictive in determining medicinal marijuana legislation. By broadening the terminology, these data suggest the more conservative a state's morality, the less likely that state will accept this more liberal stance toward marijuana. Morality, therefore, appears to be at the core of the success of the struggle for medical marijuana's acceptance.

The intrastate characteristics all clearly indicate that if one is interested in knowing why one state has passed medical marijuana and another state has not, the degree to which that state can be measured as morally more conservative or morally more liberal is a key to that understanding. Thinking about the role of morality, however, can also help to understand the ways by which medical marijuana policy innovation is being spread across states. Looking at the still upward trajectory of the minimal S-curve of the cumulative frequency distribution of states that have passed medical marijuana legislation, it would appear that there is still momentum for the passage of similar policies in other states. States do not pass policy in a bubble, however, particularly controversial morality policies. "Social learning occurs when subsequent adopters learn from earlier adopters as an innovation diffuses," (Hays 1996: 633). As potential adopters hear stories of the challenges of implementation and of the successes of medical marijuana policy, particularly in neighboring states, the substance and direction of their

debates will be influenced by earlier (and recent) adopters. There may, therefore, be a *cumulative effect of changing morality*. As more states see medical marijuana as morally acceptable, this will impact the ways by which national media may cover the issue, the ways by which politicians may frame the issue, and the direction of the debates in general. Each discussion of the topic of medical marijuana then has the potential to be influenced by and influence understandings of the morality of marijuana. In order to get a more comprehensive picture of the role morality plays in shaping these policies, it is necessary to move the focus to the ways by which this morality is not only constructed, but also how it changes as more states adopt medical marijuana legislation.

As was stated at the beginning of this chapter, these quantitative statistics can only provide a static snapshot of the pattern of medical marijuana policy adoption. The next chapter will add another layer to the story, exploring the ways by which national conversations of marijuana attach meaning to the drug, giving shape to medical marijuana debates.

Chapter 5:
Media Presentations of Drug Ideology: Reshaping Morality

THE MEANING OF MARIJUANA

Linking Past to Present

> The media provided an enormous build-up for President Bush's "war on drugs" speech from the Oval Office in September 1989. By then, some news accounts mentioned that public opinion saw drugs as the nation's number-one problem. When pollsters asked Americans "What do you think is the most important problem facing this country today?" in July 1989, barely over 20 percent answered "Drugs". Two months later, well over 60 percent gave that answer. Amazing what some media hype can do. (Lee and Solomon 1990).

More than two decades after President Bush's "war on drugs" speech, the public's attitudes toward marijuana, a federally defined enemy in the war on drugs, appears to have undergone seismic shifts. In 2011, Gallup reported that, for the first time since they began asking about attitudes toward marijuana in 1970, there were more individuals who were in favor of legalizing marijuana than wanted marijuana to remain illegal (at 50% and 46% respectively) (Newport 2011). The percent of individuals who were in favor of legalizing marijuana went up four percentage points within a year's time. (ibid). There is significantly more support for medicinal marijuana, with Gallup finding in 2010 that "seventy percent of Americans say they favor making marijuana legally available for doctors to prescribe in order to reduce pain and suffering," (Mendes 2010). Although support for pure legalization has been growing in the past few decades, support for medical marijuana has dropped slightly in the past few years, from 75% in 2003 and 78% support in 2005 to the current 70% (ibid).

Since marijuana gained national attention in the 1930s, attitudes toward marijuana and the corresponding federal and state-level policies appear decidedly inconsistent and

mercurial. Until Anslinger went on his media blitz to garner momentum for the Unified Narcotics Drug Acts and later the Marijuana Tax Act of 1937, the public was unaware even of the existence of the drug the "reefers", let alone the dangers that he and his FBN claimed the drug would bring to society. The amotivational syndrome would not have been picked up and used as a valid medical diagnosis for marijuana users in the 60s and 70s by psychiatrists, politicians, judges, and others had the media and other claimsmakers not perpetuated the perspective that marijuana was a public health threat. In the quote above, the public did not express a high fear of drugs until President Bush made it an issue and the media covered the drug threat accordingly. Today, with 19 states plus Washington, DC having favorable policies toward medical marijuana, others looking to follow their lead, and still others clinging staunchly to the notion that marijuana is a dangerous drug and should not move into any more accepted category, the nation is engaged in another conversation that is, at its core, debating the *meaning* of the drug marijuana.

The picture presented in the previous chapter established that medical marijuana policy outcomes may be more nuanced than simple quantitative snapshots can capture. The lack of relationship between crime and medical marijuana policy, and the seemingly contradictory positive relationship between use and policy and negative relationship between treatment admissions for marijuana and medical marijuana policy poses questions that cannot be answered with quantitative data. Similarly, looking at the variables that were both more indicative and predictive of medical marijuana policy, a state's morality stances and political party preferences, leads to questions about what might affect change in morality constructions of marijuana, and how. As more states

move toward more liberal policies, accepting marijuana as a legitimate medicine, is the construction of marijuana (and its users) still deemed harmful, or has there been a change in the perception of the harms of marijuana? Have the meanings of the drug, its harms, and the construction of the user been presented to the public in a way that allows for greater acceptance of policies that contradict previous strict policies (and the current strict federal stance)? Has a new morality emerged that would allow for more Americans to see marijuana not as a drug to fear, but a drug that is, at least, minimally harmful, and, at best, medically helpful? The previous chapter's snapshot provided an overview regarding what the picture looks like. Now it is time to turn to looking at the details of that picture and answering part of *if* and perhaps *why* that change might be occurring.

One way by which to answer these questions is to look at the types of stories the media present to the public regarding marijuana issues. The previous chapters discuss many possible ways by which to debate issues surrounding medical marijuana and marijuana in general: as a public health threat, a crime problem, a medical issue, a subject for scientific inquiry, a moral dilemma. Whether or not the public and, perhaps, politicians, will be willing to entertain the idea of medical marijuana legislation may be dictated by the meanings that are attached to the drug.

> …classification systems are often sites of political and social struggles, but…these sites are difficult to approach. Politically and socially charged agendas are often first presented as purely technical and they are difficult even to see. As layers of classification system become enfolded into a working infrastructure, the original political intervention becomes more and more firmly entrenched. In many cases, this leads to a naturalization of the political category, through a process of convergence. It becomes taken for granted. (Bowker and Star 2000: 196).

Defining the meaning of marijuana, either as a dangerous drug, helpful medicine, or something in between is politically charged. The ways by which marijuana is

discussed, particularly in the media, will impact not only the public's perception of the drug, but, by extension, the legitimacy of policy suggestions. As Gary Alan Fine says, "meaning depends upon a community of shared understanding," (1995: 245). The media, whether purposive or not, are able to use their influence in order to construct and reinforce the classification of marijuana and its users, turning a collective focus in a particular direction. Put simply, "social scientists have shown that citizens' political judgments often depend on how an issue or problem is framed,"(Druckman 2001: 225). This chapter will serve, therefore, to not only reveal the ways by which the media covers marijuana issues, but look to see if there is a dominant picture that is presented to the public that may influence the ways by which the public make sense of the potential impact of marijuana on society.

The current climate within which medical marijuana policy is debated today seems comparable to the idiosyncratic contexts that were present in state (and federal) policies toward marijuana prior to the Marijuana Tax Act of 1937 and the Controlled Substances Act of 1970. In both of those historical time periods, battles emerged for control over the ideological paradigm that would structure the debate about marijuana. Those in power vied for the ability to structure the conversation in a particular way, ensuring an understanding of the marijuana problem that would be consistent with the claimsmakers' desired policy outcomes. In the 1930s, most of the discussions focused on public safety, emphasizing the harms done to citizens by dangerous and immoral users. In the 1960s and 70s, the paradigm shifted, even if temporarily, to one of public health, emphasizing the need to protect users from themselves and the harm that the drug would cause to these users, and, by extension, society. The public safety paradigm of the 1930s,

however, never fully disappeared, being further strengthened by the Nixon, Reagan, and Bush administrations, for example. The policies of the times were reflections of the ways by which the nation heard about and, therefore, talked about the drug. This chapter will highlight the ideological paradigms that are present in conversations regarding marijuana generally today.

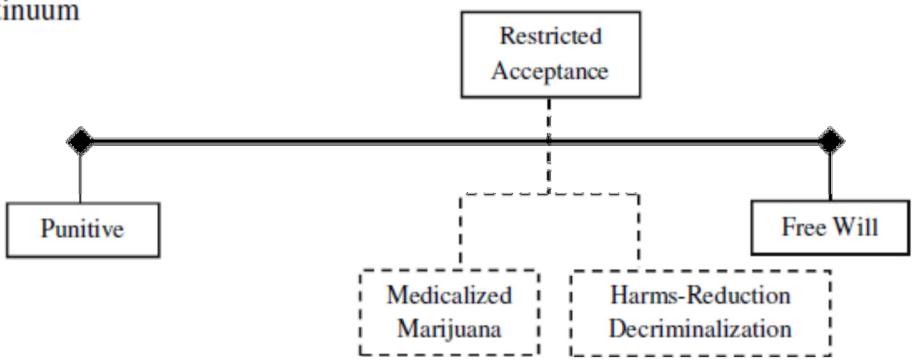
Defining, Classifying, and Constructing the Marijuana "Problem"

Medical marijuana debates do not exist in their own medical and scientific bubble. Instead, the criminality and immorality of the drug will impact the likelihood that the drug will be viewed as a viable medicine. When thinking about the coverage of medical marijuana in the news, therefore, it is important to consider that looking only at the ways by which the media covers the *medical* aspect of the debate would ignore other constructions of the drug that, although they may seem only tangentially related, may have a major impact on how the drug is perceived in the public's collective eye. "The reality of illegal drugs as social objects has always been dependent on how people agreed to define such objects," (Katovich 1998: 277). If the predominant frame by which marijuana is discussed is a criminal one, that perspective may serve to undermine claims made for marijuana's medical utility. Claims that marijuana is immoral and/or linked to criminality define the drug in a way that is inconsistent and perhaps incompatible with accepting marijuana as a medicine, even when the issue of medicalization is not at the forefront of that particular conversation. It is necessary, therefore, to consider *all* claims/ideological frames of marijuana, not just those that deal with medical marijuana specifically.

Medical marijuana falls within a larger debate of the legalization of drugs in general. Although often presented as political opposites (conservative vs. liberal), stances toward drugs fall on a broad continuum, collapsed into three categories (see figure E). On the *punitive* extreme, marijuana poses a great threat to the individual user and to society and should have strict legal and normative punishments attached. On the other extreme, those advocating complete legalization suggest that if there is any harm done to the user it is minimal compared to other legal drugs (such as tobacco and alcohol) and the federal government should not be able to enforce a law that impedes an individual's *free will*. There are two positions that may fall somewhere in the middle, both classified under a *restricted acceptance* category. The harms-reduction/decriminalization approach to marijuana would remove penalties for the possession of marijuana, but would continue to punish those with the intent to distribute (Kleinman, Caulkins, and Hawken 2011; Levinson 2002). This approach does not suggest that marijuana and other drugs should be made completely legal, but managed with non-punitive treatments. The other restricted acceptance position is the argument for medical legalization.[1]

[1] For more details regarding the drug legalization debate see, for instance, (Anderson 1981; Earleywine 2002; Goode 1997; Grinspoon and Bakalar 1993; Inciardi 1999; Isralowitz 2002; Kleinman, Caulkins, and Hawken 2011; Luper-Foy, Brown, and eds. 1994; Mathre 1997; Miller 1991).

Figure E. Drug
Ideology Continuum



The media have the task of presenting this complex and intricate debate to the public. Journalists have a number of possible ways to approach a topic, and rely on an "index" as a "quick and ready guide for editors and reporters to use in deciding how to cover a story," (Bennett 1990: 108). Just because of the sheer number of news stories for which there is no available air time or print space, choices have to be made in the newsroom regarding not just which stories to include but also how to include them. Journalists, editors, and others act as "gatekeepers," guiding some stories in, escorting others out, and shaping those that make it in so that they fit within the confines of the media space. In this sense, "the mass media serve as an ideological vehicle," (Binder 1993: 753). Once choices of inclusion and exclusion have been made, stories must then be "framed," fit into a particular "schemata of interpretation".

> …media writers use frames to selectively represent certain elements of their stories and to emphasize some information to the exclusion of other data. Framing an issue by using a repertoire of arguments creates a dominant reading of the text, thereby reducing readers' capacities to comprehend the text differently. (ibid: 755).

News frames, therefore, ensure, to some degree, a particular or at least a similar comprehension of the story. The way drugs and drug users are portrayed in the media

begins to pattern collective understanding of the drug, reactions to the drug, and, therefore, the drug's reality.

Using the stories of both present-day and historical struggles over the meaning of marijuana presented in earlier chapters as a foundation, four master frames emerge. These frames serve to focus the ideological arguments on *any* side of the marijuana debate. Each of the drug stances listed above (and seen in figure E) can be framed by the following common, master frames (which will be further clarified in the methods section): *legal*, *moral/social*, *medical*, and *pragmatic*. The degree to which the media coverage highlights one ideological frame over another will provide a context for the ways by which the meaning of marijuana, and therefore the likelihood of policy changes is being constructed today. It is necessary, therefore, to not only uncover and analyze which news frames are being chosen to structure the debate, but also determine whether or not there is a dominant frame and stance that may possibly bias the presentation of marijuana issues toward one perspective over another. Recognizing if there is a dominant frame may have implications for the potential success or failure of medical marijuana policy across states.

Looking for Balanced Bias

Entman defines bias as "a tendency to frame different actors, events, and issues in the same way, to select and highlight the same sorts of selective realities, thus crafting a similar tale across a range of potential news stories," (1996: 78). But, in attempting to measure bias, what would that mean? Would that mean that there would need to be equal coverage of all sides of a debate? If so, would the coverage need to be equal within a story? A week? A year? Is unequal coverage necessarily unfair? If the public elect

government officials, then wouldn't the logic follow that these views should be overrepresented in the media? (Dickson 1994; Kuklinski and Sigelman 1992; Niven 2002). Because of the problematic nature of the term "bias", researchers have attempted to measure the extent and variety of diverse opinions in controversial debates that occur within media spaces.

There have been three major focuses of news bias research. 1. The *production* of the news bias, suggesting institutional, instrumental, and professional reasons why particular biases exist. (Bagdikian 1985; Bennett 1983; Cohen and Solomon 1995; Dennis 1997; Gitlin 1979; Lee and Solomon 1990; McQuail 1985; Zaller and Chiu 1996). 2. *Audience reaction* studies, locating the bias not in the presentation of facts by journalists, but instead in the way the audience members relate to the news topic at hand. (Cerulo 1998; Chebat, Filiatrault, and Perrien 2001; Cohen 2001; D'Alessio and Allen 2000; Lee and Solomon 1990; Lee 2005; Oliver and Myers 1999; Schmitt, Gunther, and Liebhart 2004; Vallone, Ross, and Lepper 1985; Wiley 2003). 3. And finally, and arguably the predominant research method by which researchers attempt to locate and study media biases, are *content* analyses in which texts are codified, classified, and quantified. Because of the nature of this particular study, it is important to briefly understand this third focus of news bias research.

There are two major types of content analyses. A more recent approach to the study of bias has been informed by Barthes and the study of semiotics. In these studies, the media act as "signification" systems that transmit culturally important meanings to the audience. Attention is given to the cultural meanings that are received and embedded in media text. (Cerulo 1995; Danesi 2002; Hodge and Cress 1988; McLuhan 1964).

Most content analyses, however, have focused on coding and analyzing the news "frame." Although definitions of news frames have often been blurred and murky, most scholars have come to accept the news frame as a way to make a story manageable both for the journalists who write the stories and the public who reads them. "Frames are schema of interpretation that bound reality, direct attention, organize experience, and suggest underlying logics with which to make sense of the world," (Noy 2009: 224). These studies, typically, either compare the presentation of a news event to "actual events" (Fishman 1978; Graber 1980; Oliver and Myers 1999), or determine the numerical distribution of codified themes or news frames. (See, for instance, Aboura 2005; D'Alessio and Allen 2000; Himmelstein 1983; Kuklinski and Sigelman 1992; Nelson, Clawson, and Oxley 1997; Niven 2003; Steensland 2008). Critics of these content analyses have argued that the way that scholars classify and define particular news frames is subjective; authors "ignore evidence of their ideological opponents and emphasize what supports their own cases, interpreting the facts in self-serving manners," (Vatz 2003: 60).

