Received: 8 October 2021 | Accepted: 6 June 2022

DOI: 10.1111/1467-9566.13513

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE

Medicalising the menace? The symbiotic convergence of medicine and law enforcement in the medicalisation of marijuana in Minnesota

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Abstract

The medicalisation of marijuana has occurred rapidly, albeit nonuniformly, across the US and around the world over the past 3 decades. This paper centres on the medicalisation of marijuana in Minnesota—which has one of the most restrictive programs in the country—as a case for evaluating the negotiation of institutional boundaries with the shift from criminalisation to medicalisation after nearly a century of criminal prohibition. Drawing upon Foucauldian discourse analyses of the medical and law enforcement associations' position statements and legislative hearings that shaped medical marijuana policy in Minnesota, this paper demonstrates a symbiotic convergence between medicine and law enforcement through the deployment of shared discursive strategies in their opposition to medical marijuana that reinforce marijuana's criminalised status by solidifying the boundaries between proper medicine and dangerous drugs. Criminal justice and medical institutions draw upon one another's definitions, logics, and practices in a mutually constitutive manner, while still maintaining distinct user subjects and institutional interventions for each based on the user's

access to state-approved forms of marijuana. The consequences for the governing of marijuana in Minnesota are explored, as well as the broader implications for the sociological study of medicalisation and criminalisation with respect to the governance of drugs and health.

KEYWORDS
criminalisation, discourse analysis, governance, institutional boundaries, medical marijuana

INTRODUCTION

The last century has seen the criminalisation of marijuana (aka cannabis), decades of racialised drug scares, efforts to frame it as medicine, and gradual reform. This contentious and uncertain relationship has provided an ongoing basis for institution-building—to control, prescribe, and proscribe; to construct institutional order and knowledge over the chaotic and ambiguous nature of drugs and the fragility of life. For that reason, the governance of psychoactive chemicals, like marijuana, has been a source of boundary-making between medicine and health, criminality and danger. The seeds of modern governing institutions are laden with the buds of this peculiar plant.

Notably, marijuana's criminalisation occurred alongside rapid advancements in pharmaceutical production and the solidification of the now dominant models of scientific medicine. As this paper demonstrates, this was not coincidence. Marijuana and other so-called 'dangerous drugs' played a central role in the formation of contemporary medical and criminal justice institutions, and movements to medicalise marijuana have been shaped by this intertwined history.

For scholars of governance and institutional control, medical marijuana policy is situated at the nexus of regulatory, criminal justice, and medical institutional authority, and provides a case for understanding how governance is negotiated and structured among these institutional bodies after a century of drug prohibition. Medical professionals' ambiguity with marijuana's medical uses is well documented (Bostwick, 2012; Zarhin et al., 2018; Zolotov et al., 2018), and this professional tension is demonstrated by the fact that 76% of US physicians support medical marijuana (Adler & Colbert, 2013) which the American Medical Association (AMA) has continuously opposed. Recent work on medical marijuana policy shows how the roles of medicine and the state are negotiated through the strategic discursive deployment of law, security, and discipline dispositives—upholding the role of law in marijuana governance, constructing knowledge to manage the risks of marijuana use, and disciplining users based on motivations, institutional gatekeeping, and legally allowable forms (Acevedo, 2007; Wagner et al., 2020). Medical professionals, law enforcement, and lawmakers both negotiate and reinforce the scope of proper medicine through the process of medical marijuana policymaking, including physician prescriptive powers, physicians' role as gatekeepers to medicine, the delineation of medical versus recreational uses of marijuana, and the scope of professional medicine vis-à-vis stigmatised drugs (Lancaster et al., 2017; Wagner et al., 2020; Zarhin et al., 2018).

