The medicalisation of revolt: a sociological analysis of medical cannabis users
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Abstract
In a qualitative study, we investigated the medical motives of 100 Norwegian cannabis users, none of whom had legal access to medical cannabis. Cannabis was used therapeutically for conditions such as multiple sclerosis, attention deficit hyperactivity disorder and rheumatism, as well as for quality of life conditions such as quality of sleep, relaxation and wellbeing. The borders between medical and recreational cannabis use were blurred. This article identifies strategies of medical cannabis users to gain social acceptance. Several respondents downplayed effects such as intoxication and euphoria. Others used the language of medicine and knowledge of current research in psychopharmacology. Cannabis was contrasted with the potential for abuse of prescription medicines. The medical cannabis movement has had little success in Norway. Medical professionals are unable to accept that users may be more knowledgeable than experts and medical users cannot discard the values of traditional cannabis culture. Calls for medical cannabis use are thus perceived as a gambit in attempts to have cannabis legalised. We argue that, despite having had little effect on health authorities, the medical cannabis movement may be having the unintended effect of medicalising cannabis use and using it as a cure for everyday problems.

Keywords: medical marijuana, medical cannabis, cannabis culture, medicalisation, symbolic boundaries

Introduction
Medical cannabis use has a long history in countries such as India and China. Medical use of the substance increased in western countries in the 19th century and then gradually levelled off at the turn of the century (Berridge 1981, Grinspoon and Bakalar 1993). Two factors triggered a revival of interest in medical cannabis in the late 1960s. Firstly, recreational cannabis use emerged among adolescents and young adults. Secondly, renewed interest in the pharmacology of cannabinoids arose with the identification of the chemical structure of tetrahydrocannabinol (Δ9 THC) (Mechoulam and Gaoni 1965). Identification of cannabinoid receptors in the brain in the late 1980s prompted further studies on the endocannabinoid system and the potential therapeutic utility of cannabis (Brown 2007, Pacher et al. 2006).

Efforts are underway worldwide to regulate and control medical cannabis. In the USA the number of medical cannabis patients is rapidly increasing (Reinarman et al. 2011). Medical cannabis use is now legal in 16 states and at least a dozen other states are considering similar
legislation (Hoffman and Weber 2010). However, at the same time, cannabis continues to be regulated at the federal level by the so-called Schedule 1 (Drug Enforcement Administration 2011).

Reviews conclude that cannabinoids have therapeutic potential, for example as appetite stimulants in cancer and autoimmune deficiency virus (AIDS) patients and in the treatment of multiple sclerosis (MS), Tourette’s syndrome, epilepsy and glaucoma, as well as chronic pain where both analgesic and psychological detachment effects have been observed (Amar 2006, Leung 2011). However, in most countries outside the USA self-defined medical cannabis use occurs illegally without a physician’s recommendation or prescription. Unfortunately, estimates are available from only one population-based Canadian study. In that study, 6.8 per cent of respondents reported non-medical cannabis use in the previous 12 months, while 1.9 per cent reported medical cannabis use, most of which was illegal (Ogborne et al. 2000). Treatment for pain or nausea was the most frequently cited reason for use. In a large self-selected sample of non-legal medical cannabis users in the UK ($N = 2969$), self-medication for pain or depression with cannabis was common. This self-defined medical use had evolved from recreational use (Ware et al. 2005). Among a sample of patients registered at medical marijuana clinics in California the most frequent uses were for treatment of pain and insomnia and to improve relaxation (Reinarman et al. 2011). In some countries a considerable proportion of patients with AIDS (Ware et al. 2003) or MS (Page et al. 2003) also use cannabis medically without having legal access to the substance.

In the USA medical cannabis has a semi-legal status. At the same time, the symbols of the cannabis culture are present in much of the American medical cannabis industry. This industry includes cooperatives, dispensaries, physicians and legal advisers, many of whom share the language of ‘organic’ products and New–Age-inspired images and symbols (West Coast Leaf 2011). Cannabis is also more commonly used recreationally and its use has been linked to psychosocial problems, dependence and crime (Hall and Degenhardt 2009, Room et al. 2010). Thus, the unclear boundaries between medical cannabis, criminal offences and recreational use with its typical rituals, symbols and values are constantly being negotiated.

There has been remarkably little research on how cannabis users interpret the ambiguous messages surrounding medical cannabis. This study examines a number of research questions: What are the medical cannabis users’ experiences of encounters with the mainstream healthcare system? How do they describe, interpret and rationalise the intoxicating and pleasurable effects of cannabis? How do they try to gain acceptance of their medical cannabis use? Is the medical cannabis movement gaining ground? How have these recent developments affected cannabis use in general?