In order to help with the difficulty of locating and classifying bias, I suggest that there is another level of analysis that can also be influential in assessing the balance of news coverage. While semiotics and news frames are both important methodological tools used to understand media bias, there is another level of analysis between the quantifiable news frame that surrounds and focuses the picture of the news story and more qualitative semiotic meanings that aids the social understanding of that picture. Bennett (1983) proposes that media products consist of both "packing and content." If one thinks of the frame as the "packing" of the story, the details provided within the text

would be the "content". Keeping within the photographic imagery, a frame is the outline for a more embellished picture of the story that only becomes more coherent with attention paid to the pixels and resolution of the image – the small details that add up to a more nuanced reflection of the complete story. Entman (1996) suggests, "specifics lend credibility, comprehensibility, and memorability to general evaluations," (81). It is not enough to look only at the approach or viewpoint of a story that draws our collective focus in a particular direction while ignoring the minutiae; nor is it enough to focus on the details of contextual and language peculiarities without recognizing its boundedness. Only when a story's frame *and* its "pixels" (textual details) are analyzed can a clearer understanding of what might affect the "bias balance" be uncovered.

Measuring Bias

I suggest that in the search to determine whether or not the media offer a biased presentation of the marijuana debate, it is useful to think of the two extreme sides of the debate (complete legalization vs. strict punitive reactions) representing the opposing balances on a scale. Any more moderate opinions would fall somewhere in the middle of this balanced scale, tipping the scale according to their position relative to the balanced center. A completely equal presentation of a debate would paint the picture of a symmetrical scale, with equal weights on either side of the central position. Typically, media scholars have measured bias, or the balance of voices in the media, by codifying, classifying, and quantifying general topics, frames, and/or stances within an article or a series of articles. Then, using a mix of quantitative and qualitative data analysis, researchers have ascertained the degree to which particular points of view are more (or less) represented in the media's presentation of events. I propose that the weight of an

opinion on the "bias balance" scale does not rest solely on the number of times an opinion is voiced and where that opinion is located within the story. That balance may also be disturbed by a number of other factors including the context, textual details, and the use of language. The subtle nuances of the story may, in fact, serve to counterbalance an unequal numerical presentation of a particular side of a debate. Coding, understanding, even defining bias is complicated at best; research methods attempting to locate this bias, or the balance of views within a series of news stories must be correspondingly nuanced and layered.

In order to reveal the ideological frames used by the media within the marijuana debate and to determine the degree to which the media's coverage of marijuana issues offers a balance of viewpoints, I conduct a multi-layered content analysis to see the manifest and latent biases embedded in marijuana stories in three newsmagazines (*Time, US News & World Report, and Newsweek*). First, a more traditional content analysis is performed in which the balanced or unbalanced presentation of the marijuana debate is measured by coding primary and secondary frames and their corresponding stances (pro or con). Understanding *how* the different sides of the debate are presented in the articles is as important as *if* they are present, so a second-tier content analysis is performed looking at the latent biases that are embedded within the contextual details and language of the stories.

Because of the muddled and inconsistent public opinion and policy perspectives regarding medical marijuana (and marijuana in general), one would expect the media presentation of this debate to be similarly hazy and fickle. Although the movement of many states toward medical marijuana acceptance may be an indication that there would

be, to some extent, manifest support expressed in the media, the continued placement of marijuana as a harmful drug war enemy as defined by the federal government could also signify that this more traditional, punitive perspective would also be present in marijuana articles. This latter, criminal-focused perspective on drugs has become, as has been shown in previous chapters, so entrenched in our understanding of marijuana it has become, to an extent, taken for granted and, perhaps, perceived as the natural reaction to the drug. For this reason, I expect biases that may lean in the direction of support for medical marijuana policies to be more explicitly stated, while biases that may lean in the direction of more traditional and punitive approaches to the drug to be more expected, and, therefore, less likely to be "on the surface". I hypothesize that while the news frames (manifest biases) may appear to be slightly slanted in a direction that supports a more lenient stance toward marijuana, especially in the case of medical marijuana, the language, context, and details within the story (latent biases) may not necessarily be consistent with the article's master frames. More specifically, the ways by which the major players in the articles are constructed, as hero, victim, loser, villain, expert, and ambiguous, offset any possible slant toward a slightly more lenient position on marijuana. In other words, even if it appears as if there is an overriding master frame that is relatively balanced, that master frame is only as powerful as the contextual details that give the picture its character. Only by looking at both the manifest biases (the news frames) *and* the latent biases (the contextual details, or pixels) of marijuana articles can one reach a more comprehensive understanding of the biases embedded in the media's portrayal of the marijuana debate.

METHODS

Coding Frames and Their Corresponding Stances

The narrative format of newsmagazines lends itself to having the stylistic and physical space to provide more detailed accounts of stories relating to marijuana. This both facilitates a more comprehensive voice in the marijuana debate as well as allows for potentially more biases to be more fully developed and, perhaps, hidden. (Bennett 1990; Zaller and Chiu 1996). Although medical marijuana battles are fought at the state-level and newsmagazines reach a national audience, it has been established thus far that federal level constructions of the drugs are instrumental in shaping state-level debates. While there are certainly discussions that may be specific to one particular state, these discussions are couched within a larger, national construction of marijuana; the way any one state will debate an issue is filtered through the choices of debate made at a national level. It follows, therefore, that if an analysis is to be done in order to determine the type and balance of diversity that is represented in media accounts of the debate surrounding marijuana issues, newsmagazines offer a fruitful place to start.

Using a search in the academic database EbscoHost/Academic Search Premier, all news articles that came up using the search term "marijuana" in the "subject field" were gathered from the top three newsmagazines: *Time, Newsweek,* and *US News & World Report*.[2] The earliest article included in this sample was published in 1993 with the end

[2] Whether an article was presented as a "straight" news piece or an opinion piece, it was included in the sample. Although opinion pieces' main goals are to present a particular side of an issue, the fact that a particular opinion has received a place within the marijuana conversation indicates that it may be influential in giving shape to the larger marijuana debate; because it is another voice with weight, it needs to be taken into account in this research. Additionally, in both types of pieces, those focused on presenting objective facts and those with a more obvious bias, some of the more interesting results came not from the obvious perspective, but from the perspective that lay hidden, and perhaps was in contradiction with, the (presumed) main perspective of the article.

date of the sample being 2010.[3] The final total was 61 articles (23 from *Newsweek*, 26 in *Time*, and 12 from *US News & World Report*)[4]. (For a complete list of all of the articles included, please see appendix 4.) Because a single article may contain multiple frames with multiple sides of an argument presented, primary and secondary frames of each of the articles were coded.[5] Primary frames were determined by assessing the theme of every paragraph within an article and determining the one that occurred the most (taking paragraph placement into account). Secondary frames were somewhat less important to the article, but were still included in the analysis.

Each article was analyzed both for its master frame (legal, social/moral, medical, and pragmatic) and its stance on the argument (con, pro, or balanced). The category of *con* was conceptualized as being consistent with the punitive approaches to marijuana in which there would be no case under which marijuana should be dealt with leniently. A category of *pro* marijuana was defined more broadly as any argument that presented a more accepting view of marijuana, whether restricted acceptance or free will. If both sides of the argument were presented or if there was no obvious "side" of the argument being represented, the article received a code of *balanced*.

There were four frames that could be coded per paragraph: legal, social/moral, medical, and pragmatic (each of which were coded with a corresponding pro, con, or balanced stance). Each of these master frames were discovered by preliminary analysis of the articles in the study and connecting these themes to those that emerged in the two

[3] The sample began in 1993 in order to see if there was any discussion regarding Proposition 215 in the few years preceding its 1996 vote in California.
[4] If an article was less than 1/3 of a page, it was excluded from the analysis. Most of these short articles were about a paragraph in length and were typically found in recurring segments that covered many news themes in an abbreviated fashion.
[5] Fewer than half of the 61 articles had tertiary themes, so these were not included in the analysis.

historical periods presented in Chapter 2. 1.) Even before Anslinger took marijuana under the wing of the federal government with the 1937 MTA, legal sanctions were deemed a fit response to marijuana. Law enforcement, particularly at the federal level, has had immense power in shaping the marijuana stories. *Legal* arguments, therefore, included arguments that revolve around political and legal issues involving marijuana. An arrest or prosecution of an individual because he or she was found in possession of marijuana would fit under the legal heading. Any arguments that deal with changing or reinforcing the law were also categorized as legal frames. 2.) Historically, the connection between marijuana use and immorality was linked to the social and recreational choices of its users, whether Mexican immigrants of the 1930s and 40s, or youthful rebels of the 60s and 70s. A *social/moral* frame incorporated arguments that were supported either by ethical, principled stances or by explanations regarding why marijuana should be acceptable or unacceptable for leisure and recreational reasons. Keeping youth away from the "evils" of drugs, suggesting that the prohibition of the drug violates our civil liberties and freedom of choice as Americans, pointing out the informal acceptance of drugs in particular social circles, for instance, would all be classified as moral/social frames. 3.) *Medical* frames were those arguments that provided evidence about the benefits or dangers of using marijuana for medicinal reasons. Stories of patients, or doctors' opinions would be classified as medical frames. If an article contained a discussion revolving around legalizing marijuana for medical purposes, it would be coded either as a legal or medical argument. The choice of primary frame was made by determining whether the medical issues or the legal issues were at the forefront of that particular paragraph's discussions. 4.) A final category that emerged from the data

encompassed arguments that were presented as practical, functional, and unemotional. Unlike the often emotional claims linking marijuana use to immorality, scientific claims of the effects of marijuana, either on the body or society, have been presented in a seemingly more matter-of-fact way. Similarly, arguments about the financial harms (or potential benefits) of marijuana are portrayed as a practical and rational argument within the marijuana debate. Reporting scientific evidence or discussions of the business and financial consequences as a result of marijuana's status, for example, were coded under a *pragmatic* frame. (Similar to the legal-medical distinction, if scientific evidence was used to discuss the merits of medicinal claims, it's code would be determined by which of the two frames, scientific or medical, were most highlighted. In most cases, scientific arguments supporting or debunking medical marijuana claims were coded as a medical, as opposed to a pragmatic, frame.)

Coding Details: Character Types and Their Characterizations

The previous chapters highlighted the importance of the many characters who were a part of the marijuana story, whether they are groups with a specific agenda and viewpoint, victims in the war on marijuana, or the users themselves. Looking only at the frames and stances, therefore, would not be enough to truly capture the diversity of views represented in stories on marijuana. As the frames for each article were being coded, a very separate narrative began to emerge from the embellishments and details provided within the stories. This narrative involved a cast of repeating character-types (users, proponents, opponents, and law enforcement) with a limited number of characterizations (expert, hero, victim, villain, loser, and ambiguous) from which to draw. The way that these characters are presented may influence an individual or group's ability to be seen as

a legitimate force within the article and, therefore, affect the weight the characters have to sway the "bias balance" scale. The characterizations of the major players, therefore, were coded.

Characterizations were analyzed each time a character "appeared" in the story. The assignment of a characterization lay not in the individual or group's title, but in the way that that particular character was used within the story. For instance, vociferous anti-drug advocate and drug czar Barry McCaffery was considered an expert if he served the purpose of providing information within a paragraph. Setting him up as a character who is "a smart, likable, earnest man who believes he can *help Americans by fighting the drug war*," (Stein et al. 4 Nov 2002: 55, *emphasis added*), would earn him the status of hero. One individual, therefore, could be characterized differently every time the character appeared in an article. Each characterization was counted as a separate code. Characters were defined as any individual or group (representing one opinion) upon which the story relied to add credence to or disqualify a particular argument in the marijuana debate.

Pre-coding a subset of the sample, four major character types emerged. The first was the drug "user", defined as any individual (or group) that was either accused of or admitted to using marijuana currently. "Proponents" were individuals or groups who supported some degree of legalization or less punitive stance on marijuana. The third category, labeled as "opponent", was defined as any individual or group who took a solely punitive approach to marijuana. Finally, a "law enforcement" category surfaced. These were individuals or groups who were responsible for carrying out the current federal or state regulations involving the drug such as local police or the DEA.

Each of these four major players was characterized in a particular way which may affect, either negatively or positively, the weight and authoritativeness of the voice. Five characterizations of these groups and individuals emerged from the data: loser, victim, hero, villain, and expert. If a character could be seen fitting into either none or more than one of these characterizations, a sixth code of "ambiguous" was assigned. These characterizations fall on a loose continuum in terms of representing a legitimate voice. On the side of the least authoritativeness and legitimacy lies the *loser*. Losers were portrayed as individuals who had no apparent usefulness to society or who had not "grown up" to join the working adult world. The adjectives used to describe this group tended to be demeaning, belittling, and generally (although harmlessly) negative. Like losers, *villains* are typically described using negative imagery, however villains are portrayed with considerable agency. These individuals and groups are represented as being actively out to harm another individual or group that represents the opposing viewpoint. Next on the continuum of legitimacy lay the *victims*. Victims are defined as those individuals who are represented as being an injured party, innocent bystanders who have been caught in the crossfire of the drug war. Although there is certainly sympathy created for these individuals, and therefore their story is important to hear, they are constructed as being individuals or groups for whom we feel bad, not individuals or groups to whom we might go in order to gain a non-biased view of the drug debate. Much more authoritative of a source, although still a character with whom we react emotionally instead of intellectually would be the *hero*. A hero is described using glowing, impressive adjectives about his or her behavior. This is an individual or group who sacrifices in order to help others. Descriptions of heroes are positive. The most

authoritative of all is that of the *expert*. This character is conveyed using much more dry language as someone or some group that has a reason to be an authoritative source. (For specific and typical examples of character types and their characterizations, please see Appendix 5.)[6]

The search for the degree of variation presented in newsmagazine articles must be a multi-faceted one looking both at the frames that focus the debate and the pixels (details) that enhance the story. I suggest that while the frames may highlight a more visible bias, with only a small number of similar frames across the three newsmagazines, the contextual details within the stories and the characterizations of the major players may serve to perpetuate more latent biases. Recognizing these biases will allow the picture of the current marijuana debates to emerge.

[6] There are other interesting ways by which one could get a glimpse of a character's constructed authoritativeness. Characteristics such as age, sex, race, educational level, and socioeconomic background of the characters within the stories, for instance, could all have an impact on the article's (perhaps hidden) bias. Although, for pragmatic reasons, I did not focus on the role these characteristics have played in this study, this is a potentially appealing focus for future research.

IDEOLOGICAL FRAMES AND THE CHARACTERS WITHIN THEM

The Balance of Marijuana Frames

Table 5.1. Primary and Secondary Themes (in percentages)

	Primary Theme*	Secondary Theme
Legal	37.7	33.9
Medical	18.0	20.3
Moral/Social	23.0	18.6
Pragmatic	21.3	27.1
Total	100.0	99.9
(N)	(61)	(59)^

* $p \leq .02$; $X^2=5.557$
^ Two articles did not have secondary themes

Table 5.2. Primary and Secondary Stances (in percentages)

	Primary Stance**	Secondary Stance
Con	18.0	35.7
Pro	13.1	21.4
Balanced	68.9	42.9
Total	100.0	100.0
(N)	(61)	(56)^^

** $p \leq .001$; $X^2=34.858$
^^ Five articles did not have secondary stances

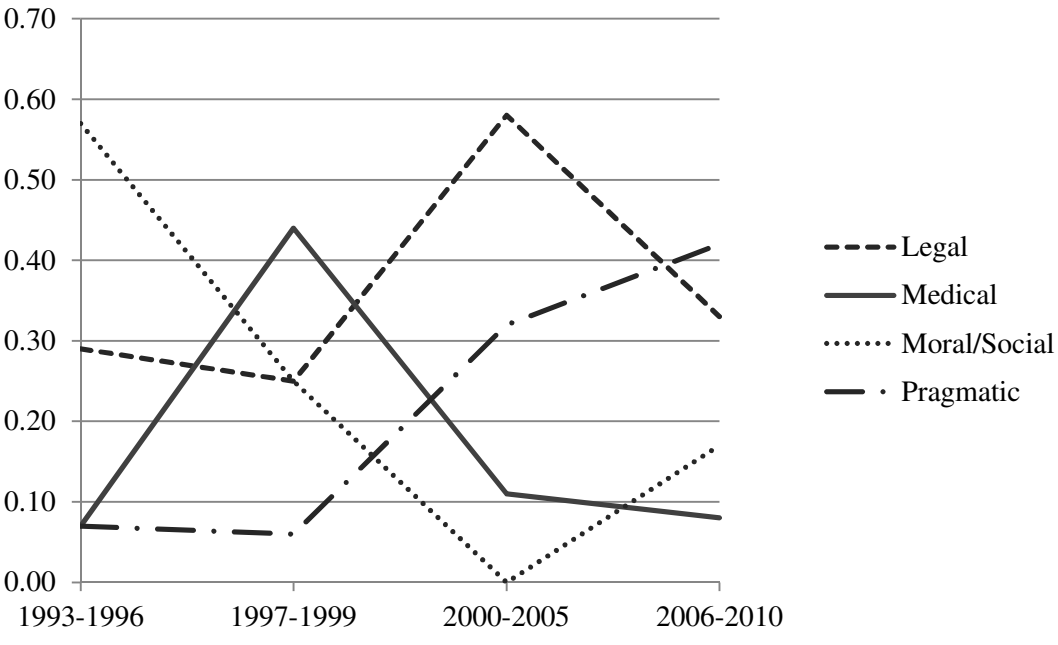
Looking at the distribution of primary and secondary frames (see table 5.1), the foremost way by which news articles framed stories regarding marijuana was through the use of legal themes. Legal arguments were used as a primary frame in 38% of all articles and as a secondary frame in 34% of all articles. The next most common primary news frame was moral/social. While pragmatic frames, basing arguments around the scientific and/or business elements of marijuana policy and use, were used slightly more often overall than moral/social arguments, pragmatic news frames were more likely to be secondary than primary frames. Scientific claims, and other less "emotional" arguments seem, once again, to fall into the background of the ideological debate. Medical frames were also more likely to occur as a secondary frame than a primary one, and represented the category least likely to be used across the sample totaling about 38% of all articles that included any medical argument.