With respect to institutional control, the medicalisation literature posits a relatively linear shift from criminalisation to medicalisation—what Conrad and Schneider (1992) describe as a shift from 'badness to sickness'. However, recent work has contested this binary framework, demonstrating how criminalisation and medicalisation form an overlapping matrix by which

each expands its control through the techniques and discourses of the other (Rafalovich, 2020; cf; Showalter, 2019). To address the institutional shifts involved with medical marijuana legalisation, Aaronson and Rothschild-Elyassi (2021) propose a 'polymorphic approach' for understanding the 'symbiotic tensions' between the regulatory and carceral state in shaping the governing structure for marijuana and users. This approach reveals how expansion of the regulatory apparatus serves to reinforce the authority of the carceral through a bifurcation of the governing structure, reproducing racially unequal policing and access issues by maintaining distinct user subjects (e.g. the medical patient vs. the criminal user) along socioeconomic and racial divisions. However, their analysis treats medicine as an ancillary institution newly incorporated into the drug governance field, and thus does not address the multifaceted and historicised processes of both medicalisation and criminalisation involved in marijuana legalisation. As I demonstrate in this paper, medical institutions have been integral to the formation of the carceral and regulatory apparatuses in the War on Drugs through their role in defining and policing 'proper medicine' and 'dangerous drugs'. To treat medicine as newly brought into this field via marijuana policy misses the ways in which the structure of drug governance has not only been deeply shaped by medicine, but also how regulatory, criminal justice, and medical institutions have shaped one another in mutually constitutive manners over the past century—and thus provide the historical and institutional backdrop from which medical marijuana initiatives have emerged and been negotiated.

From this literature, we would expect tension between regulatory, criminal justice, and medical institutions with the governing of medical marijuana, even if we would also expect control to be expanded through the reconfiguration of marijuana's governing structure (O'Brien, 2013). We would also expect a contentious process in defining the problem of marijuana use and contesting the proper scope of law enforcement, the state, and medicine in its governance. However, in Minnesota—one of the most restrictive medical cannabis programs in the US that only allows the use of oil-based products for patients with relatively severe qualifying medical conditions—even though we see an expansion of institutional control of marijuana use, we do not see contestation between law enforcement and medicine in defining marijuana and assigning institutional turf. In professional position statements leading up to legislative hearings, law enforcement and medical professionals mutually deployed medical scientific and legal-criminal discourses in their shared opposition to medical marijuana, and in so doing shored up the proper scope of medical and criminal justice authority and constructed distinct subjects for each to govern.

Rather than expanding control through a bifurcated structure of governance between the regulatory and carceral state, I argue that, in the case of Minnesota's medical cannabis programme, governance is expanded through a refined distinction of 'proper medicine', user subjects, and use forms which the state, law enforcement, and medicine mutually construct to reinforce each institution's governing authority. Instead of observing 'symbiotic tension', I argue that, in this case, there is a *symbiotic convergence* between law enforcement, the state, and medicine, as demonstrated by their mutually beneficial deployment of scientific medical discourse in a juridically restricted research context, which not only serves to uphold marijuana's criminalised status as a dangerous drug, in general, but also produces distinct forms and users of marijuana for both law enforcement and medicine to govern—acknowledging marijuana as medically beneficial while retaining its criminalised status as a dangerous drug with no medical value.

In the case of medical marijuana in Minnesota, what Gusfield (1967) describes as the 'sick' and 'criminal' deviant identities are maintained as both legally and morally distinct, and are reinforced through distinct institutional sorting: The sick patient user is given moral and legal reprieve for their use of state-approved medical marijuana products, whereas the criminal user is

marked by their use of illicit forms of marijuana and is (potentially) subject to criminal punishment. In this schema, however, medical marijuana patients may easily slip into criminal users if caught using a non-state-approved form of marijuana, such as smokable flower, which many patients I interviewed regularly use.[1] In that sense, this case more closely aligns with Rose's (2000) definition of control that operates through the creation and management of distinct circuits of access and consumption: 'Control is better understood as operating through conditional access to circuits of consumption and civility: constant scrutiny of the right of individuals to access certain kinds of flows of consumption goods; recurrent switch points to be passed in order to access the benefits of liberty' (326). Access to these circuits of consumption in Minnesota links together the subject type (e.g. patient vs. criminal) and form of marijuana (e.g. state-approved products vs. smokable flower) into a criminal-legal typology. It is by having to pass through these recurrent switch points as particular subject-marijuana types that medical and criminal justice institutions which govern them establish and enforce their authority.