This study was conducted in Norway, where recreational cannabis use was introduced in the late 1960s. Prevalence rates have remained at a medium to low level by European standards (European Monitoring Centre for Drugs and Drug Addiction 2011). Nevertheless, a considerable proportion of the Norwegian population experiments with cannabis. In the Greater Oslo area – the only metropolitan area in Norway with close to one million inhabitants – more than 50% of young adults report a lifetime prevalence of cannabis use (Pedersen 2009). Norway has a rather punitive drug regime and medical cannabis is not formally accepted. Patients may be treated with cannabis-based medications such as Marinol and Sativex (Pertwee 2009). However, these medications are not authorised for general marketing and prescriptions are available only through physicians, who must seek permission from the health authorities for each patient on a ‘named patient’ basis. In practice, very few patients (11 in 2010) have legal access to such medication.
Methods

Data were collected as part of an extensive investigation of cannabis users in Norway in 2006–2010. The study was based on fieldwork and interviews with 100 cannabis users ranging in age from 20 to 62 years. Users were recruited through our own social networks, among students at the University of Oslo, from organisations such as the National Organisation for the Reform of Marijuana Laws and through an internet advertisement. Some participants were in prison for drug-related offences (Sandberg and Pedersen 2010). We recruited widely to ensure that the sample represented a broad range of experiences with cannabis. Participants included youths from the hip-hop culture, students, sporadic and regular users, small-scale and large-scale dealers, domestic growers and cannabis activists. All participants had used cannabis for several years, some sporadically, others regularly and more heavily. None was recruited from a clinical setting. They varied by degree of social integration, ranging from the highly educated and socially functional to others with a more marginal existence.

The interviewees comprised 88 men and 12 women. Most were aged in their twenties or early thirties. The nine participants aged over 50 represent the first generation of Norwegians initiated into cannabis use towards the end of the 1960s. Approximately one-third of the participants were employed, one-third were students and the remaining one-third were receiving unemployment or other state benefits. Many ‘ordinary’ cannabis users in this study described using cannabis for medical purposes. Towards the completion of our data collection, we noticed this importance of medical motives for contemporary cannabis users. We then purposively sampled participants who used cannabis medically for more serious diseases. Most of the ‘activists’ described below were in this group. None of the participants used medical cannabis legally.

The semi-structured interviews lasted from 90 minutes to three hours. They were audiorecorded, transcribed and coded in NVivo, version 9, a qualitative data processing program, for analysis (QSR 2011). The main coding key contained 134 codes. Those most relevant to our analysis were the general ‘medical cannabis’ (general description of medical cannabis use), and the sub-codes of ‘muscular pain’, ‘back pain’, ‘rheumatism’, ‘multiple sclerosis’, ‘mental health problems’, attention deficit hyperactivity disorder ‘ADHD’, ‘anxiety’, ‘stress’ and ‘insomnia’. For analysis, the data were arranged along two dimensions: (i) the degree of embeddedness in traditional cannabis culture; and (ii) the degree of involvement in the emerging medical cannabis movement. Our analysis indicates a tendency towards what may be characterised as the medicalisation of cannabis use (Conrad 2007). An ongoing struggle to gain acceptance from the medical establishment is shaping the lives of many cannabis users.

Two groups of medical cannabis users

Twenty-five participants (25%) stated explicitly that they used cannabis medically. However, many distinguished only vaguely between recreational and medical patterns of use. Cannabis was typically described as useful – for treating stress, insomnia and pain, as well as for relaxation. Similar descriptions are found in other studies of medical cannabis users (Ogborne et al. 2000, Reinarman et al. 2011, Ware et al. 2005). A female participant with muscular pain stated: ‘To smoke a couple of joints a day – it takes care of the pain, it relieves stress’. Many of the participants used cannabis to improve their sleep. A young man said:
To smoke a joint before you go to sleep, to be sure you sleep safe till the next morning, without waking up – that’s been a large part of my cannabis use.

Most medical users in this study had limited research-based knowledge of the possible therapeutic properties of cannabis. They continued to embrace the rituals, argot, political opposition and ‘green values’ of the traditional Norwegian cannabis culture (Sandberg 2012). They had started using cannabis recreationally for its pleasurable and euphoric effects. Over time, they had appropriated the medical properties of the substance as another ‘good reason’ to smoke.

Other medical cannabis users described medical conditions that were more serious, such as MS, Tourette’s syndrome and severe rheumatism. Many of these users had substantial knowledge of the possible medical properties of cannabis as well as the physiological effects of different cannabinoids. Some had made addressing the lack of legal opportunities to use medical cannabis in Norway their life purpose. We classified this group (comprising between five and seven members, depending on how we defined them) as ‘medical activists’. We accessed them mainly in the final phase of data collection when we were searching for experienced medical cannabis users. They were at the forefront of what may be described as an emerging medical cannabis movement in Norway. They communicated through personal networks, blogs and the Norwegian Cannabis Forum (2011), an internet site for medical cannabis use and cannabis cultivation. They were also active on international internet-based medical cannabis forums. Several had visited The Netherlands, the USA and Canada, where medical cannabis regimes are more developed than in Norway.