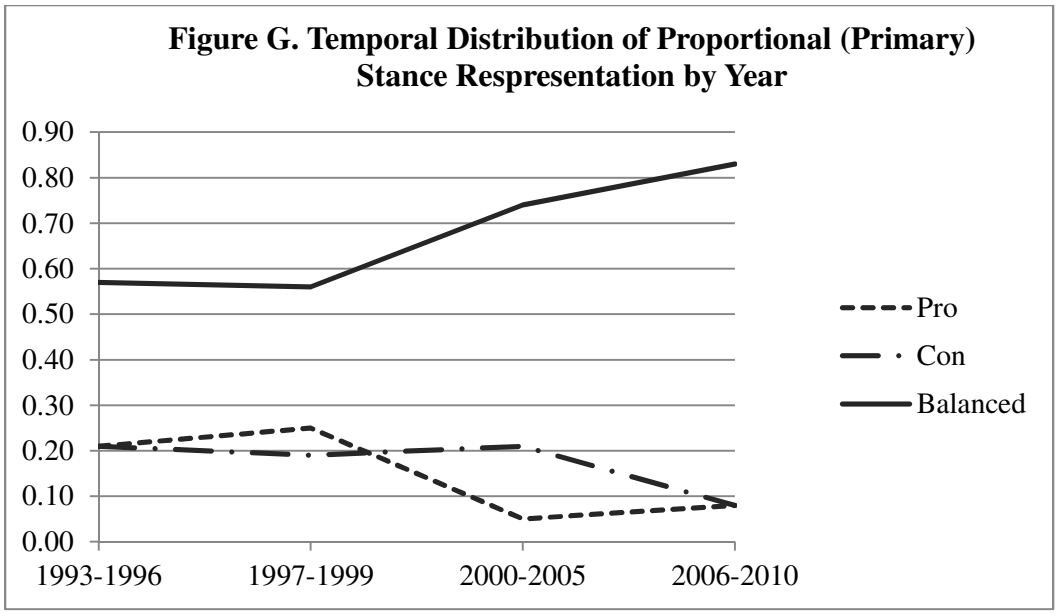
It would appear from the frames' corresponding stances (see table 5.2) that the vast majority of the articles offered a balance of views both in the primary and secondary frames. Articles that did take a stance, whether pro or con, were likely to have those stances as a secondary frame as opposed to a primary frame, and there was a higher percentage of articles with a secondary stance that is opposed in some form to marijuana than in support of marijuana issues, at 36% and 21% respectively. These data, so far, support the notion that articles offer a balanced view, with a slight tendency toward anti-marijuana stances. The initial conclusion that might be drawn after looking at a preliminary snapshot of the articles' news frames and stances is that these news articles are predominantly balanced legal stories.

Comparing the presence of article themes and stances across time periods would also seem to support these preliminary findings (see figures B and C). Because there was not an even distribution of articles across each year, four time periods were created. The first time period, 1993-1996 represents early discussions that occurred just prior to and concurrently with the passage of California's Proposition 215. There were 14 articles during this time period. Between 1997 and 1999, with 16 articles in the sample, five more states passed medical marijuana policy, each via voter ballot. During this time, these states could be considered early adopters that had to rely on public support in order to pass these pieces of legislation. The year 2000 saw the first bill passed through a state's legislature (Hawaii), and coincided with a new Presidency. This third time period, from 2000-2005, with 19 articles having been written about marijuana, saw another five states successfully pass medical marijuana legislation. Finally, beginning exactly one decade after the first medical marijuana policy was passed, 2006-2010 marks more recent

marijuana discussions, and includes the time period during which President Obama took office, with his (supposedly) more lenient stance on the drug than his predecessor. The fewest number of articles, 12, were written about marijuana during this last time period in the sample. In order to account for the numeric differences in article themes and stances across the four time periods, the representation of each theme or stance in a particular time frame was measured proportional to the total number of that themes or stances coded for that time period. (For instance, since there were seven articles coded as having a primary medical theme from 1997-1999, and 16 articles coded in that time frame, it received a proportional score of 7/16 = 0.44. See the tables in Appendix 6 for the numeric and proportional themes and stances for each time period.)

Figure F. Temporal Distribution of Proportional (Primary) Theme Representation by Year





Looking first at the temporal distribution of article themes (see figure F), moral/social arguments were much more likely than any other type of argument to be used in early conversations about marijuana. The next two time periods saw moral/social arguments declining dramatically, with a slight increase in the past few years. Although legal and pragmatic arguments were slow to become a part of the conversation, they followed similar paths to each other, both increasing during the time of legislative marijuana passage, 2000-2005. In the past few years, pragmatic arguments have increased slightly, while legal arguments declined more dramatically. Medical arguments peaked during the 1997-1999 timeframe. Perhaps it is not surprising that this is when medical marijuana began to accumulate its momentum, with ballot initiatives being tried in a number of states and five states finding enough citizen support to allow for passage.

The data become more telling when looking at the temporal distribution of themes (figure F) compared to the temporal distribution of stances (figure G). Figure G clearly shows that there is a higher proportion of articles with a balanced stance across all of the time periods. Comparing the patterns of articles offering a pro versus a con stance, the

only time period during which there was a higher proportion of pro-marijuana articles than those with anti-marijuana stances coincided with the time period during which the majority of medical arguments were being used, 1997-1999. Although it is not possible to determine from these data whether or not these specific medical frames appeared in articles with an associated "pro" stance, it does indicate the general tenor of marijuana discussions in the media at the time. As both pro-marijuana articles and those dealing with medical issues were declining across the final two time periods, articles taking advantage of moral/social arguments were also declining, with no articles between 2000 and 2005 that used a moral/social frame to cover a marijuana story.

Articles that took a more restrictive ("con") approach to marijuana were most likely to occur during that same time period, 2000-2005, when the Bush administration was trying to up the ante in the war on drugs as state legislatures tried to (some successfully) get medical marijuana on their state legislative agendas. At the same time, arguments that centered around legal or pragmatic (financial implications, scientific discoveries, etc.) issues were also relatively highly represented. The tone of the debates at this time seems to have moved to a more rational, perhaps less impassioned perspective. Articles that offered a more balanced perspective were also increasing during this time period. As the debate entered its final stage (for this sample), there were approximately the same proportion of articles offering a pro stance as a con stance, while articles offering a more balanced approach to the topic had a much higher proportional representation (see figure G).

Although the temporal distribution can begin to shed light on the tone and type of debates that were occurring in the media across these four time periods, these data are

unable to determine which of the corresponding themes took a pro, con, or balanced approach. In order to more fully understand whether or not there is an imbalance in the news frames and ideologies present in the sample, it is necessary to consider the relationship between article frames and stances.

Table 5.3. Primary Theme by Primary Stance (in percentages)*

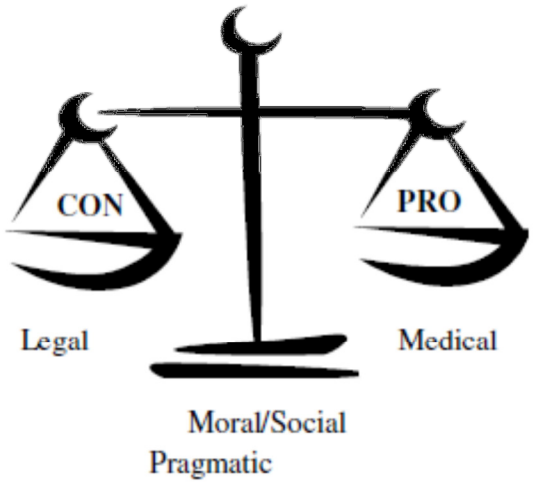
	Legal	Medical	Moral/Social	Pragmatic
Pro	0.0	36.4	28.6	0.0
Con	26.1	0.0	21.4	15.4
Balanced	74.0	63.6	50.0	84.6
Total	100.1	100.0	100.0	100.0
(N)	(23)	(11)	(14)	(13)

* $p \leq .02$; $X^2=16.52$; Cramer's V=.368

There is a significant relationship between an article's primary news frame and its corresponding stance (table 5.3). Perhaps one of the most striking findings in this table is that there were no pro-legal or pro-pragmatic arguments. Supporting the idea that legal frames were likely to be dealt with in a punitive fashion, the theme that was most likely to be categorized as "con" were legal arguments. Alternatively, there were no articles with an anti-medical marijuana stance, and over a third (36%) of the articles with a medical frame used arguments that were in favor of less punitive reaction to marijuana issues. Moral/social arguments were the only other arguments, other than medical, that offered a more favorable perspective on the drug. There were only slightly fewer articles with an anti-moral/social argument, and an even 50% of all of these frames were balanced in nature.

Thinking back to the imagery of the balanced scale as representing a possible bias in one direction or another, it would appear that moral/social is in a balancing position with medical and legal frames on opposite ends. While pragmatic themes would lean slightly against marijuana, this category would be close to the fulcrum. (See figure H.)

Figure H. The Balance of Marijuana Frames



When thinking about the implications for medical marijuana legislation, these frames seem to be consistent with what has been described in earlier chapters. Although the presentation of medical information seems to be favorable for medical marijuana legislation, discussions of medical marijuana are impacted by the other constructions of the drug. It is perhaps surprising that the frames that depict marijuana as an issue of morality and/or a recreational substance would be cast in a more balanced light. This may begin to explain the movement of many states toward legal acceptance of marijuana as a medicine. That, however, seems to be countered by the still punitive legal understanding of marijuana as a criminal social object. It is difficult, therefore, to judge this sample as being biased in one direction or another without taking the frame of the article into account. Legal frames tip the "bias balance" scale in the direction of punitive reactions to marijuana, medical frames, representing a smaller percentage of the total

sample, are tipped in the direction of support for medical acceptance, and the other two news frames, about 44% of all primary frames in the sample, appear to be somewhat more balanced.[7]

If one were to draw conclusions about the position of newsmagazine coverage of marijuana issues using only the news frames and their corresponding stances above, it would appear that newsmagazines tend to favor legal stories that are most likely to be against marijuana. Although the results lean slightly in the direction of punitive legal responses to the marijuana issue, the picture presented so far certainly does not lead one to deduce that the media's overall representation of the marijuana debate is grossly tipped in one direction or another.

The Balance of Character Types and Their Characterizations

As previously stated, if one looks only at which news frames appear and whether or not these frames support strict or loose reactions to marijuana, this represents only a partial picture of the image being presented to the public to shape their views on marijuana. Another way by which to capture how these particular news stories are placed within the marijuana debate is to consider the characters who appear in the stories and how they are being depicted.

[7] Secondary themes and their corresponding stances followed the same patterns as the primary themes.

Table 5.4. Character Types (in percentages) **

Law Enforcement	13.8
Opponent	25.2
Proponent	34.0
User	27.0
Total	100.0
N	(500)

** $p \leq .001$; $X^2 = 42.096$

At first glance, the proportion of different character types who appear in the articles may seem to tip the scales in the direction of pro-marijuana arguments, with 34% of all characters being proponents of some degree of legalization of marijuana, and users representing 27% (see table 5.4). The individuals and groups who might be stereotypically associated with a more punitive approach to marijuana, opponents and law enforcement, represent only about 25% and 14% of all of the characters respectively. The picture of a possible pro-marijuana bias becomes less clear when the characterizations of these character types are revealed.

Table 5.5. Characterization by Character Type (in percentages)**

	Law Enforcement	Opponent	Proponent	User
Ambiguous	18.8	10.3	17.1	18.5
Expert	3.0	49.2	38.2	0.0
Hero	31.9	19.0	14.1	3.0
Loser	7.2	8.7	13.5	42.2
Victim	20.3	1.6	15.9	30.4
Villain	18.8	11.1	1.2	6.0
Total	100.0	99.9	100.0	100.1
N	(69)	(126)	(170)	(135)

** $p \leq .001$; X^2=226.328; Cramer's V=.388 N=500

There is a significant relationship between a character and how that character is portrayed, and the data above appear to point the "bias balance" back toward a more balanced/slightly anti-marijuana direction (table 5.5). Fitting within a bias leaning in the direction of punitive reactions to marijuana, the cells with the two highest values are loser users and opponent experts. Almost half of all opponents of marijuana mentioned in the articles were characterized as experts, the classification with the highest level of authority (closely followed by 38% of proponents who were classified as experts; see the following section for a more detailed discussion of this difference). Forty-two percent of all users were portrayed as losers, significantly higher than any other character type to be described in such a negative light. Thinking about the high percentage of user loser, opponent expert, and law enforcement hero, the scales appear tipped in this same punitive, anti-marijuana direction. Law enforcement, although characterized as a hero 32% of the time, was also the group most likely to be classified as a villain, almost 20% of all the law enforcement classifications. The only category that clearly tips the scales in

a more pro-marijuana direction is the victim category, with 30% of all users being characterized as victims. Both law enforcement and user categories reveal incongruous characterizations, a possible indicator of the ambiguous nature of marijuana.

Trying to position these characterizations appropriately on the "bias balance" scale becomes difficult, however, without more textual support that would serve to illuminate the true differences between each character type. This bounded snap-shot is actually much more complex than these numbers may make it appear. The quantitative differences shown in table 5.5 above are, in fact, qualitatively different once the snapshot's pixels, the textual details embedded (perhaps hidden) within these news stories, are analyzed. Identifying these details will bring a deeper level of understanding not only of the claimsmakers and other characters involved in the marijuana saga, but also how the construction of the meaning of the drug itself is made by a supporting cast of characters.

THE NUANCES OF TEXTUAL ANALYSIS

The Unequal Status of Proponent/Opponent Experts

Although, looking at table 5.4, there were more proponents than opponents in the sample, opponents are more likely to be characterized as experts than proponents. (There were no expert-users and very few expert-law enforcement officials.) Almost 50% of opponent characters are classified as experts compared to 38% of proponents (as shown in table 5.5). While the numerical difference may not seem substantial, the distinction between expert-opponent and expert-proponent becomes even further emboldened by looking at the details within the text. As the characterization with the highest level of

authority, understanding how the media attempt to portray these experts is important. There are two ways by which the expert-opponent category represents an, arguably, more authoritative voice than expert-proponent.

The first distinction found between opponent and proponent expert lies in the difference between the character's proximity to high levels of government and the associated title attached to the expert in question.[8] Almost three-quarters of all opponent experts coded are high government officials who are specifically linked to the White House. Former "drug czar" Barry McCaffery is the expert-opponent who is most often cited, almost always with direct mention of his position at the Office of National Drug Control Policy (ONDCP) and an explicit link to the White House. The Supreme Court, Justice Clarence Thomas, both Bush and Clinton administrations, Republican Bill McCollum as head of the Drug Enforcement Agency (DEA), former drug czar William Bennett, and national organizations such as the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Service Administration (SAMHSA) are some of the heavy hitting anti-marijuana authoritative expert voices.

In contrast, it was not until 2001, after nine states had passed medical marijuana legislation, that high ranking federal level experts appear in articles in which they voiced a more liberal position on marijuana. In the first article in which a high ranking proponent-expert appeared, the author examined the 2001 Supreme Court declaration that "illness is no excuse for legalizing marijuana," noting that there were "three liberal Justices, led by John Paul Stevens, [who] chided the conservative majority," (Roosevelt

[8] The lack of high-ranking government officials may be due to a real lack of government officials who support more acceptance of marijuana, an unwillingness of government officials to come out publicly with a less punitive stance towards drugs, or journalists' selection of sources. Whatever the reason for the dearth of high ranking politicians representing a more pro-marijuana stance, this does not negate the fact that the public are receiving a picture of experts that is slanted in the direction of more legitimate expert-opponents.

and Shannon 28 May 2001: 50). Although reasons were given why these "liberal justices" dissented from the majority of the court, this group of high ranking expert-proponents appeared in an article discussing their loss. In a November, 2010 article, "Pot and the GOP" (Conant and Maloney), pragmatic arguments were used to discuss some potential financial benefits of loosening marijuana laws. Although Republican politicians were cited in support of marijuana, there were just as many Republican politicians used as experts defending the status quo position of marijuana as a criminal and dangerous drug. There were only three other instances in which high ranking expert-proponents appeared, and each voiced an opinion only on supporting *medical* marijuana.