As I demonstrate in this paper, the reason for this convergence's possibility and symbiotic nature is a result of the ways in which the institutional turf between medicine and law enforcement has been deeply intertwined and mutually constituted through a century of drug prohibition, regulation, and production. This symbiotic convergence that occurred in Minnesota not only provides useful analytical applications for understanding the mutually beneficial aspects of criminalisation and medicalisation from an institutional standpoint, but also for understanding how they operate collectively and cooperatively from the standpoint of governance.

'PROPER MEDICINE' AND THE WAR ON DRUGS

Marijuana was federally regulated with the Marihuana Tax Act of 1937, and federally criminalised with the passage of the 1970 Controlled Substances Act as Schedule I—a designation for drugs with no medical value and high abuse potential. In 1996, Californians passed a landmark medical marijuana decriminalisation measure that laid out a moralised strategy for advocates: Marijuana is not a dangerous drug but a necessary medicine for those suffering most in society; it is immoral to prevent suffering *patients* from accessing this necessary *medicine*. Marijuana reform had a new precedent set within a moralised and medicalised framework (Barnes, 2000; Dioun, 2018; Ferraiola, 2014).

During the first half of the twentieth century, efforts to prohibit drugs occurred alongside the solidification of mass-produced pharmaceuticals and evidence-based medicine. According to Conrad (2007), claiming an ideological monopoly over the control and distribution of medicine was a major institution-building win for medicine in the 20th century. The merging of pharmacology with modern medicine set the stage for a massive overhaul in the way drugs are made, regulated, and distributed—both in content and form. The imperative for evidence-based medicine to be established by randomized clinical trials (through the FDA) and be rationally dosed, prescribed, and administered also provides rationale for the use of synthetic compounds cleansed of unnecessary (or 'dirty') elements (Britten, 2008). The oft-contentious relationship between criminalisation efforts and the medical profession points to the ways in which drug prohibition and the rise of pharmaceutical, evidence-based medicine are mutually intertwined.

In many respects, the US Food and Drug Administration (FDA) embodies the historic imbrication of the medicalisation and criminalisation of drugs. Before the Federal Bureau of Narcotics shifted from the Treasury Department to the Department of Justice in 1968, the FDA was the primary policing agency for the illegal distribution of domestically manufactured 'dangerous

drugs', such as barbiturates and amphetamines. Not only did the FDA have the primary authority to delineate 'safe' from 'dangerous' drugs, they also dedicated personnel and resources to policing 'dangerous drugs', including undercover agents conducting amphetamine busts at truck stops (June, 2018).

The FDA's regulatory practices also placed physicians as the primary gatekeeper to 'dangerous drugs' by requiring and regulating licenced-physician prescriptions (1951 Durham-Humphrey Amendment), while protecting pharmaceutical companies' patents and profits. It wasn't until the 1960s (Drug Amendments Act of 1962) that the FDA started to become a more scientific organisation by requiring clinical trial research to demonstrate both a drug's safety *and* efficacy (Junod, 2008; Plank, 2011). Importantly, this shift from a predominantly policing agency to a rigorous scientific organisation only began to take institutional hold around the time that the Bureau of Narcotics and Dangerous Drugs was created within the Justice Department in 1968 (a merger of the Treasury Department's Federal Bureau of Narcotics with the FDA's Bureau of Drug Abuse Control—Plank, 2011). Indeed, the FDA was not only integral to the formation and regulation of 'proper medicine' but also the criminalisation of so-called 'dangerous drugs', laying the institutional foundations for both the normalisation of pharmaceutically produced, physician-mediated medicine, as well as the criminalised drug war (June, 2018). In that sense, the constitution of scientific 'proper medicine' emerged through the same agency and processes through which criminalised, dangerous drugs were constructed in the laws, political discourse, and institutions governing drugs in the US.