Most of the medical activists had a long history of health problems and had attempted to find treatment within the mainstream healthcare system. Several of them had spent a lot of time interacting with authorities in the healthcare system and acquiring research-based knowledge. A previous study of medical cannabis revealed ‘increasing despair and desperation, as [traditional] medical treatments failed to live up to expectations’ in contrast to the ‘life-preserving’ effects of subsequent medical cannabis use (Bottorff et al. 2011). Many of the activists in this study used similar terms to describe their experiences of turning to cannabis.

Views on cannabis diverged between the wider population of recreational users and the self-defined groups of medical cannabis users. Many medical activists, for example, actively sought to distance themselves from the larger groups of users. The remainder of the article describes the strategies of medical cannabis users and discusses the obstacles they face. It concludes with a discussion of the long-term consequences of an increased focus on the medical use of cannabis.

A personal search for acceptance

One of the most striking observations to be made of medical cannabis users is their ongoing search for acceptance in the healthcare system. Many had endured fruitless years of negotiating with the health authorities, which they described in detail during interviews.

One participant was a 26-year-old man with severe MS. He experienced muscle spasms, difficulties in moving and severe stammering, for which he had tried numerous treatments. He had first tried cannabis in his late teens, with what he described as an instant and astonishing result. Over several years, he had invested heavily in his case for legal access to medical cannabis. He presented us with a large number of letters and recommendations that included statements from general practitioners and the head of a university hospital clinic.
He had also finally obtained a statement from the Norwegian Directorate of Health concluding that he had the right to undergo ‘exploratory’ treatment with cannabis medication.

Many Norwegian medical activists were organised through personal networks and various internet sites and blogs. They also strongly identified with and perceived themselves as being part of an international medical cannabis movement. Internet-driven social mobilisation has become increasingly relevant (in the Arab spring, for example). These networks are heterogeneous and informal; they do not have leaders or a centre, and communication usually takes place through the internet and social media. Nevertheless, they display many of the characteristics of a social movement. A social movement is a series of contentious performances, displays and campaigns by which ordinary people make collective claims on others (Tilly 2004). These include campaigns, a repertoire of contention and some shared public representations, often described as ‘collective action frames’ (Gamson 1995, McAdam et al. 1996). Collective action frames are especially important for internet-driven social movements and they are easy to identify in the emerging Norwegian medical cannabis movement.

Information spreads rapidly in social movements. The case described above was well known within these networks, and several medical activists referred to his ‘victory’. One said: ‘Now, he’s got all the papers he needs – from the police, the hospital, the ministry, so he can travel all over the world carrying cannabis’. Another added: ‘He has really got himself sorted legally. He is the first person in Norway who can legally import and grow’.

His strategy had been to persuade the medical authorities that he needed cannabis medication. However, the statements from various health officials were more ambiguous than he had initially expected, and his was less of a success story than many of the medical activists believed it to be. For example, he did not actually get his preferred brand of medication, Sativex (GWPharm 2011), which is a non-synthetic cannabis-based drug with well-established effects in the management of spasticity associated with MS (Sastre-Garriga et al. 2011).

In a similar vein, many medical cannabis users described spending years in negotiation with their general practitioners. One activist said: ‘I have spent five years trying to persuade my doctor’. While gradually becoming more receptive, the doctor still felt the need for more professional backing. The doctor had reportedly said: ‘We need an expert opinion, preferably someone in neuropsychiatry, someone here in Norway, to support you’. A key point in this activist’s story was that he had finally made an alliance. However, most physicians were sceptical and even those who were supportive did no more than refer the patients to another medical professional. A female user said: ‘It varies between the different doctors and psychologists. Some have zero tolerance. Others may say: I do understand you’. Medical cannabis users seldom got any real help, and even an ‘ally’ in the medical system often provided no more than personal support and understanding.

Activists within the medical cannabis movement typically adopted a strategy of individually persuading medical authorities by using diagnoses, arguments and knowledge. Some had also presented their stories through the news media. Although this kind of individual initiative has driven some social movements (for example, the Civil Rights Movement in the USA), this strategy has not proved successful for the medical cannabis movement in Norway. All activists in our study had experienced setbacks when trying to gain acceptance. Most failed to persuade either health authorities or medical professionals, and many were bitter and angry after years of neglect and rejection.
Better than prescription drugs

One of the medical cannabis users had a particularly long and complicated history in the healthcare system. He argued that the doctors had never taken any real responsibility but 'just slapped on random diagnostic labels'. What upset him most was that the doctors seemed eager to combine such diagnostic labels with prescriptions for dependence-producing drugs:

They push diagnoses on me, and benzo medication, sleeping medication. After three consultations with the doctor, I got an offer of Ritalin. After three consultations! But cannabis? Damned if I can get it.