The contrast of position becomes more evident when examining articles that include both opponent and proponent experts, pitting anti-marijuana federal officials against lower ranking state officials. The lead line in a 1997 article "Can Marijuana Be Medicine" sets up the weight of each of the experts presented in the article stating "the claims are unproven, but many patients say the drug helps them," (Cowley and Hager). The expert-proponent who is cited in the article is Keith Vines, a prosecutor and former district attorney in San Francisco. Although his perspective from having been in the legal field is raised, his expert status comes from his having suffered from AIDS, using anecdotal evidence suggesting, "'Without marijuana,' he says earnestly, 'I would be dead'", (ibid). His experience, however, is countered by expert-opponents then drug czar McCaffery and two doctors disputing the medical utility of the drug. In another article that describes some European countries' gradual acceptance of marijuana (Power, Johnson, and Theil 1 Nov 1999: 53), the apparent quantitatively "equal" presentation of sides is, arguably, destabilized when considering who the experts are. The two anti-

marijuana voices in the article were England's Prime Minister Tony Blair and White House drug czar Barry McCaffery. The two voices supporting the other side of the debate were two foreigners who are most likely unknown to *Newsweek's* readers including Bonn, Germany's police chief, Dierk-Henning Schnitzler and harms-reduction advocate Nicole Maestracci, director of France's Interministerial Mission Against Drugs and Addiction. In an earlier *Newsweek* article (Kalb et al. 29 Mar 1999: 35), Harvard doctor Lester Grinspoon is the only expert voice in support of medical marijuana. The other side is supported by experts "drug czar Gen. Barry McCaffery" (explicitly stating his title at the ONDCP) and "Rep. Bill McCollum, who last fall introduced a House resolution urging states not to pass marijuana referenda." (That was directly followed in the article by noting McCollum's victory on the referenda by a vote of 310-93.) The unbalanced representation of high-ranking opponents of marijuana and comparatively lower ranking proponents of marijuana occurred in every article that included experts on both sides.

The second difference found between proponent and opponent expert lies in the phrasing and adjectives surrounding these experts that serve either to boost or undermine the authoritativeness of the voice. The vast majority of expert-opponents were introduced into the stories by using straight-forward language emphasizing their title, years of experience, and credentials. For example, two typical examples of the language surrounding the use of an expert opponent are: "…Says Mark Kleiman, a UCLA professor who specializes in national drug policy…" (Morrow and Graff 9 Dec 1999: 28), and "As Dr. Volkow, director of the National Institute of Drug Abuse puts it," (Gupta and Sloane 6 Nov 2006: 98). Of the few cases in which expert-opponents were described

using more descriptive language, the prose could be, arguably, read to be positive in nature. A typical example, Dan Lungren, was described in a *Time* article as "California's *politically ambitious* attorney general," (Lacayo and McDowell 28 Oct 1996: 37, emphasis added). Although some could certainly read "politically ambitious" as a negative, power seeking characteristic of Lungren, this embellishment does not delegitimize his voice the way that the more elaborate descriptions of expert-proponents served to undermine their clout.

In contrast, very few expert-proponents were introduced *without* some descriptive language, often not at all related to their title, years of experience, or credentials. The focus instead was placed on the character quirks and traits of the individual or group. Advocate for more leniency toward marijuana, Arcata, California's Mayor, Bob Ornelas, is described as "a ponytailed electrician," (Hornblower 3 May 1999: 7). Dennis Peron, medical marijuana activist, marijuana club owner, medical marijuana user, and a key player in drafting Proposition 215, California's medical marijuana initiative, was the expert who was most often cited in favor of medical marijuana. He is introduced as a "pro-pot proselytizer" in one article (Shannon and Harrison 8 Dec 1997: 84) and another undermines his status as expert.

> In this era of pot clubs-cum-health clinics, [San Francisco Cannabis Cultivators Club] is becoming a relic, albeit a big one. It's a media favorite, though, because its freewheeling atmosphere fits many of the critics' stereotypes of what would happen once pot use was legalized. … The thrift-store couches are fraying but comfortable and there is an endless supply of pot, which patients can often be seen sharing. This place has a …shrine to the dead guitarist [Jerry Garcia]. It also has *Dennis Peron, the oft convicted drug dealer and activist who started the club and helped lead the drive for Prop. 215*. (Streisand 19 May 1997: 28, *emphasis added*).

Not only is he described as being a "drug-dealer" (with activist close behind), but he is closely linked with negative imagery of the frivolous (perhaps dangerous) marijuana culture. It is hard to take any expert seriously when his or her introduction serves to discredit the argument before it is made. The weight and authoritativeness of experts' arguments are affected not only by the *number* of different experts and their corresponding stances, but also by the *textual details* that may highlight or undermine their status as expert. When thinking about the implications of the different portrayals of expert-opponent and expert-proponent for the construction of marijuana as a medicine, punitive reactions to the drug appear to have not only more space within newsmagazine coverage, but more legitimate experts, suggesting more support for marijuana as a criminal substance.

The Ambiguity of Heroes and Villains

As demonstrated by the historical battles that were fought against marijuana, the credibility of an argument, and the likelihood that the presence of a particular "side" of an argument will tip the scales in one direction or another may also be affected by the portrayal of certain characters as either villains or heroes. The distribution of the category villain (see table 5.5) seems to support a pro-marijuana bias. There were only two proponents characterized as villains and surprisingly few users obtaining the villain code (only about 6%). Of the few villain-users who appeared in the articles, all of them were written as faceless groups with only generic identifiers attached. Mennonite farmers using their reputation as innocent, law-abiding citizens, to get past the border inspectors and sneak marijuana into the country were portrayed as the "Mennonite mob" out to hurt the youth of this country (Padgett 17 Jul 1995: 33). In another article, the

Angeles National Forest officials were fighting some visitors to the woods who "indulge in felonious activities: there are murders, carjackings, gang fights, graffiti, and pot farming on a grand scale," (Murr 4 Nov 1996: 69). Similarly, when drug smugglers and the "scores of Mexican workers arrive to harvest and process the pot, shoot-outs occur between law-enforcement agents and camouflage-clad growers touting AK-47s," posing a threat to law enforcement and the public (Roosevelt 4 Aug 2003: 45).

Compared to their more lenient marijuana counterparts above, there were more law enforcement officials and opponents who were characterized as villains (almost 19% and about 11% respectively, admittedly not large percentages). With the exception of two articles dealing with an Olympic Scandal in 1998 when a snowboarder tested positive for marijuana, and two articles dealing with Olympic swimmer Michael Phelps' 2008 picture made public of him with a bong [water pipe], *all of the other opponent and law enforcement villains pitted themselves against the medical marijuana fight*. Two of the articles mentioned Attorney General Janet Reno's threats "to prosecute doctors who prescribe marijuana to patients," and these doctors "risked losing their licenses," (Brookheiser 13 Jan 1997: 9; Rogers 13 Jan 1997: 60). In these cases, the Attorney General was positioned as the individual who would stand between doctors and sick patients who desperately needed the help that marijuana could provide. Governor Pete Wilson found himself in a villainous position in a *Newsweek* article because he twice vetoed bills that the people of California had positively voted for by a margin of 2 to 1 (King and Peyser 14 Oct 1996: 42). While these examples serve to demonstrate that the federal government and its representatives can harm "the little people", their targeted villainous actions are often justified within the text.

> The fight [for medical marijuana] has done quite well, especially when, to their [medical marijuana advocates'] surprise, the Federal Government took the bait and started arresting little old ladies and storming peaceful pot-growing initiatives. In fact, the pro-pot people have done well enough that some of them feel it is time to drop the ruse and fight for full legalization. (Stein et al. 4 Nov 2002).

On the one hand, the Federal Government appears to be bullying helpless individuals who are peacefully trying to have the law changed for the greater good. On the other hand, the pro-marijuana victims are not shown to be as helpless and sympathetic as our initial reaction might be to "little old ladies". Pro-marijuana advocates are seen as calculating and somewhat manipulative. Even the villainous status is not as clear cut a category as one might imagine considering the questionable nature of their adversaries.

As mentioned earlier, with the exception of the articles on the two athletic scandals involving marijuana, all of the other villain-opponents appear in articles and paragraphs dealing with medical marijuana, an issue that garners a great deal of public opinion support. On the other hand, all of the articles in which law enforcement officials and opponents of marijuana received *heroic* status were in situations that had a much stronger base of public support. About 20% more of Americans are in favor of medical marijuana than support complete legalization (Newport 2011). Threatening a less clearly established boundary regarding marijuana's legal status becomes a much more egregious act than enforcing federal law when ordinary (non-sick) individuals are involved. Federal agents stopping individuals from growing marijuana for medicinal reasons may appear to be somewhat villainous, however federal agents making drug busts to ensure that marijuana does not find our healthy youth is constructed as much more obviously heroic. While there were four proponents of marijuana who were concerned with the ways bringing marijuana into the ally side of the war on drugs would be financially

prudent, all of the other proponents of marijuana received a heroic classification in stories discussing medical marijuana issues. The topic and frame of an article, therefore, matters when trying to understand how proponent and opponent character types are classified.

Context affects whether a proponent or opponent is deemed a hero. Although there is little difference between the likelihood that an opponent will be categorized as a hero compared to a proponent (19% compared to just over 14% respectively), law enforcement groups and officials were most likely to be classified as heroes (at almost 32%, see table 5.5). The difference between anti-marijuana heroes (opponents and law enforcement) and pro-marijuana heroes (proponents and users) lies in the textual details that surround the hero classification. Compare the following two paragraphs that are both the closing statements in the articles.

> It's not just gangs, though. More marijuana is now grown in the Angeles and southern California's three other national forests than in all of the notorious "emerald triangle" forests in northern California. Pot growers clear acres of underbrush with chain saws, run hundreds of yards of irrigation hosing to water plants with creek water and foul the area with fertilizers, rat poisons and pesticides. As the pot problem grows, the "tree police" have grown more adept at surveillance and busts. With night-stalking equipment, they can track dealers and interrupt moonlit harvests. Forest Service cops recently bushwhacked for 16 hours through steep canyons to arrest three startled pot farmers. But such efforts are time-consuming and take the 14 Forest Service cops away from standard park patrols. It's getting to the point in the national woods where they can't see the forest for the keys. (Murr 4 Nov 1996: 69).

> Republican Dennis Peron, the author of Proposition 215 and one of the most outspoken figures of the medical-marijuana movement [was prompted] to enter the race for governor. The flamboyant Peron, founder of the 9,000-member San Francisco Cannabis Healing Center, which resembles a '60s hippie den, says he will go to jail rather than shut the club. And should he triumph in his steeply uphill race for governor, he is prepared: 'My first act will be to pardon myself." (Streisand 19 May 1997: 28).

In both cases the prose is very descriptive, a common stylistic technique for newsmagazines. The differences between the descriptions of the two heroes, Dennis

Peron and "14 Forest Service cops" are striking and typical of the differences between opponent and proponent heroes in the sample. In the first case, the police responsible for patrolling the Angeles woods are constructed as being in a fight to protect the public and willing to go to any, selfless lengths to ensure that the laws that protect the public are being upheld. In the second case, while Peron is willing to risk his freedom for the right of patients to use medical marijuana, his selflessness and authority as an heroic figure are called into question by describing him as "flamboyant" and likening his supposed medical establishment to a "60s-hippie den." Not only is the use of language a powerful way to either support or weaken one's status as a hero or villain, but the circumstances of the stories influence who receives a villain versus a hero label. While fighting to promote medical marijuana acceptance, these heroes seem to be undermined. This is in contrast to the opponent/law enforcement heroes who are fighting a less ambiguous battle against marijuana as a recreational drug. Although these groups' villainous status is constructed in opposition to medical marijuana, the dubious nature of their victims adds to the murky state of legitimizing marijuana as a medicine.

Losers Fighting a Medical Battle

Portrayed in a negative light, however not as actively playing a role against others as the villain category, are losers. Although relatively small percentages compared to some other categories, opponents were almost as likely as proponents to receive a classification of loser (at almost 9% and 13.5% respectively), and *all* of the loser-opponent and loser-proponent characterizations occurred in medical marijuana stories. The text offered subtle differences between proponent loser and opponent loser, categories that would not be visible looking only at quantitative differences.

Losers were characterized by using strong language, portraying proponents of medical marijuana to be irresponsible "hippies" out to use the medical issue as a façade for eventual complete legalization and opponents as unsympathetic soul-less individuals who would take needed medicine out of the hands of sick and dying patients. The differences lay in *who was making the negative characterizations*. Only one of the opponent loser classifications was made by a journalist with no obvious source, who claimed that "opponents of medical marijuana typically make three arguments, all of them mistaken," (Brookheiser 13 Jan 1997: 9). This was one of the least colorful ways to attack the other side, and was not aimed at any one individual. All of the other opponent loser characterizations were attributed to their adversaries. For instance, two well-known marijuana advocates accused the DEA of "acting like a bunch of bullies" and called drug czar Walters "a pathetic drug-war soul [who is] defending a whole catalog of horrors he's indifferent to," (Stein et al. 4 Nov 2002).

While there were some direct quotes made by anti-marijuana advocates personally attacking their pro-marijuana counterparts, the vast majority of the proponent loser classifications were generalizations made by the journalists themselves.[9] Most of these classifications by journalists hinted at proponents' irresponsibility. Three articles talked of "Dr. Feelgoods," "friendly doctors," and "crooked doctors" who would write a prescription for medical marijuana for any reason, (Hornblower 3 May 1999; Shamma 19 Jul 2010; Streisand 19 May 1997). After five years of fighting for the first clinical trial of marijuana, the scientist at the helm was described as "a stubborn and irreverent oncologist," (Cloud 4 Nov 2002). At the end of a story about a paraplegic woman who

[9] It is unknown whether it is more or less powerful to have negative portrayals made by journalists as opposed to quotes from other, more specific sources. This is, perhaps, an interesting research question for a future study on audience reactions to possible news bias.

was arrested for using marijuana in her home, journalist Joel Stein declares that "pot people, surprisingly, can move pretty fast when they want to," (Stein 4 Nov 2002). In a tongue-and-cheek article looking at the effect that many poorly run marijuana clinics have on the illegal marijuana market, Stein begins the article characterizing a marijuana activist. "Some dude outside my supermarket just asked me to sign a petition to legalize marijuana. Apparently he was so high that he forgot he's in California, where pot is already more legal than budget-balancing," (16 Nov 2009: 64). Although both opponents and proponents who were classified as losers appeared in medical marijuana stories, the differences lay in who was making the characterization. This may indicate that while there needs to be a direct source calling into question the status of opponents of marijuana, disparaging marijuana's proponents, in contrast, is part of the journalistic prose, seeming to assume a taken-for-granted, perhaps commonsense notion of the trustworthiness of the proponents of marijuana.

The only character type classified as loser under non-medical circumstances was the user. Some of the descriptions were outright attacks on individuals who used marijuana. Although this *Time* article goes on to cite some scientific evidence of the effects of marijuana on brain activity, the statement "potheads are dumber than nonusers" begins that particular paragraph. Earlier in the article the author had made another attack on the intelligence of marijuana users after stating that "a 160-lb. person would have to smoke roughly 900 joints in a sitting to reach a lethal dose" and that "no doubt some have tried,"(Cloud 4 Nov 2002). In a *Time* title article entitled "The Science of Pot", the author quips, "The timeless question of whether pot makes you stupid seems easy to answer just by watching a stoner movie. Do those guys look smart to you?" (Kluger and

Szalavitz 22 Nov 2010). Another journalist suggests that "pot smokers aren't outsiders anymore; at worst, they're arrested adolscents," (Luscombe 7 Jul 2008).

One might expect that individuals who used marijuana for medicinal purposes would not be characterized as losers, however more than half of all user loser classifications were in situations in (supposedly) medical use cases. One of the ways by which medicinal users were portrayed as losers was by linking them to a less than savory subculture.

> Behind the counter [of the Cannabis Cultivators' Club in San Francisco], volunteers prepare nickel and dime bags of Californian weed for a long line of wheelchair-bound veterans, AIDS patients and other sick and dying people waiting for their morning high. In a violet-painted party room decorated with origami mobiles, *club regulars pass around fat joints, looking like extras from a Cheech and Chong movie*. *(Hammer 16 Mar 1998: 32, emphasis added*).

In the passage above, "wheelchair-bound veterans, AIDS patients and other sick and dying people" garner our sympathy as victims, and have been coded as such. Their status as patient, however, is weakened by the immediate references to the stereotypical marijuana culture of the 1960s. These victims quickly become the "club regulars [who] pass around fat joints…", likening them to the buffoon-like pop-culture characters who are, perhaps, iconic marijuana losers. In the vast majority of the loser category involving medical users, their roles as patient is called into question and, perhaps, undermined. They are called "potheads" (King and Peyser 14 Oct 1996: 42) and "patients" with quotation marks to emphasize the disputed nature of the role (Hammer 16 Mar 1998: 32). A number of articles pointed out that individuals who obtained medical marijuana prescriptions had "dubious diasgnoses" and unconvincing reasons such as ingrown toenails and yeast infections (Hornblower 3 May 1999; Streisand 19 May 1997; Streisand 30 Mar 1998). Although not discussing a legitimate medical user, one journalist calls

into question the legitimacy of medicalizing marijuana by stating, "Of all the potheads I know…only one still uses a dealer. He hasn't made the logical switch from purchasing illegal drugs to committing medical fraud," insinuating that many medical users obtain the drug fraudulently and without medical merit (Stein 16 Nov 2009: 64). In fact, some users were portrayed as so desperate for the drug they would forge doctors' notes (Lacayo and McDowell 28 Oct 1996; Shannon and Harrison 8 Dec 1997). Although it may appear that these users were only hurting themselves, a couple of the articles added that the medical initiatives would make it so easy to get that other non-medical users, especially youth, would be in harm's way. A 22-year old who did not want to be identified by name explained that marijuana was "hella easy to get" (Hamilton et al.23 Aug 2004: 37) and a "teenage boy" asked of medical dispensaries, "can you get me some of that pot y'all got up there for cheap?" (Streisand 19 May 1997: 29). The characterization of these young men as losers while raising the possibility that if the medical marijuana fight were won our youth would be at risk seems to counter the forces that initially appeared to be tipping the scales in the pro- medical marijuana direction

The Duality of Victim Status

The repercussions of legalizing marijuana, either for medical or non-medical purposes, not only affect some character types' likelihood of being categorized as losers, but also as victims. With the exception of two articles telling of the Canadian Olympic snowboarder who had to fight for his medal because of a positive test result for marijuana, all of the other victim characterizations for proponents and users dealt with one of two topics. The first, and less frequent, of which were articles dealing with the potential harm that could be caused to the hemp industry if marijuana were completely

outlawed, fitting within the pragmatic frame. Although hemp is quite different from the marijuana that is used as an intoxicating drug, its connection to marijuana could seal its demise if the war against marijuana is won.

> Economically speaking, though, a ban [of marijuana] could ruin the 20 or so companies that make and sell more than $5 million worth of hemp waffles, salad oils, and other foods a year. Hemp Universe here in Lexington stopped selling food weeks ago, and Whole Foods Market of Austin, Texas, recommended last week that its 129 stores remove hemp products. Other retailers are holding firm, saying hemp foods contain such tiny traces of THC that the chemical wouldn't register in a routine lab test. But that's not the same as having zero THC…" (Cloud 18 Feb 2002: 61).

The farmers who grow hemp and the companies who sell these products all have a stake in the outcome of the marijuana debate, and are being portrayed across the newsmagazines as victims to the Federal Government's stance on marijuana and all related products. Again, the characterization of these hemp proponents as victims appears to support a more lenient position toward marijuana, but considering this is a product that is not used as a drug, this characterization may not seem surprising.

The second, much larger, topic in which all of the other proponents and users obtained the characterization of victim dealt in the realm of medical marijuana. Considering that users were the group most likely classified as victims (at just over 30%), and proponents were victims almost 16% of the time (see table 5.5), and that these characters appeared to be victimized when it comes to medical marijuana, the medical frame seems, once again, to be tipping the "bias balance" scales in the pro-marijuana direction. This apparently pro-marijuana frame, however, is called into question in almost every passage describing a victim of the laws against the drug. As seen in the "wheel-chair bound veterans, AIDS patients and other sick and dying patients" as "extras from a Cheech and Chong movie" quoted above (Hammer 16 Mar 1998: 32), there was a

very fine line between victim and loser in almost every passage that included a proponent or user victim. As quoted at the beginning of Chapter 3,

> Their side [advocates for medical marijuana] got a major media boost in California in September, when federal agents busted Santa Cruz's Wo-Men's Alliance for Medical Marijuana in an early morning raid. The feds dragged the farm's owners, who were legally growing pot under California law, to a federal building in San Jose for breaking federal law and held a paraplegic resident at the farm for hours. 'I opened my eyes to see five federal agents pointing assault rifles at my head. 'Get your hands over your head. Get up. Get up.' I took the respirator off my face, and I explained to them that I'm paralyzed,' said Suzanne Pheil, 44, who is disabled by the effects of postpolio syndrome. Her story was broadcast everywhere since the pro-pot people had basically been waiting for her to be harassed, punching every phone number on their media list minutes after the raid. Pot people, surprisingly, can move pretty fast when they want to. (Stein et al. 4 Nov 2002: 56).

Suzanne Pheil, a paralyzed business woman, is clearly a victim in the passage above. Our sympathies for her story and, therefore, the side of medical marijuana, however, are quickly checked. At first, one could be led to think that the "pro-pot people" are calculating suggesting that "their side got a major media boost" when this raid occurred. After Pheil's description of the events, the community that uses marijuana, labeled "pot people" seem to be dealt with in a flippant and tongue-in-cheek manner in the last sentence. A supporter of medical marijuana, or a user for medicinal purposes, are not, in these cases, only victims; they are victims who are also linked to the negative stigma that is attached to the drug when it is used for recreational purposes. No one seems immune to these partly sympathetic partly belittling portrayals. "Though six states…have voted to legalize medicinal marijuana, federal law still requires them to prosecute any *wheelchair-bound granny smoking a bong*," (Hornblower 3 May 1999: 7, *emphasis added*). The status of victim is undermined for users and proponents.

Taking the convoluted descriptions of users as victims into account and adding the 42% of the time that users were classified as losers, it is not surprising that users were one of the two groups most likely to have been written about ambiguously. The other group was law enforcement. Law enforcement officials, who were classified as victims about 20% of the time (see table 5.5), second only to users, received the victim label for very different reasons, serving to bolster not only their sympathetic constructions, but also, perhaps, their credibility. This pull for law enforcement between hero and villain may not only explain their classification as ambiguous, but also as victim. They were only slightly more likely to be written about as victims than villains (at about 20% and 19% respectively, see table 5.5). Law enforcement officials, also likely to be characterized as victims within articles and paragraphs dealing with medical marijuana, are shown to be caught between public support for medical marijuana and their job to uphold the law. A tough place to be as a *Time* magazine article points out:

> But what's a conscientious cop to do when California voters pass a ballot measure legalizing the cultivation and possession of marijuana for medicinal purposes? And when all it takes to prove need is the approval, written or oral, of a friendly doctor? And when not just patients with AIDS, cancer and multiple sclerosis are clamoring for the drug, but also people with backaches, stress and drinking problems? One arrested planter told sheriff's deputies he was suffering from an ingrown toenail, an excuse that did not impress them. Lucy Mae Tuck, a volunteer who edits the newsletter at the Humboldt Cannabid Center, a co-op that grows the drug for medicinal use, has a physician's certificate to treat her hot flashes with the weed. Since Prop. 215 passed more than two years ago, says Police Chief Brown, 'everyone we try to arrest has a recommendation from Dr. Feelgood,' (Hornblower 3 May 1999: 7).

Police officers and other law enforcement officials are faced with the challenge of denying patients who may need the drug (AIDS, cancer and multiple sclerosis sufferers) while dealing with individuals who are, perhaps, in a less morally "ok" category such as

the poor soul with toenail troubles. Not only are our sympathies drawn toward individuals who must uphold an ambiguous law, but away from medicinal users because of the focus on the individuals who are accused of taking advantage of the new category "medical marijuana". Proponent and user victims are not enjoying the same textual support for this classification as are law enforcement officials. The frames in which these characters operate may be the same, but the details surrounding these classifications, the pixels, are not.

THE MEDIA AND MEDICAL MORALITY

When trying to get a handle on the medical marijuana debate today, looking specifically at newsmagazine coverage of all marijuana issues, the ambiguous national position seems to be reinforced. While states struggle to cope with their own idiosyncratic laws and reactions to the potential of legalizing marijuana for medicinal purposes, the national coverage of the issue seems not to add any clarity. Both determining which frames and ideological arguments are presented in the media coverage as well as analyzing the over- or under-representation of any one "side" of the ideological continuum of drug related stances, adds more context to the climate in which local marijuana policies are debated. Media scholars have documented that there is a relationship between public opinion, policy formation, and what the media are saying about a particular issue. As Bennett states, "perhaps more than any other source, journalists themselves have fueled popular expectations about the news as a window on democracy," (1990: 104-105). There is a taken-for-granted assumption that the media should play a major role in a democratic society, educating citizens and questioning

power holders. In that sense, the media not only report on, but in essence, shape the debate about the country's war on drugs. This has possible consequences for policy formation. Framing a particular policy is, in some ways, dependent on the ways by which the debate itself is framed.

> This discursive field [within which policy framing occurs] establishes the limits of policy discourse by defining the range of relevant problems to be addressed and by providing the fundamental categories that shape decision-making. (Steensland 2008).

While there is not a lack of studies on media bias, most of these studies fall into one of three categories: detecting possible reasons for the production of bias, looking at reactions to bias, or codifying and classifying media text in order to quantitatively study a possible imbalance in media content. Thinking about the degree to which diverse views are being represented in the media and whether or not these views are given a balanced portrayal, each of the above types of studies are certainly important in their own right. There are, however, nuances within the text that may affect this balance that cannot be seen by looking only at the quantitative differences of codified categories. After a preliminary and quantitative analysis of the frames used in articles on marijuana across three newsmagazines, a temporal pattern emerged that suggested that the tone of the debate moved from a more pro-marijuana stance with arguments focusing on the moral/social and medical aspects of the issue to a more anti-marijuana stance with the focus on more legal and/or pragmatic arguments. The conclusion was drawn that the different possible news frames offered a different "bias". Specifically, legal stories were most likely to have an anti-marijuana stance, medical stories were most likely to have a pro-marijuana stance, while moral/social and pragmatic stories offered more of a balanced portrayal of the range of drug ideologies. The numerical distribution of

character types and their characterizations within these stories adds slightly more complexity to the balance of views offered in the drug debate. Although there are more pro-marijuana character types to appear in these stories, their presence alone may actually tip the scales slightly further in the anti-marijuana direction because of the likelihood that these characters will be portrayed in a more negative light.

One receives a very different picture of the marijuana "bias balance" scale when the textual details of each of these characterizations are analyzed. Although the categories of experts, victims, and heroes may appear to have similar distributions across both sides of the debate, the numerical similarities hide the vast and nuanced differences that appear within the text. The media's role in the conversation about marijuana does appear to support, at least to a certain degree, the medicalization of marijuana. Seeing medical marijuana users as victims and opponents and law enforcement as villains when pitted against the medical marijuana cause is an indication of a willingness to accept marijuana as a medicine. Perhaps the change in morality that may seem to open the door for medical marijuana legislation is not a sweeping change in morality, but instead, a focused and specific change in attitudes toward a possible treatment for legitimate pain and suffering. Although science may not play a large and forceful role within the debate, it appears that medical marijuana advocates are most successful, not when emphasizing the *scientific* legitimacy of medical marijuana, but instead, re-contouring the morality discussion to include and perhaps emphasize the morality of helping those in need of a medical treatment.

This reshaping of morality discussions, however, has not completely turned the tide against a more historically supported construction of marijuana as morally wrong and

harmful. The different language that surrounds descriptions of experts, victims, and heroes, for example, serve to act as counter-weights against the presence of pro-marijuana figures, tipping the scales further in a more punitive direction. As the example of loser points out, the source of a characterization, from a journalist or an outside informant, may also affect the degree to which an individual or group's presence within a story may have a positive or negative impact.

Determining the ways by which the media take part in debates as important as the drug debate are crucial in understanding the impact the media can have in the realm of policy formation. Studies on media bias cannot ignore the many ways by which the media can tip the scales of balancing diverse views. As was stated earlier, it is not enough to look only at the approach or viewpoint of a story that draws our collective focus in a particular direction while ignoring the minutiae; nor is it enough to focus on the details of contextual and semiotic peculiarities without recognizing its boundedness. Taking both the marijuana's story's frame *and* its "pixels" into account, this analysis points to a partially changing morality. While the data give support to marijuana debates favoring medical marijuana legislation, the opposing viewpoint appears too strong, and perhaps too well hidden or masked, to be fully dismissed. As long as the negative moral and legal constructions outweigh the more positive moral and legal constructions of marijuana, there will continue to be ambiguity regarding the acceptance of marijuana as a legal medicine.

Chapter 6:
The Moral Meanings of Marijuana

MOVING FORWARD

Pending Legislation

In the most recent, November 2012 election, not only did Massachusetts become the twentieth state (which includes Washington, DC) [1] to have passed legislation favorable to medical marijuana, but two more states, Washington and Colorado, passed legislation fully legalizing marijuana for recreational use. While many states are at various stages of re-thinking their policies toward marijuana in general, four states, New York, Ohio, Illinois, and Pennsylvania, have clear momentum toward medical marijuana policy.

In New York, a judge has spoken out in favor of passing medical marijuana in his state as a bill languishes in the state legislature (Reichbach 16 May 2012). It is not yet clear if any action will be taken, however New York state Governor Cuomo has noted that he does not support medical marijuana (MPP 25 June 2012). Although activist groups in Ohio did not obtain enough signatures to get an initiative on the November 2012 ballot, these groups continue to mobilize with the goal of legally medicalizing marijuana. The state has a history of liberal policies toward the drug. Ohio considers possession of up to four ounces of the drug a minor misdemeanor, and just recently reduced charges for carrying marijuana paraphernalia. (Ghose 29 Mar 2012; Johnson 20

[1] As explained earlier in the work, I have conceptualized marijuana policies as being *favorable* toward medical marijuana legislation. Maryland, which allows for a medical marijuana defense, is included as a pro-medical marijuana state. Much of the popular media coverage on this issue excludes Maryland because while they allow for a medical defense against marijuana charges, the policy does not fit the more traditional notion of medical marijuana legislation.

Sept 2011; MPP 10 Jul 2012). At the end of November 2012, the Illinois legislature will be meeting for a special "veto" session in which they will decide the fate of House Bill 30, its compassionate use bill. Advocates are optimistic it will be successful. (MPP 5 Nov 2012; Riffle 9 Nov 2012). Since the last failed attempt in 2010, Senate Bill 1003 has been introduced in the Pennsylvania state legislature. Although it is unclear if the bill will pass, groups fighting for its passage have suggested that the bill be named after past Pennsylvania Governor and head of Nixon's National Commission on Marijuana and Drug Abuse, Raymond P. Shafer (LoBasso 27 Apr 2011).

Contradictions and Uncertainty

While these four cases are concrete stories of the potential momentum of medical marijuana, it is unlikely that the medical marijuana tale will stop here. A new understanding of marijuana is emerging. Many of the nation's citizens are outwardly embracing the notion that marijuana may not be the dangerous and immoral drug it has been constructed as being for the past eight decades. And yet, this new accepting attitude toward marijuana is in direct contrast to the federal government's continued stance that marijuana is a dangerous substance that is better left as an enemy in the War on Drugs. The contradiction between some states' liberal policies toward marijuana and the federal government's classification of marijuana as a Schedule I, illegal narcotic seems bewildering. How could there be such inconsistencies in the meaning of and policies toward one drug? What has led to the successful passage of medical marijuana in some states, and what is the likely outcome of those that are currently considering such legislation?

The findings in this work highlight the forces that have set the stage for legitimizing marijuana as a medicine embedded within a stricter federal environment. Inconsistent state level policies supporting medical marijuana and contradictions between these states' policies and the federal government's position suggest that only some conditions have been met that would allow for the full medicalization of the drug. The war to medicalize marijuana is still being waged. As battles are won and lost, with both sides of the issue feeling the thrill of some victories and the stings of defeats, a climate of uncertainty surrounding the drug is becoming more pervasive. In the jockeying for the power to construct the drug's ultimate meaning, and therefore its associated policies, the rhetoric used to control the debates has become increasingly muddied. In attempts to cut through the lack of clarity, the role of morality has been magnified.

TODAY'S BATTLES

Historically, changes in marijuana law were determined by the outcomes in four specific battle sites (as discussed in Chapter 3): the interplay between state and federal forces, an entrepreneur willing to take on the issue who has access to bureaucratic power, constructing a user in a way that is consistent with the proposed policy changes, and, finally, the defeat of science by morality. Since California first passed its Compassionate Use policy in 1996, these four battles have been waged both nationally and at the state-wide level, although they have often hidden behind the more palpable and theatrical mud-slinging and name calling that is often a part of debate rhetoric. Removing the emotions attached to the opponents in this fight, and assembling the findings that have been discussed in this work, one is able to make out some patterns that help to explain the

extent to which the path toward medical marijuana legislation has been only partially cleared.