A young woman with rheumatism described her situation like this:

*Interviewee:* As I say, I have taken so many chemicals, I don’t want more.

*Interviewer:* What kind of pills do the physicians suggest?

*Interviewee:* Ordinary painkillers, Sobril (a benzodiazepine), strong painkillers for my back, anti-inflammatory medication. All of them are chemical, pharmaceutical medicines.

*Interviewer:* You got a prescription for Sobril?

*Interviewee:* Yes, yes. But as I said, right from the first prescription, it hasn’t worked for me. I feel I get distant [slang for an intoxication effect]. Then there is the dependence. OK, one evening you want to become more than only sleepy, you want to become intoxicated.

For many participants, prescription medicine was synonymous with ‘chemicals’ and linked to side effects such as dependence and tolerance. The organic and ‘green’ values of the traditional cannabis culture emerged in many of these accounts. Another young woman said:

I wish I lived in a country where I could have grown it in my own garden. I could have used it [cannabis] in food. Then you get it clean. The tobacco [when smoking cannabis] is actually most dangerous. Then you can drop these damned pills the doctors want to give us.

The participants argued that cannabis works better than prescription drugs but without the side effects. The side effects of prescription drugs were described in rich and living language: you become dizzy, you lose contact with yourself and it is easy to use too much. One of the medical users said:

I don’t want pills with red triangles! Who knows if in a weak moment I’d say, now I want to take five of them, now I want to become distant.

These comparisons between prescription drugs and cannabis are well known in the literature on medical cannabis (Dahl and Frank 2011). Such comparisons function as a ‘comparison between risks’, or denying one risk by comparing it with a risk already widely accepted (Peretti-Watel 2003). In this way, the medical use of cannabis is justified by claiming that prescribed medication represents a greater risk. The argument is one with which most general practitioners would agree. Many prescription drugs have a potential for abuse and they often
result in serious side effects. Medical cannabis users rarely addressed the possibility that cannabis may also have such side effects.

**Using the language of ‘the system’**

The arguments and language of the medical activists were technical, complicated and designed for gaining acceptance by the medical system. Several of the activists had invested time in reading research reports on medical cannabis. One had experienced maltreatment and failed duty of care as a child, and bullying in school. After re-experiencing his childhood traumas, he was diagnosed with post-traumatic stress disorder (PTSD) and became interested in researching cannabis as a treatment:

Post-traumatic stress is a huge problem in Israel. You know, Raphael Mechoulam was the first to isolate THC in 1964. He is now leading the experiments at the Hebrew University in Jerusalem. However, concrete results are still lacking. What I do have, absolutely concrete, is based on my own experience. And also the millions of other [medical users] in the USA, whom you can read about on the internet, the doctors in the USA who support it, the research in Canada, and at the Max Planck Institute in Germany, which is a serious research institution. They have done so much when it comes to how to process memory. Actually, I’m so furious now that I don’t know what to do. I feel I’ve been fooled.

Many medical cannabis users sought legitimacy from prestigious medical research, but this evidence was often mixed with their personal experiences and lay knowledge. Another participant explained:

I have a defective CB1-receptor. It doesn’t send signals to the cells. There are 60 to 70 different cannabinoids. Some of them help with such defects, some are good for post-traumatic stress syndrome. They actually help take care of the good memories and delete the bad ones. The body produces such substances itself, but my body produces too few, and I have to add them from an external source.

Many medical cannabis users appeared to be highly knowledgeable about the medical uses of cannabis and could provide a number of references to the medical literature. They also criticised the lack of knowledge on medical cannabis among Norwegian physicians and researchers. One said: ‘I phoned the medical faculty at NTNU [Norwegian University of Science and Technology] and talked to several neurologists. They had no faith in cannabis. It’s quite frightening that they don’t know about this research’. Another said: ‘There was even an article about medical cannabis in *Legetidsskriftet* [the Journal of the Norwegian Medical Association]. I thought at least they read through that kind of stuff’.

While reflecting a generally high level of knowledge, this form of argument can also be analysed as a political strategy. By speaking the ‘language of the system’, sometimes even better than the system itself, medical cannabis users demonstrated they were serious and professional, unlike the negative stereotype of the languid cannabis smoker. Medical cannabis activists were playing the game of the medical professionals, on their own ground and using their language, in the same way that other social movements have taken issues to court and rephrased their claims through the language of law.