Struggles between Federal and State Law

Although almost two dozen states have passed legislation favorable to medical marijuana, each state has its own way of instituting these policies; there is very little consistency regarding how these policies will be carried out across the states. In the historical chapter in this work, a conclusion was drawn that, when looking at the back and forth struggles between state and federal control over marijuana issues, as long as there are inconsistencies about what policies should be passed and how those policies should be instituted, the final say in the matter is in the hands of the federal government. The Department of Justice memos sent to medical marijuana states in 2011 (and discussed in the first chapter), in which the Deputy Attorney General very clearly lays out how the government will react to states that institute policies that contradict federal law, are indicative of the federal government laying jurisdictional claim to the issue of marijuana. Although states can institute their own policies, they are at the mercy of whether or not the federal government will decide to look the other way or insist that federal rule trumps state law, and apply penalties.

The statistical picture presented in Chapter 4 focused on characteristics that individual states share, categorized by whether or not a state has passed medical marijuana policy. Once the lens is pulled back, one gets a picture of a divided nation. This division is further emboldened by the national media's presentation of the issue.

> Frame battles and contests must be understood as part of a unified political field in which framing and counter-framing are not seen as two separate processes, but are mapped as part of one interlinked cultural arena. (Noy 2009: 225).

As the major players attempt to shape the national debate, the trajectory of the entire discussion will be impacted. Medical, legal, moral/social, and pragmatic arguments are not four separate narratives, but instead, are involved in the telling of one story. The apparent positions that frame news stories, found to be more pro-marijuana when framed by medical arguments, anti-marijuana when framed by pragmatic or legal arguments, and more balanced when presented with moral arguments, was undermined by the presentation of the individuals involved in marijuana struggles. Thinking specifically about the role of the federal government in these battles, federal law enforcement officials were characterized to be both heroes and villains. Their role within the marijuana saga is blurred. The available rhetoric that surrounds the national marijuana debate is decidedly mixed. There is a lack of clarity about whether marijuana should be controlled by criminal justice organizations, medical and health professionals, plant science experts, or others. While all of these players struggle to take control and the nation attempts to make sense of policy contradictions, the overriding default position will be the federal government's. As more states change their marijuana laws, the federal government may, in fact, be more open to changing its own position. Until a consensus is reached, however, the status quo remains.

The Bureaucratic Status Quo

> The mission of the Drug Enforcement Administration (DEA) is to enforce the controlled substances laws and regulations of the United States and to bring to the criminal and civil justice system of the United States, or any other competent jurisdiction, those organizations and principal members of organizations, involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the United States; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. (DEA).

The DEA mission statement quoted above identifies the primary objective of this agency – to enforce federal policy on drugs. Just as Anslinger used the battle against marijuana in its early years as a way to justify the existence of the Federal Bureau of Narcotics (in addition to Chapter 3, see, for instance, Becker 1977; Bonnie and Whitebread 1999; Booth 2003; Himmelstein 1983; Lee 2012), the DEA has a vested interest in keeping marijuana as an enemy.

> Bureaucracies are mission-oriented collectivities; over time, every bureau becomes an advocate for the policy it implements. The bureaucracies involved in sin policy are law enforcement bureaucracies. …Bureaucracies, therefore, will overestimate the danger of any sin and continually seek greater resources. (Meier 2001: 24).

Any movement toward marijuana acceptance could, arguably, be a threat to what is currently DEA "turf". The battles presented in Chapter 2 over which is the "best" science is symbolic of a larger struggle over which group has the right to define the meaning of the drug and therefore, have control over its policies. In order to have one's voice heard, however, there needs to be a powerful structure to hold one's stance up high enough for it to dominate public rhetoric. The DEA's hesitation to acknowledge marijuana science that contradicts its position demonstrates that the agency is only likely to put its bureaucratic weight behind those groups that will ensure the agency's continued control over the drug.

Measuring the political party distribution of U.S. Senators and Representatives as an indicator of bureaucratic power, the statistical analysis found that the higher the percentage of Democratic legislators in a state, the more likely that state would have been to have passed medical marijuana policy. While this finding may not be particularly surprising, it does emphasize the importance of having a person in a position of power to

not just take a stance, but to be willing to take action through entrepreneurial policy initiative. While there may be Democrats (and a handful of Republicans) willing to take a stand for the medicinal properties of the drug, the magazine content analyzed in the media chapter reveals that it is more likely that advocates and experts who stand in opposition to the status quo are marginalized or demonized. This points to a probable political reticence to get fully behind the issue, creating a hampering effect on medical marijuana momentum. Contrarily, experts and advocates of stricter marijuana policies may find themselves to be in a more advantageous position, given more weight within the subtle nuances in news coverage of the debates.

A Less Threatening User

Another battlefront that was vital to ensure the successful passage of the 1937 Marihuana Tax Act and marijuana's place in the Controlled Substances Act of 1970, and applicable to today's medical marijuana fight, is the construction of the user. In shaping drug policy, the meaning of the drug works in tandem with the image of the user. Both medical marijuana advocates and opponents are currently in a fierce battle to create an impression of users. Although the conclusions drawn from the statistical analysis point to the possibility that the stigma of marijuana use is decreasing, supported by the lack of connection between crime and medical marijuana legislation and the positive association between marijuana use in a state and the likelihood of having passed medical marijuana policy, the complex ways by which users are portrayed in newsmagazine articles adds more nuance to that understanding.

On the surface, it does appear that the stigma attached to marijuana use is, in fact, decreasing. Although users were likely to be characterized as losers, they were also quite

likely to be characterized as victims, particularly in cases of medical marijuana use. This would support a partial change in the way that the public may react when presented with an image of a marijuana user. Underneath the surface, however, stereotypical images persist. Even in cases where our sympathies may be drawn to the medical struggles that some individuals may have to endure, this victim category can be compromised by an association with a less than savory recreational image of lazy, ne'er do well, immoral users. The negative characterizations discussed in the previous chapter, however, have a significant difference from the historical characterizations of users in the 1930s and 40s and 1960s and 70s. While medical marijuana users may walk a fine line between victim and loser, they are rarely portrayed as villains. The threat of the user has been minimalized. While there may still be a stigma attached to *any* kind of user, these users are less likely to be portrayed as a threat to the fabric of society the way they have been in past constructions. While a stigma of use persists, it has loosened.

Marijuana Morality

Each previous chapter has emphasized what is perhaps the fiercest battle in the medical marijuana fight today – the conflicting relationship between science and morality. Marijuana science has its own battles to wage (as was explored in Chapter 2). Scientists can quibble over the chemical make-up of the complex drug and debate about the merits of anecdotal evidence of medicinal benefits. But, as has been demonstrated throughout this work, these scientific debates are only tangentially influential in the process of medicalizing marijuana. Whether or not this drug will eventually gain a place as a legitimate medicine is unrelated to medical science. The outcome will be dependent not on the science of marijuana, but on the winning construction of marijuana morality.

When taking a glance at the differences between those states that have passed medical marijuana policy today and those that have not, the most statistically predictive elements are those that capture a part of a state's moral sensibilities. Perhaps surprisingly, the single most predictive variable was the percentage of citizens who say that religion is important; the more important religion is to a population, the more likely that population will cling to the more traditional and historically embedded notions of marijuana as a dangerous, illegal, perhaps sinful substance. Medical marijuana policy is shaped not by science, but by value systems. The *construction* of the meaning of the drug, therefore, is the keystone in understanding how medical marijuana policy has proliferated. The rhetoric of marijuana morality matters.

In his op-ed piece in *The New York Times*, Judge Gustin L. Reichbach, cancer patient and medical marijuana user, makes the case for marijuana as a medicine. Although he leans on the scientific merits of marijuana as a medicine, the crux of his argument is only indirectly linked to scientific claims.

> This is not a law-and-order issue; it is a medical and human rights issue. Being treated at Memorial Sloan Kettering Cancer Center, I am receiving the absolute gold standard of medical care. But doctors cannot be expected to do what the law prohibits, even when they know it is in the best interests of their patients. When palliative care is understood as a fundamental human and medical right, marijuana for medical use should be beyond controversy. (Reichbach 16 May 2012).

A new morality of marijuana has come to the fore. It is no longer a drug that is relegated to college dorm rooms and city streets. The narrative of legitimate medicinal use is now a part of the national conversation of marijuana. But, even as this new morality of marijuana is growing in its ability to have a legitimate voice in the debate, the drug is still tethered to its competing constructions as a social nuisance, a criminal problem, a sin. These competing constructions add merit, on the one hand, to policies

legitimizing marijuana as a medicine, and, on the other hand, policies consistent with the federal government's strict punitive stance. Some medical marijuana advocates are aware of the weight that past constructions have on their cause.

> Just days after the passage of Proposition 215 [California's Compassionate Use Act], Dennis Peron was quoted in the *New York Times* saying that "all use is medical use." Many who had worked on the campaign cringed. It was felt that his comments were deeply irresponsible and that such claims had the potential to sabotage the efforts to help those who were actually ill. (Werner 2011: 139).

There is a tension between the morality of marijuana that is associated with recreational use and the morality associated with medicinal use. This tension undermines efforts to medicalize the drug. Unlike those drugs that are first constructed as legitimately medical, and then abused (pharmaceutical drugs, for instance), or drugs that are constructed for recreational purposes only (alcohol, for example), the ability for marijuana to be medicalized relies on an ability to put the recreational "genie" back in its proverbial bottle. In cases of abuse with other drugs, the drug itself is not the issue. It has already garnered the label of legitimate medicine. The blame for misuse tends to fall on the circumstances of the individual user. With marijuana, however, it is the very morality of the drug itself that is questioned. In order for a user to be able to legitimately use marijuana medicinally, not only does this individual need to show just motive for medicinal use, but the drug must become fully medicalized in the eyes of the policy-making public. The ties to recreational and/or immoral use encumber its ability to become a fully legitimized medicine.

Combatants in the marijuana struggle, therefore, are not just fighting about whether or not a drug has medical potential. They are waging a war of morality in which the winner gets the ability to control the image of the users, the drug's availability to the

public, reactions to use, and policy responses. The policy shifts in response to marijuana suggest that while the battles are still underway, the winning moral construction has not yet been determined.

IMPLICATIONS, LIMITATIONS, AND OPPORTUNITIES

Contributions to the Conversation

As the country continues to debate the merits of medical marijuana, and as the landscape continues to change, this research adds to the understanding of the process of medical marijuana policy adoption. Reacting to the growing numbers of states that have implemented medical marijuana policies, the literature on the *consequences* of these policies is growing, as it should. There has, however, been surprisingly little research on the process of adoption. With a number of states currently considering legislation, and many more that are likely to follow, the path to legislation is an important piece in the medical marijuana story.

Perhaps the biggest contribution this study has added to understanding the path to medical marijuana adoption has been the focus on the gradual change in marijuana morality. While advocates and opponents point to science in order to support their perspectives, the role of science was found to have been surprisingly muted. This research may serve as a call to strengthen the scientific voice in the debate and, further, perhaps even demoralize the science of medical marijuana. With lives being impacted by policy choices, perhaps just recognizing that science has been silenced by moral arguments may serve to balance the voices a bit more. The emphasis placed on morality in the construction of medical marijuana policy may also help to shed light on other drug

policies. "Any item of consumption can assume properties as an indication of the social position of its consumers," (Gusfield 1972: 24). Like previous scholars have done before me, thinking about the ways by which drug meanings are constructed, and the consequences that arise because of those constructions, can help add another layer of understanding to the ways by which policies are adopted (or not), implemented, and the outcomes of those policies.

As it stands currently, states that have adopted medical marijuana legislation have done so with the full awareness that these policies are in direct contradiction with federal law. As a Schedule I, illegal narcotic, the federal government has classified marijuana as a dangerous drug having a high likelihood of abuse and no medical potential. Nineteen states and the District of Columbia have disagreed. The patterns at work in the adoption of these state-level policies may have implications for understanding other policies that are inconsistent with the federal government's position. Recognizing the role that scientific inquiry, historical context, demographic and state-level characteristics, media coverage and rhetoric choices, and competing constructions of morality plays when states pit themselves against the federal government may add insight to other policy adoption processes. Many of the policies that are in high tension with the federal government's stance have a moral base to them. The morality policy literature is a broad and multi-faceted scholarship arena. It has provided a solid foundation on which to ground an understanding of medical marijuana policy. Just as it has informed this research, the contributions of this specific policy, medical marijuana, will be another voice in the conversation about the role of morality in the process of policy adoption.

Broad Brush Strokes and Nuance

> The definition of morality policy lies not in any intrinsic, objective characteristic of a policy or the substantive topic. … A policy is classified as a morality policy based on the *perceptions* of the actors involved and the terms of debate among them. Perceptions of issues drive political behavior. (Mooney 2001: 4).

The scope of this research was intentionally broad. The goal was to paint a picture of the ways by which the *perceptions* of marijuana have impacted the choices many states have made to adopt policies that favor the medicinal aspect of the drug. Beneath the arch of the broad brush strokes, however, some of the details of these journeys have been lost. While this research was able to capture some of the national patterns of medical marijuana policy adoption, the peculiarities of individual state stories would add another level of nuance to these findings. It would be interesting, for instance, particularly knowing the role of rhetoric and the importance of marijuana morality, to look in detail at the mechanisms at work at the interactional level of medical marijuana policy debates. How might one group's construction of the meaning of the drug for its state's citizens bound or change another group's response, for instance? Specifically, what is the role between politicians, special interest groups, local media, and citizens in shaping the likely passage of medical marijuana policy? This dissertation took a decidedly holistic and bird's-eye view of the issue. With the national context in place, a subsequent and complimentary study could narrow the lens to get a more specific, insider perspective.

While the scope of the research was large, trying to capture the role of science, history, state-level characteristics, and media coverage on such a complex issue necessitated some choices in data collection and research methods. While each of the independent variables in the quantitative chapter was able to get a general sense of the

grouping it was meant to represent, future research may want to expand the ways by which the underlying factors that impact medical marijuana passage are measured. Specifically, there are many other ways to measure a state's characteristics and personality both demographically and morally. The quantitative piece of this research focused primarily on the internal differences between those states that passed medical marijuana policy and those that did not. Able to capture a glimpse at the temporal and geographic diffusion of these policies, future studies may want to address the interplay between the inter- and intrastate forces that give shape to the medical marijuana policy landscape.

The analysis of the media coverage of this issue could also be expanded. In order to take a more in-depth look at the coverage, I chose to focus on marijuana coverage in three newsmagazines. The advantages of the magazines' national audiences, more in-depth stories with more prose, and the ability to look across one periodical over a span of a number of years served useful for this research. There would be additional benefits to looking at the different types of coverage across different media. Delving into local coverage or investigating the differences between how the debates are framed on television news compared to newspapers, for instance, would help to fill out the details of the medical marijuana story that much more.

Looking at the four states that are currently actively considering medical marijuana legislation, and thinking about the number of other states that are likely to follow, this is an important area of research. This study has been able to shed some light on the patterns that have allowed some states to medicalize a drug that has simultaneous strong negative constructions. It has also suggested the path it would need to take in

order to become fully medicalized. As states move to liberalize their attitudes toward marijuana, and the federal government, and many other states continue to push back, insight can be gained by continuing to look into the ways these battles are waged and won.

MULTIPLE MARIJUANA MORALITIES

> There was once a time when anyone could go to the corner druggist and buy grams of morphine or heroin for just a few pennies. There was no need to have a prescription from a physician. The middle and upper classes purchased more than the lower and working classes, and there was no moral stigma attached to such narcotics use. The year was 1900, and the country was the United States. (Duster 1970: 3).

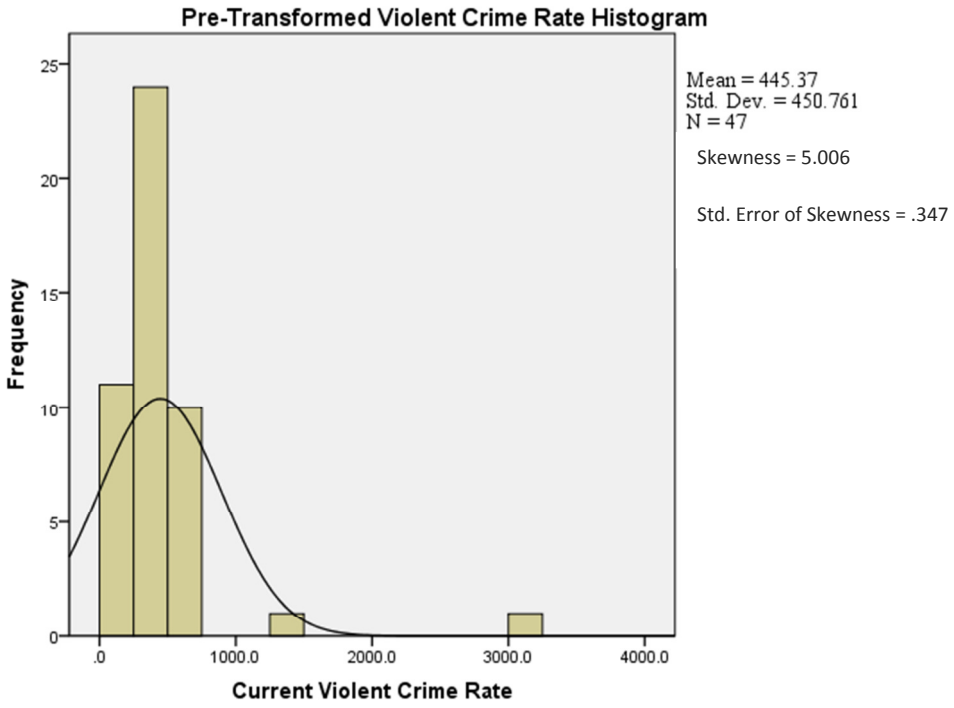
Might we reach a point where the strict punitive reactions to marijuana seem as outdated and ludicrous as buying a gram of morphine or heroin from the corner drug store? Would we want them to? Marijuana is currently undergoing an identity shift. Its meaning is being, and has been contested in state legislatures and ballot boxes across the country. And yet, even as the majority of citizens now believe that there are therapeutic qualities to the drug, its meaning is still being contested. Marijuana lives between the worlds of dangerous enemy combatant in the war on drugs and useful medicinal remedy. These contradictory and conflicting constructions of the drug have led to an interesting battleground within the policy making process. The sites of the struggles are chosen, but not always evident at first glance. The federal government's position is boosted by history and the momentum of status quo, but states are beginning to loosen the federal government's grip over the drug, if even slightly. Although the majority of the power to structure marijuana policy still lies with the federal government, policy entrepreneurs have grasped onto bureaucratic power at the state level. The negative imagery of a

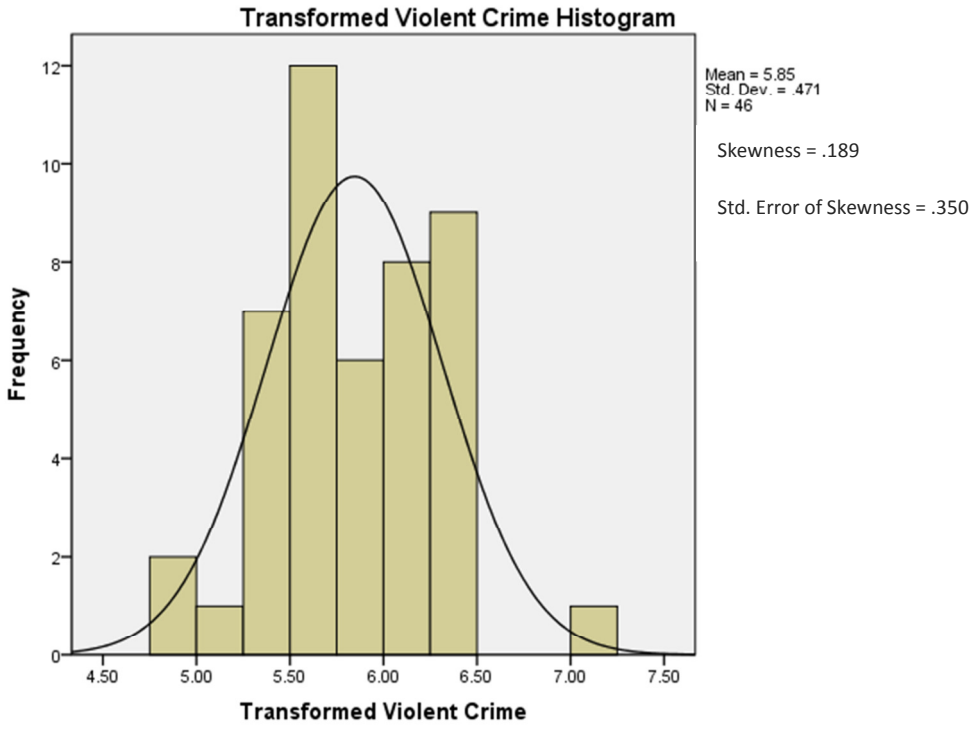
marijuana user still persists, and the "stoner" continues to be both fodder for comedy and a useful tool to undermine medical marijuana momentum. Simultaneously, a new, more sympathetic user has taken the edge off of the threat that the marijuana user may pose to society. But, perhaps the most important site of battle, science squares off against morality. So far, morality has won.

Although morality has served to silence science, there is no longer one morality attached to marijuana. The United States is a nation with multiple marijuana moralities which generate complex and passionate struggles over this symbolic weed. There is no clear consensus regarding whether marijuana should be under the jurisdiction of politicians, the criminal justice system, health professionals, or other groups with a vested interest in the meaning of the drug and its policy outcomes. The lack of consistency in the meaning of marijuana leads to an ambiguity in how (and whether) to change policy, who should be in control of the substance, and which side is "right". The path to medical marijuana policy is only as clear as the meaning of the drug itself. The legitimacy of marijuana as a medicine lies not in its medicinal potential, but in its symbolic morality.

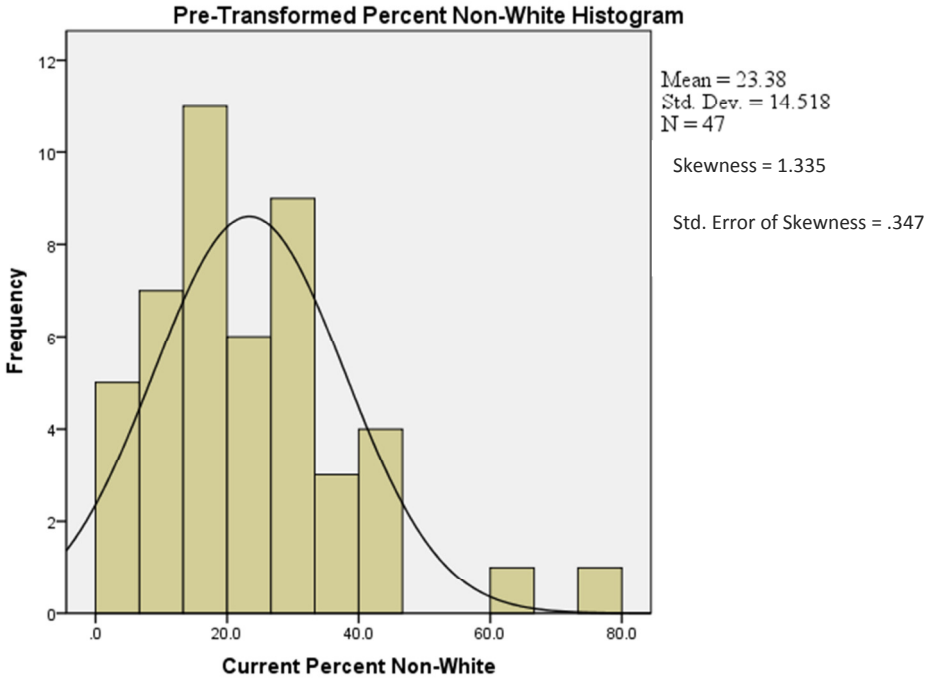
Appendix 1:

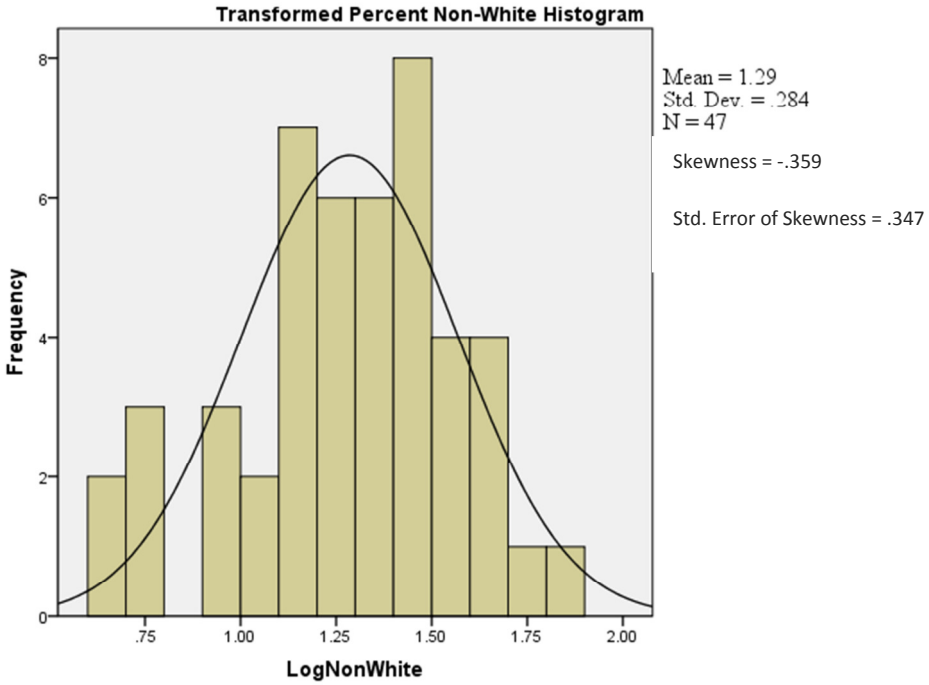
Data Transformations, Independent Variables





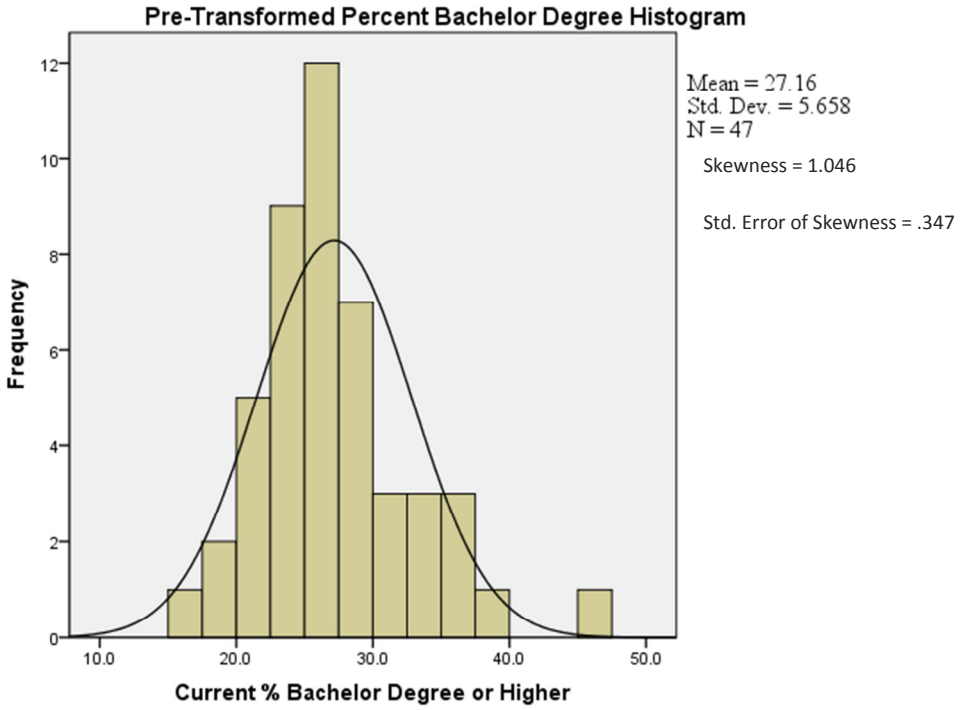
Appendix 1:
Data Transformations, Independent Variables

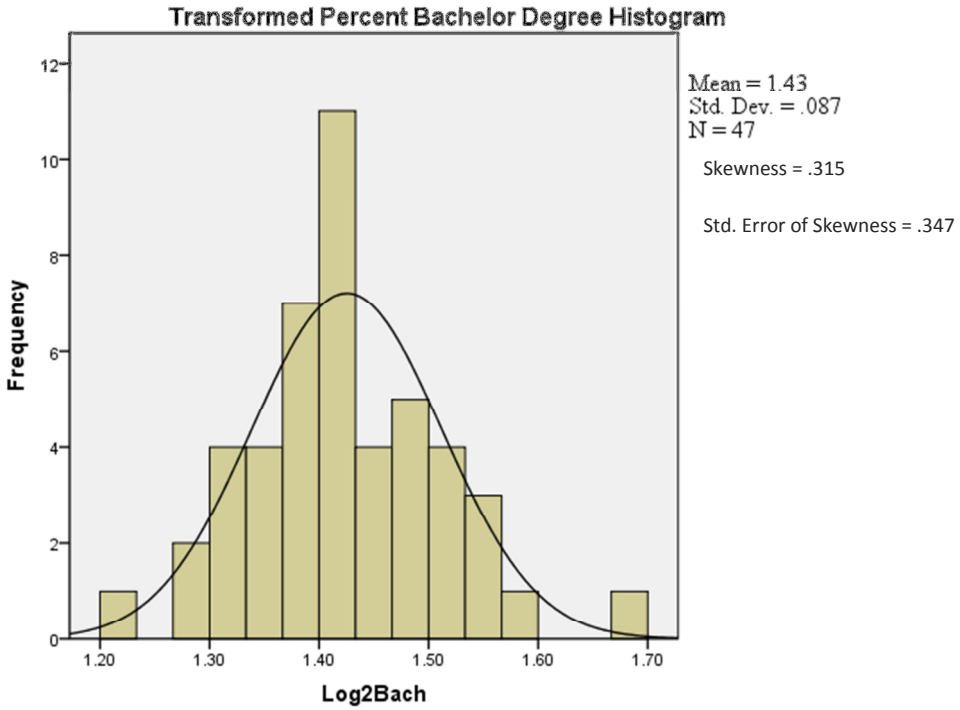




Appendix 1:

Data Transformations, Independent Variables





Appendix 2:

Correlations: Individual Independent Variables by Medical Marijuana Policy

Appendix Table 2.1 Correlations among State Ideology/Morality Indicators and Presence of Medical Marijuana Drug Policy (Pearson Product-Moment Correlation Coefficients)

	Medical Marijuana Policy	% Upper House Democratic	% Lower House Democratic	% Identify/ Lean Democratic	% Who Say Religion Is Important
Medical Marijuana Policy	1.000	.526**	.499**	.484**	-.687**
% Upper House Democratic		1.000	.865**	.733**	-.298*
% Lower House Democratic			1.000	.699**	-.338*
% Identify/Lean Democratic				1.000	-.196
% Who Say Religion Is Important					1.000

** Correlation is significant at the .01 level

* Correlation is significant at the .05 level

Appendix 2:

Correlations: Individual Independent Variables by Medical Marijuana Policy

Appendix Table 2.2 Correlations among Drug Use Trends and Presence of Medical Marijuana Drug Policy
(Pearson Product-Moment Correlation Coefficients)

	Medical Marijuana Policy	% Reporting Past Year Marijuana Use	% Reporting Past Year Non-Medical Pain Relief Use	% Treatment Admissions for Marijuana
Medical Marijuana Policy	1.000	.694**	-.106	-.305*
% Reporting Past Year Marijuana Use		1.000	.254	-.419**
% Reporting Past Year Non-Medical Pain Relief Use			1.000	-.059
% Treatment Admissions for Marijuana				1.000

** Correlation is significant at the .01 level
* Correlation is significant at the .05 level

Appendix 2:

Correlations: Individual Independent Variables by Medical Marijuana Policy

Appendix Table 2.3 Correlations among Crime Indicators and Presence of Medical Marijuana Drug Policy
(Pearson Product-Moment Correlation Coefficients)

	Medical Marijuana Policy	Violent Crime Rate	Property Crime Rate	Drug Arrest Rate
Medical Marijuana Policy	1.000	.151	.283	-.164
Violent Crime Rate		1.000	.582**	.472**
Property Crime Rate			1.000	.131
Drug Arrest Rate				1.000

** Correlation is significant at the .01 level
* Correlation is significant at the .05 level

Appendix 2:

Correlations: Individual Independent Variables by Medical Marijuana Policy

Appendix Table 2.4 Correlations among Demographic/Economic Indicators and Presence of Medical Marijuana Drug Policy (Pearson Product-Moment Correlation Coefficients)

	Medical Marijuana Policy	% over 65	% Non-White	% Bachelor Degree or higher	Median Income
Medical Marijuana Policy	1.000	-.081	.221	.522**	.527**
% over 65		1.000	-.354*	-.175	-.329*
% Non-White			1.000	.142	.229
% Bachelor Degree or higher				1.000	.790**
Median Income					1.000

** Correlation is significant at the .01 level
* Correlation is significant at the .05 level

Appendix 3:
Full Model Logistic Regression

Appendix Table 3.1	**Full Model Logistic Regression**	
	β (S.E.)	Exp(B)
Religious Importance	-.169 (.114)	.844
Democratic	.107 (.059)	.068
Past Year Marijuana Use	.369 (.425)	1.447
Marijuana Treatment Admissions	-.008 (.092)	.993
Socioeconomics	.000 (.000)	1.000

N.S.

Appendix 4:
Newsmagazine Articles by Magazine and Date

Newsweek:

Zeman, Ned and Donna Foote. 8 February 1993. "Turning over a New, Old Leaf." *Newsweek.* 121(6): 60.