Generally, sociologists have argued that lay–professional relationships in the medical field both reflect and reinforce structural inequalities, and that the values perpetuated within these
relationships often form key dimensions of social control and regulation (Nettleton 2010: 137–8). However, the nature of these relationships is changing. What was once seen as a meeting of the knowledgeable expert and the ignorant layperson is now more often seen as a meeting of different experts (Tuckett et al. 1985).

Some of the problems of the medical cannabis movement can be interpreted within this frame of reference. Medical cannabis users have much practical and research-based expertise, whereas the healthcare system has little or no knowledge of the medical use of cannabis. Medical professionals are traditionally considered the experts and it may be difficult for them to accept a reversed structural inequality. Instead of taking cannabis users’ claims seriously, it may be easier for the professionals to follow the general rules about cannabis as a restricted substance with little therapeutic utility, and thus return the doctor–patient relationship to normal.

The symbolic boundary between pleasure and medicine

Medical activists described having diseases and problems with obviously disabling consequences, such as MS, PTSD, Tourette’s syndrome or rheumatism. A broad research tradition has confirmed an informal ordering of medical specialties within a hierarchy of prestige (Hinze 1999). Recently, a Norwegian study showed a similar ranking of diseases in terms of prestige. Brain tumours were ranked among the highest, while fibromyalgia was among the lowest (Album and Westin 2008). Although none of the diseases described by the participants in this study ranked highly, a similar hierarchy of diseases emerged among the medical cannabis users.

While most medical cannabis users report everyday problems such as insomnia, pain and tension, the activists described having problems and diseases that are usually considered more serious. They presented their illness histories in diagnostic terms and with references to physicians, specialists and researchers. Several distanced themselves from people who claimed to be using cannabis for medical purposes but were, in their opinion, motivated by intoxication. One of the activists told us ironically about a friend who used cannabis ‘because he is afraid of the dark’; fear of the dark was too trivial a complaint to justify the medical use of cannabis, he argued. Through similar ‘symbolic boundary work’ (Lamont and Molnár 2002), many medical cannabis activists excluded large groups of people and diseases from the category of justifiable medical cannabis use.

Symbolic boundary work was also important for most medical cannabis users, for example, in drawing the line between the recreational and medical uses of cannabis, and between intoxication and medical effects. One participant said: ‘For me, it is completely medical. I don’t get any intoxication at all.’ He concretised and justified this claim based on his knowledge of the psychopharmacological properties of cannabis: ‘I do not need so much THC, I only need cannabinoids that do not result in intoxication. They’re called CBD.’ He explained that cannabidiol (CBD) ‘works on your body’, and does not produce typical intoxication effects. He focused on this point for some time during the interview: THC produces a ‘high’, which is the effect sought by recreational cannabis users. He also claimed that he needed lower doses of cannabis than those who were interested in intoxication. A young woman with rheumatism explained in a similar way: ‘You don’t become intoxicated in that way. But you feel that it has an effect on the body, at least when you have a lot of pain.’

One respondent was a 30-year-old woman who had been smoking cannabis for many years. She had combined dealing cannabis in clubs in downtown Oslo with an intense nightlife that involved consuming alcohol and other drugs. She suffered from rheumatic pain...
and depression. She explained that a medical pattern of use is different from one in which intoxication is at the centre. She herself had come further:

I have passed that stage – ‘Oh God, now I’m stoned’ – because that’s not what you are after [any more]. When you smoke medically, you don’t sit and smoke all the time.

She strengthened her argument by linking it to other important changes in her life. She had stopped dealing and frequenting clubs: ‘Now, it is only medical and relaxation use. It’s not that intoxication any more’.

For many of the medical users, in particular the group we call medical activists, negotiating the symbolic boundaries of medical cannabis use and rejecting euphoria and intoxication were important. For some it implied distancing oneself from a lifestyle characterised by partying and nightlife, or even from the symbols, rituals and liberal stance on intoxication of the traditional cannabis culture. It was important for them to qualify the medical cannabis experience as something different from pleasure and euphoria. Many were able to describe subtle nuances between various intoxication effects. Being ‘stoned’ connoted a tranquil, restful feeling, while ‘high’ and ‘skew’ connoted more psychedelic effects. Medical use, by contrast, was claimed to have completely different effects, such as reducing spasms, nausea and pain, and improving relaxation and sleep.

Fragile boundaries – problematic framing

The complex symbolic boundaries between pleasure and medicine are continually negotiated by medical cannabis users’ personal experiences with the substance. Many of the medical activists accepted that cannabis, even when used medically, produced intoxication and euphoria, but they argued that these effects gradually become less important. Whereas in the past they had smoked large quantities of cannabis throughout the day with the aim of becoming ‘as stoned as possible’, they had gradually developed a more responsible pattern of medical use. A young man with ADHD who had been smoking since his early teens said: ‘No, I don’t become so intoxicated any more. Now, I come to a certain level, and remain there. I think that’s suitable. I like to stay there.’

However, for those with less contact with other medical cannabis users, constructing symbolic boundaries between cannabis use for pleasure and medical purposes was less important. A young man said: ‘I don’t really understand the problem. When I am ill, and hash may help? Why must I forget it, kind of?’ He lived in a small village, isolated in a studio building. He said that cannabis had a remarkable effect on his MS and he smoked it regularly. His reasoning was that if cannabis works, then he should use it, even though it also gave him a feeling of euphoria. In his opinion, cannabis as medication improved his MS symptoms as well as his mood: ‘My quality of life improves’. He was not sensitive to the political controversies regarding the intoxicating effect of cannabis, and therefore saw no reason to justify or neutralise the euphoric effects the substance had for him.

Another participant was a 40-year-old man who had used cannabis for 25 years. His long hair, moccasins and Indian-style leather jacket signified his bohemian lifestyle. He claimed that he derived medical benefits from cannabis but he was also well aware of the problems he represented for medical users:

For a medical user to be associated with a so-called hippie is crushing. Of course we also use it medically, but in addition, we are very fond of the intoxication.
He was strongly in favour of legalising cannabis as a recreational drug. However, he was not
interested in taking ‘the medical cannabis route’. He was too firmly rooted in the traditional
cannabis culture for that and he saw no reason why cannabis should not be legalised as a
drug with euphoric effects, in line with alcohol and tobacco.

The framing perspective of social movement theory describes the interpretative work that
goes into mobilising popular support (McAdam et al. 1996). Gamson, for example, lists three
components of collective action frames present in most social movements (Gamson 1992,
1995). Injustice frames are the ‘hot cognition’ of moral indignation. Examples are the stories
of neglect and ignorance told by the medical cannabis users in this study. Agency frames refer
to the belief that it is possible to create change, and are often embedded in a rhetoric of
change that systematically exaggerates the degree of available political opportunity (Gamson
and Meyer 1996). For example, the medical cannabis movement in Norway often points to
the developments in California as a first step towards the legalisation of medical cannabis use
in Norway. Finally, identity framing is the creation of a shared identity for social movement
participants. It often involves complex symbolic boundary work. Any identity that endorses
recreational cannabis use and traditional cannabis culture jeopardises the identity frame of
the medical cannabis movement and risks the medical cannabis cause being seen as ‘just
another way’ to legalise cannabis.

Discussion

Participants in this study reported using cannabis to treat diseases such as MS, Tourette’s
syndrome, ADHD and rheumatism. However, many considered its use for relaxation, pain
reduction and sleep to be equally important. For many medical users, the borders with
recreational use were unclear. All medical cannabis use was illegal and none of our
participants had legal access to it through the healthcare system. Thus, medical cannabis use,
vaguely distinguished from its recreational use, seems to be spreading outside the control of
the healthcare system.

Medical cannabis users may be regarded as patients attempting to access better treatment.
An increasingly active role played by the patient is typical of the development of
contemporary healthcare systems (Nettleton 2010: 167). Thus, from the perspective of
medical activism, the emergence of medical cannabis users is not unexpected. Cannabis,
however, is also used recreationally, it may have adverse mental health and psychosocial
consequences and it can lead to dependence. Furthermore, the substance is illegal.

Recognising medical effects

In several publications, Howard Becker discusses how drug experiences are learned through
the kind of knowledge available to the person taking the drug (Becker 1953, 1974).
‘Knowledge’ is taken in an extended sense to refer to:

any ideas or beliefs about the drug that any of the actors in the drug use network (for
example, illicit drug sellers, physicians, researchers, or lay drug users) believe have been
tested against experience. (Becker 1974: 26)

This implies that the experience of taking opiates in the context of surgery at a hospital
differs from the experience had when they are taken by users of illegal drugs. In both cases,
knowledge from authoritative sources guides the user in identifying the drug’s effects.
Moreover, Becker argues that the notions of ‘main effects’ and ‘side effects’ of drugs are not
pharmacologically distinct categories. Rather, what must be taken into account is whether the effects are desired or not desired – by the user, by the person administering the drug and by society. Both intended effects and unintended side effects are socially constructed categories.