Leland, John and Debra Rosenberg. 1 November 1993. "Just Say Maybe." *Newsweek.* 122(18): 50, 5 pages.

Padgett, Tim. 17 July 1995. "'It's hard to watch.' (Mennonite community in Mexico involved in drug trafficking)". *Newsweek.* 126(3): 33.

King, Patricia and Marc Peyser. 14 October 1996. "Pot shots in the war on drugs: 'Doonesbury' mixes it up over marijuana. (California's Prop 215 to legalize marijuana for certain medical patients)." *Newsweek.* 128(16): 42.

Murr, Andrew. 4 November 1996. "The prime evil forest; into the woods for mayhem and marijuana (illegal activities in California's Angeles National Forest)." *Newsweek.* 128(19): 69.

Rogers, Adam. 13 January 1997. "Seeing through the Haze: Can marijuana ever be good medicine?" *Newsweek.* 129(2): 60.

Cowley, Geoffrey and Mary Hager. 3 February 1997. "Can Marijuana Be Medicine?" *Newsweek.* 129(5): 22, 5 pages.

Morganthau, Tom and Patricia King. 3 February 1997. "The War over Weed." *Newsweek.* 129(5): 20, 3 pages.

Rosenberg, Debra and Thomas Hayden. 23 February 1998. "Into Thick Air: Snowboarding Makes It High-Anxiety Olympic Debut." *Newsweek.* 131(8): 49.

Hammer, Joshua. 16 March 1998. "The War over Weed (legal dispute over marijuana in California)." *Newsweek.* 131(11): 32-33.

Kalb, Claudia, Pat Wingert, Debra Rosenberg, Anne Underwood, and Joshua Hammer. 29 March 1999. "No Green Light Yet: A long-awaited report supports medical marijuana. So now what?" *Newsweek.* 133(13): 35.

Power, Carla, Scott Johnson, and Stefan Theil. 1 November 1999. "Europeans Just Say 'Maybe.' (New Policies Suggest Accepting Drug Use as Part of Society)." *Newsweek.* 134(18): 53-54.

Foote, Donna. 28 May 2001. "In California, smoke and fire over pot: The proponents of medical marijuana continue to fight." *Newsweek.* 137(22): 30.

Hawkins, Asher. 29 July 2002. "Drugs: Will the Silver State Go Green?" *Newsweek.* 140(5): 12.

Tolme, Paul. 28 October 2002. "High Time." *Newsweek.* 140(18): 12.

Friess, Steve. 4 November 2002. "Condoning Cannabis." *Newsweek.* 140(19): 8.

Salooja, Anjali. 18 July 2005. "A New Generation of Lollipops." *Newsweek.* 146(3): 12.

Smalley, Suzanne and Weston Kosova. 2 March 2009. "Reefer Madness." *Newsweek.* 153(9): 29.

Weisberg, Jacob. 9 November 2009. "Gay Marriage and Marijuana." *Newsweek.* 154(19): 24.

James, Emily. 7 June 2010. "Smoking out Pot Growers from the Capital." *Newsweek.* 155(23): 6.

Shamma, Tasnim. 19 July 2010. "The Case for Selling Weed in New Jersey." *Newsweek.* 156(3): 10.

Schneiderman, R.M. 22 August 2010. "Legal Weed Gets a Reality Check in California." *Newsweek.* 156(5): 10.

Conant, Eve and Katie Maloney. 1 November 2010. "Pot and the GOP". *Newsweek.* 156(18): 30, 6 pages.

Appendix 4:
Newsmagazine Articles by Magazine and Date

Time:

Farley, Christopher John. 19 April 1993. "Hello Again, Mary Jane: Pot Culture is Back as Rockers and Rappers Are Singing the Praises of Marijuana." *Time*. 141(16): 59.

Trillin, Calvin. 19 August 1996. "High on Experimentation." *Time*. 148(9): 17.

Lemonick, Michael D. and Christine Sadlowski. 2 September 1996. "No wonder you can't resist: Chocolate and marijuana share some chemistry." *Time*. 148(11): 58.

Trudeau, Garry. 16 September 1996. "Getting over Getting Stoned: An Impolitic Proposal for the Post-Pot Generation." *Time*. 148(13): 94.

Lacayo, Richard and Jeanne McDowell. 28 October 1996. "Marijuana: Where There's Smoke, There's Fire." *Time*. 148(20): 36-38.

Morrow, Lance and James L. Graff. 9 December 1996. "Kids & Pot: Marijuana use among teens is up, but baby-boomer parents (who know something about the subject) aren't sure what to do." *Time*. 148(26): 26, 5 pages.

Elders, Jocelyn and Joseph A. Califano, Jr. 9 December 1996. "What I Would Say…". *Time*. 148(26): 30-31.

Shannon, Elaine and Laird Harrison. 8 December 1997. "Too High in California? For those in medical need, pot clubs offer help, but Washington may try to spoil the party atmosphere." *Time*. 150(24): 84.

Galbraith, Jeff, Barry Hillenbrand, Lawrence Mondi, Mary Jollimore, and Maggie Sieger. 23 February 1998. "Dazed and Confused: A Whiff of Pot Smoke and Controversy Gives Evidence of the Culture Clash between Snowboarders and the Games." *Time*. 151(7): 78-80.

Hornblower, Margot. 3 May 1999. "Here's My Marijuana Card, Officer. In the Capital of Legal Pot, You Don't Need Much of an Excuse." *Time*. 153(17): 7.

Shannon, Elaine. 13 March 2000. "Meanwhile in Canada…The World's Best Pot Now Comes from Vancouver." *Time*. 155(10): 66.

Roosevelt, Margot and Elaine Shannon. 28 May 2001. "A Setback for Medipot after a Supreme Court Decision, Distributors of Medical Marijuana Fear a Federal Shutdown." *Time*. 157(21): 50.

McAllister, J.F.O., Alex Brant-Zawadzki, Martha de la Cal, Steven Frank, Nicole Gerard, Nicholas Le Quesne, Thea MacRuairi, and Jane Walker. 20 August 2001. "Europe Goes to Pot." *Time*. 158(7): 60-61.

Cloud, John. 18 February 2002. "This Bud's Not for You." *Time*. 159(7): 60-62.

Cloud, John. 4 November 2002. "Is Pot Good for You?" *Time*. 160(19): 62, 5p.

Stein, Joel, Matt Baron, Laura Locke, Viveca Novak, Sean Scully. 4 November 2002. "The New Politics of Pot: Can It Go Legit?" *Time*. 160(19): 55, 6p.

Grossman, Lev. 28 April 2003. "Keep off the Grass." *Time*. 161(17): 71.

Roosevelt, Margot. 4 August 2003. "Busted!" *Time.* 162(5): 44-46.

Hamilton, Anita, Ben Bergman, Laura Blue, Chris Daniels, Deborah Jones, Elaine Shannon. 23 August 2004. "This Bud's for the U.S.: Canada's Relaxed Drug Laws May Be Fueling a Boom in Marijuana Exports to America." *Time*. 164(8): 36-37.

Roosevelt, Margot. 22 November 2004. "Red States Weigh in as the Court Goes to Pot." *Time*. 164(21): 20.

Kluger, Jeffrey and Jeffrey Ressner. 23 January 2006. "Balding, Wrinkled, and Stoned." *Time*. 167(4): 54-56.

Gupta, Sanjay and Matt Sloane. 6 November 2006. "Why I Would Vote No on Pot." *Time.* 168(19): 98.

Appendix 4:
Newsmagazine Articles by Magazine and Date

Time (cont):

Luscombe, Belinda. 7 July 2008. "Why Grass Is Green." *Time.* 172(1): 59-60.
Stein, Joel. 16 November 2009. "Save the Pot Dealers!" *Time*. 174(19): 64.
Webley, Kayla. 21 June 2010. "Brief History: Medical Marijuana." *Time*. 175(24): 22.
Kluger, Jeffrey and Maia Szalavitz. 22 November 2010. "The Science of Pot." *Time*. 176(21): 37.

U.S. News & World Report:

[Staff Writer]. 15 April 1996. "A Marijuana Mecca Rethinks Its Drug Laws." *U.S. News & World Report*. 120(15): 15.
Leo, John. 28 October 1996. "The Voters Go To Pot." *U.S. News & World Report.* 121(17): 23.
Brookhiser, Richard. 13 January 1997. "Lost in the Weed." *U.S. News & World Report.* 122(1): 9.
Zuckerman, Mortimer B. 24 February 1997. "Great Idea for Ruining Kids: The Case for Legalizing Some Drugs Is Seductive – and Completely Wrong." *U.S. News & World Report*. 122(7): 68.
Streisand, Betsy. 19 May 1997. "Thank You for Not Toking: California's legal pot clubs try to lose the head-shop smell." *U.S. News & World Report*. 122(19): 28-29.
Shenk, Joshua Wolf. 17 November 1997. "Lighting Up Controversy." *U.S. News & World Report*. 123(19): 11.
Streisand, Betsy. 30 March 1998. "California's pot clubs may go up in smoke." *U.S. News & World Report*. 124(12): 4.
Loeb, Penny and Stacy Shultz. 29 March 1999. "Pot report yields fodder for both sides." *U.S. News & World Report*. 126(12): 16.
Whitman, David. 6 November 2000. "Let the voters settle the tough cases." *U.S. News & World Report.* 129(18): 28.
Curry, Andrew. 28 May 2001. "Help from My Friends: The High Court's Marijuana Ruling Won't Play in Mendocino." *US News & World Report*. 130(21): 40-43.
Sohn, Emily. 28 May 2001. "Is grass a proven tonic? Rx munchies." *U.S. News & World Report*. 130(21): 41.
Curry, Andrew. 11 February 2002. "The Munchies Crackdown." *US News & World Report*. 132(4): 63.

Appendix 5:
Detailed Descriptions of Character Types and Their Characterizations
(Some Typical Examples)

Expert: *Arguably the most authoritative character, descriptions of experts usually include (but are not necessarily limited to) current or past affiliation(s), years of experience, credentials, or any information that might help to establish what type of knowledge this individual or group could bring to the debate that would be of value to others.*

Law Enforcement	An expert on the consequences of drugs and drug use, "'It's still a dangerous drug,' says *James Capra, the DEA's chief of domestic operations*. 'People are killing each other over it.'"[1]
Opponent	"'These propositions are not about compassion,' *McCaffrey* said at the press conference. 'They are about legalizing dangerous drugs.' Both the *government* and the *American Medical Association* say that there is no scientific evidence that marijuana is useful." [2]
Proponent	"The case for medical marijuana has its merits, and a history. In their book, 'Marihuana: The Forbidden Medicine,' *Harvard psychiatrist Lester Grinspoon and his writing partner, James Bakalar*, describe a dozen of marijuana's possible benefits, which include easing nausea and vomiting from cancer chemotherapy, improving the appetite of people with AIDS and lowering pressure inside the eye due to glaucoma."[2]
User	**(There are no expert-users in the sample.)**

Loser: *An individual with no apparent usefulness to society, depicted using demeaning, belittling and generally negative (although harmlessly) negative adjectives.*

Law Enforcement	"It is not that *Mel Brown, police chief* of this tie-dye-and-tofu town, set out to flout federal law. But here he is, a 53-year-old father of two who has never inhaled, issuing laminated and embossed get-out-of-jail-free cards for partakers of the infamous Humboldt bud, a potent local variety of marijuana." [3]
Opponent	"'*Lungren* [California's Attorney General and 'anti-pot crusader'] is a drunk with power,' charges Peron." [4]
Proponent	"The *marijuana legalizers, including the billionaires…[George Soros, Peter Lewis, and John Sperling]* don't have much kinder things to say about him [Drug Czar John Walters]. In fact, for old rich men, they can sound a lot like Tupac. One of them, Sperling, 81, is founder of the highly profitable nationwide chain the University of Phoenix. He has spent $13 million on drug-reform campaigns and lots of other money on other pet projects, including cloning his cat." [6]
User	"[L]egitimizing pot hasn't created more *users*; it has just produced more *annoying ones*, who now apply Whole Foods-ian levels of snobbiness to the differences between Hawaiian Sativa and Humboldt Indica."[7]

Appendix 5:
Detailed Descriptions of Character Types and Their Characterizations
(Some Typical Examples)

Hero: *An individual (or group) that sacrifices to help others, usually praised with positive, complimentary adjectives (although certainly not always).*

Law Enforcement	"Last year *state and local officials* eradicated 136,957 [marijuana] plants, many 10 ft. tall, with a wholesale value of $450 million." [3]
Opponent	"*Karl Rove* says the *vast majority of Republicans* rightly stand against full legalization of marijuana. 'I believe that the social cost to the United States of legalization of drugs would be enormous, and would be something that would deeply harm our society, particularly those least equipped to deal with the ravages of drug dependency,' he says." [13]
Proponent	"*Club owners* counter that they provide a safe and readily available supply of cannabis to suffering people who would otherwise be forced to purchase it on the street." [4]
User	Former users are encouraged to work with addicts in prison, such as, "*a middle-aged heroin addict*, [who] runs the Drug Users Union." [5]

Victim: *An injured, innocent, generally mostly helpless individual or group who is the target of some negative forces.*

Law Enforcement	"Seizures of B.C. Bud by U.S. law-enforcement agencies have doubled and redoubled over the past 2 1/2 years. 'They're killing us,' says *Mike Flego, head of the U.S. Drug Enforcement Administration's office in Blaine, Wash*. Seattle customs enforcement chief Rodney Tureaud Jr. agrees, 'We could double our numbers at the border and still be understaffed.'" [8]
Opponent	"Marijuana activists have amassed enough support to force *Marin County District Attorney Paula Kamena* into a 'recall' vote. (If the measure passes, Kamena will lose her job to a candidate more favorable to the pro-pot crowd.) Her alleged misdeed: harassing marijuana-smoking patients with legal action. The 55-year-old Kamena insists that she has been unfairly targeted by the 'medipot' forces." [9]
Proponent	*Donald Abrams, an AIDS researcher*, has been trying to get marijuana from the National Institute on Drug Abuse. All he gets is the brushoff. If it supplies Abrams, NIDA says, it might be overwhelmed by requests from other researchers. Can't have that--then there might be some research. [10]
User	"If you know anybody who ever had cancer--or if you ever had it yourself--you know the ordeal that *Jo Daly* has gone through. When she started chemotherapy for colon cancer, the side effects included a 'nuclear implosion' of nausea. Then came a burning pain under the nails of her fingers and toes. The good news is that she eventually found relief. The bad news is that it came from marijuana, which is not available by legal means". [11]

Appendix 5:
Detailed Descriptions of Character Types and Their Characterizations
(Some Typical Examples)

Villain: *Like losers, villains are typically described using negative imagery. Villains, however, are represented as being active individuals or groups who are out to purposely harm another individual or group.*

Law Enforcement	…a "tightly operated [medical marijuana] club…was raided by *DEA agents* and may become the federal test case of the new [medical marijuana] law." [12]
Opponent	At a joint press conference, *drug czar Barry McCaffrey, Health and Human Services Secretary Donna Shalala and Attorney General Janet Reno* said that doctors who prescribed marijuana risked losing their licenses to prescribe drugs and might face prosecution. [2]
Proponent	"Parents can specifically blame *Cypress Hill*. The LosAngeles-based group sings the praises of weed in songs such as 'Something for the Blunted' on its million-selling debut album – and is the official band of the National Organization for the Reform of Marijuana Laws (NORML)." [14]
User	Threatening the legitimacy of medical marijuana clubs, and placing more police scrutiny on these "tightly operated" clubs, "*a patient* admitted to having a forged prescription." [12]

Appendix 5:
Detailed Descriptions of Character Types and Their Characterizations

Endnotes for Appendix 5

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Appendix 6:
Numeric and Proportional Themes and Stances across Time Periods

Appendix Table 5.1 **Temporal Distribution of Numeric and Proportional Primary Themes**

	1993-1996		1997-1999		2000-2005		2006-2010		
	N	*N* / *Year Total*	*N*	*N* / *Year Total*	*N*	*N* / *Year Total*	*N*	*N* / *Year Total*	
Legal	4	.29	4	.25	11	.58	4	.33	
Medical	1	.07	7	.44	2	.11	1	.08	
Moral/Social	8	.57	4	.25	0	.00	2	.17	
Pragmatic	1	.07	1	.06	6	.32	5	.42	
Year Total	14	(1.00)	16	(1.00)	19	(1.01)	12	(1.00)	61

Appendix Table 5.2 **Temporal Distribution of Numeric and Proportional Primary Stances**

	1993-1996		1997-1999		2000-2005		2006-2010		
	N	*N* / *Year Total*	*N*	*N* / *Year Total*	*N*	*N* / *Year Total*	*N*	*N* / *Year Total*	
Pro	3	.21	4	.25	1	.05	1	.08	
Con	3	.21	3	.19	4	.21	1	.08	
Balanced	8	.57	9	.56	14	.74	10	.83	
Total	14	(0.99)	16	(1.00)	19	(1.00)	12	(0.99)	61

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