We obtained many descriptions from recreational cannabis users who had invested considerable time in identifying their highs when they first started using cannabis. Becker’s analysis of the process whereby marijuana users learn to interpret the substance’s subtle effects as pleasurable provides a useful framework (Becker 1953). Several participants described how they had to identify new intended effects of the substance when starting to use cannabis medically. Whereas the main effect sought had previously been pleasure, it had to be relearned as, for example, the ‘reduction of pain’ or ‘reduced spasms’. Such conflicts are not exclusive to cannabis. Prescription drugs such as benzodiazepines may also result in intoxication and pleasure. However, these effects are usually described as side effects and are accompanied by warnings about drowsiness and an inability to complete complex tasks under their influence. In a similar vein, it has been argued that the high resulting from cannabis ingestion ideally should be considered a side effect or a bad effect, and that this effect should be eliminated before medical cannabis can be used (Chapkis and Webb 2008).

Several medical activists in this study shared this view. For them, the boundary between intoxication and therapeutic effects was clear-cut and the distinction was often underpinned by psychopharmacological knowledge of the differences between the effects of the cannabinoids THC and CBD. Many were familiar with current research on CBD and its pharmacological status as a non-psychoactive agent (Russo 2011, Stott and Guy 2004). They argued that a medical pattern of use involved taking lower doses than used in a recreational pattern. For some, a rejection of the traditional cannabis culture was part of the process of redefining cannabis from a recreational drug to a medical one. Thus, their use of cannabis had to be reframed within a new context of medical knowledge, a shift that clearly also influenced their experience of the effects of cannabis.

Those with a less central position in the emerging medical cannabis movement took a softer stance. They accepted that cannabis had euphoria-producing effects but argued that these effects were less important than they once had been for them, and stated that they were now satisfied with a more moderate level of intoxication. Finally, some on the periphery of the emerging medical cannabis movement were less concerned with the symbolic boundaries between intoxication and medical use. Their lack of interest may simply stem from a naive lack of awareness of possible dilemmas in this area. Among those who identified with the traditional cannabis culture, however, this lack of interest also sometimes reflected a view of the emerging medical cannabis movement as an inadequate or unwanted political strategy for gaining legal access to cannabis.

The stigma of intoxication
At the centre of the debate around medical cannabis is its ambivalent status as both a psychoactive and euphoria-producing drug and a medical therapeutic. It is important to note that this ambivalence does not distinguish cannabis from legal medications. Many prescription drugs appeal to recreational users and numerous research reports have described the misuse of benzodiazepines (Modelon et al. 2007), codeine combinations (McDonough 2011) and prescription medicine for ADHD such as Ritalin (McGabe et al. 2005). The participants in this study were well aware of such facts. Thus, they could make the case for medical cannabis use by contrasting the ‘natural, organic’ cannabis plant with ‘toxic, dangerous and chemical’ prescription drugs that also have the potential for abuse and dependence.
Many health professionals and medical cannabis users seem to make a sharp distinction between the ‘high’ and the ‘medical’ effects of cannabis. This distinction may be understandable from a political perspective but it otherwise remains doubtful. Norman Zinberg observed that the anti-nausea effects of cannabis were usually accompanied by the ‘high’ state and that nausea and vomiting would resume when the high wore off (Zinberg 1979). In a Danish study of medical cannabis, the ‘mind calming and soothing effects in relation to psychological discomfort’ were among the most highly valued effects (Dahl and Frank 2011: 63). In a study of medical cannabis users in California, what was coined ‘a sense of wellness’ was reported as equally important as more narrow ‘medical effects’. For those who suffered from pain, cannabis could produce a shift in attitude and allow them to ‘sideline pain, and refocus on pleasures and possibilities’ (Chapkis and Webb 2008: 120). Many participants in this study pointed to similar effects. Cannabis made them relax, made them feel better and, for some, even made them able to see new possibilities in their life situation.

One may ask why distinguishing between therapeutic and intoxication effects was so important. In a comparative study of the degree of social disapproval associated with various health and social problems, alcoholism and drug addiction both ranked near the top in all countries studied. A drug addict was more stigmatised than a person who appeared ‘dirty and unkempt’ (Room 2005: 148). Further, moralisation and stigmatisation were directed at the intoxication experience itself. Many did not accept the idea of getting drunk or high at all, and those who did, argued that it should be in regulated circumstances and during ‘time-out’ periods. One of the most stigmatising experiences was to be seen in public under the influence of alcohol or another drug (Room 2005).

Distinguishing between therapeutic and intoxication effects was probably important for medical cannabis users in this study because there is no real tradition of medical cannabis use in Norway. For almost five decades the drug has been associated with recreational use, intoxication and euphoria. Moreover, the substance has been associated with terms such as drug addict, misuse and dependence. The key actors in the emerging medical cannabis movement in Norway, as elsewhere, struggle discursively to change this image of the substance. They attempt to legitimate medical cannabis use based on non-psychoactive cannabinoids and argue that ideally, medical cannabis should not result in euphoria and should reflect a lifestyle that is not centred around parties and nightlife. For some, a rejection of the subculture of cannabis was necessary in order to present it as a medical alternative.

Medicalisation
The term ‘medicalisation’ refers to a development whereby a medical vocabulary is expanded to define a new problem – a problem that previously had been regarded as a form of deviance (for example, alcohol problems, opiate addiction) or normal life events (menopause, infertility) (Gabe et al. 2009). It has been argued that we are now witnessing a medicalisation, or rather a re-medicalisation, of cannabis (Taylor 2008). The forces behind the process seem to be related to: (i) research in the wake of the discovery of the cannabinoid receptor system; (ii) pharmaceutical companies’ interests; and (iii) pressure from sufferers of diseases (for example, AIDS and MS) for access to safe and effective treatments. Our data set clearly indicates a similar medicalisation process. However, this is primarily the result of item (iii): pressure from medical cannabis users themselves.

Early studies on medicalisation assumed that physicians and the medical profession were key actors in the process. However, the process has gradually been conceptualised as being more complex. In the development of alcoholism as a disease, for example, medicalisation was primarily achieved through Alcoholics Anonymous (Appleton 1995, Conrad and
Schneider 1992). Generally, social movements, patients’ organisations and individual patients have all been important advocates of medicalisation (Broom and Woodward 1996). In the Norwegian context, physicians, researchers and pharmaceutical companies have taken little interest in this area. The driving force has been the medical cannabis users themselves. There may be several reasons for this, and a comparison with opiate use may be illuminating.

Conrad and Schneider (1992) describe the history of the definitional changes of opiate use from when it was not defined as much of a problem, to its definition as a medical problem, through its criminalisation, and again to limited re-medicalisation. The key idea is that there has been a continuous debate for more than 100 years over the utility versus the possible misuse of opiates. The result has been a prevalent, but highly controlled, use in all parts of the healthcare system. Pharmaceutical companies, medical professionals and prestigious researchers underpin the regimes surrounding medical opiate use. Indeed, nobody seriously questions the utility of the substance and it is not difficult to define the boundaries between the medical and recreational uses of opiates.

The medical use of cannabis also has received some scattered research support. However, such support still comes mainly from the periphery of the medical establishment. In the Norwegian context most physicians still consider that other drugs are more efficient in the reduction of symptoms of, for example, cancer and AIDS (Ernst and Kongsgaard 2008). Moreover, applying for the general approval of medications such as Sativex and Marinol would be expensive for pharmaceutical companies, and the possible profits resulting from this may be regarded as limited. Finally, Norway has never had a real subculture of opiate users. By contrast, the cannabis subculture has been visible since the 1960s. Distinguishing between the recreational and medical uses of cannabis is therefore more important than has been the case for opiates.

In summary, there is little doubt that some patients with serious diseases could benefit from medical cannabis. On the other hand, the medicalisation of social life may ultimately transform ordinary human differences into pathologies. Paradoxically, the medical cannabis movement, which expresses values that are often critical of the expansion of expert knowledge, has inadvertently contributed to this medicalisation process. The medical perspective has influenced cannabis users far beyond the medical cannabis movement. In this way, cannabis users traditionally in favour of political opposition, autonomy and lay perspectives have become involved in a process traditionally associated with increased social and state control and people’s reduced ability to engage in self-care (Zola 1972). Among all the cannabis users in this study (N = 100), we observed a tendency towards a change in the viewpoint of understanding cannabis – from oppositional to medical – and of everyday problems as being more in need of medication than of societal change.

Conclusion

Medical cannabis use is increasing in many countries. However, most alleged medical cannabis use remains unregulated and illegal, and its boundaries with recreational use are vague. This study revealed an evolving medical cannabis movement anchored in a group of activists characterised by their considerable research-based knowledge. Most of these activists had ongoing interactions with the healthcare system as they attempted to obtain legal access to cannabis; thus far with limited success.

We analysed a number of strategies developed to defend the medical use of cannabis. Firstly, medical cannabis users were in contact with medical professionals in attempts to obtain cannabis-based medications. They described complex medical histories and serious
diseases and often used sophisticated terminology from medicine and psychopharmacology. Secondly, prescription-based medications such as benzodiazepines were contrasted with cannabis as having a greater potential for dependence and more adverse side effects. Thirdly, medical cannabis users rejected intoxication and euphoria as features of their cannabis use. The obstacles they encountered include the medical profession’s difficulty in accepting that users can be knowledgeable, and the tendency among some medical cannabis users to embrace the intoxicating effects of cannabis and the values of traditional cannabis culture.

One may argue that Norwegian health authorities have taken an overly control-oriented position in the medical cannabis field. At the same time, even though traditional cannabis culture represents values that are critical of expert knowledge, subtle processes of medicalisation may accompany the introduction and development of medical cannabis.

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