Despite this historically constitutive relationship, criminal drug reform efforts have often involved a contentious relationship between law enforcement and medicine in determining the proper scope of drugs. For that reason, medical marijuana policy is a key site for exploring the politics of control because it is situated at a 'medico-legal borderland' whereby 'the meeting of the two realms inevitably generates friction and misalignments, often requiring translations in public ways' (Timmermans & Gabe, 2002, p. 509). For example, despite initially opposing the criminalisation of marijuana, in the last few decades the American Medical Association (AMA) acquiesced to its criminalised status by consistently opposing medical marijuana, while gradually advocating for non-criminalised approaches and fostering scientific research. At the core of the AMA's opposition to medical marijuana is that (1) there is insufficient clinical research and FDA guidelines for marijuana's medical use, (2) smoking is not a healthy or acceptable medical modality, and (3) ballot initiatives and legislative processes are inappropriate avenues for introducing medicine to the public. In that respect, the scope of evidence-based 'proper medicine' has been deeply shaped by the Drug War, whereby the legal limits for research on marijuana as a Schedule I substance, alongside the solidification of evidence-based medicine, serve to reinforce medicine's opposition to medical marijuana based on lack of clinical evidence and its potential danger/abuse.

In Minnesota, attempts to reform marijuana laws have entailed heavy-handed opposition from politically powerful law enforcement groups and lawmakers willing to oblige their concerns, reinforced by a hesitant and cautious Minnesota Medical Association. In 2009, Republican Governor Tim Pawlenty, citing opposition from law enforcement, vetoed a medical marijuana bill which would have allowed smokable flower, home cultivation, and dispensary licencing. In 2014, this legislation was taken up again. Following Pawlenty's lead, Democratic Governor Mark Dayton publicly made clear he would only sign a bill with the full support of law enforcement. The central role of law enforcement in Minnesota politics, in general (Lansing, 2021), and in shaping this legislation, specifically, cannot be overstated—as state Rep. Carly Melin said during 2014 legislative hearings, 'I'm starting to wonder who makes the laws around here... It seems like

we take [law enforcement's] opinion into pretty heavy consideration whenever we're passing legislation.' Following a 2015 closed-door session, the legislature passed into law one of the US's most restrictive medical marijuana programs.

The programme originally restricted access to 11 severe health conditions (gradually expanded to 17 by 2021), and restricts legal marijuana to pharmaceuticalized, oil-based forms (no variety of strains, no home cultivation) produced by two licenced manufacturers, resulting in prohibitively high costs.[2] Moreover, the law does not require insurance companies to cover medical marijuana-related costs, and patients must also pay annual state (re)certification fees.[3] Many patients I interviewed have either left the programme because of the costs and/or also use cheaper illicit marijuana flower—pushing patients into the black market.

At the same time that patients face structural barriers to accessing the relief that medical marijuana is intended to provide, Minnesota continues to have some of the highest racial disparities (a Black/White arrest ratio of 5.37 to 1) for marijuana-related arrests (ACLU, 2020)—with nearly 9000 marijuana-related arrests in 2018, alone. The ongoing criminalisation of marijuana flower—despite state recognition of its medical efficacy—provides law enforcement the ability to readily identify illicit marijuana, which is a lucrative (through asset seizure-forfeiture and Byrne Justice Grant funds) and strategic source for law enforcement to disproportionately police, punish, and govern users and perpetuate racial disparities. For example, in the 2016 police killing of Philando Castile in a suburb of St. Paul, defence lawyers for Officer Yanez argued that charges should be dropped because Castile and his girlfriend were under the influence of marijuana—identified by the 'smell of marijuana' in the car. That Castile had at some point used marijuana was sufficient to acquit Officer Yanez for shooting Castile seven times at point blank range with his girlfriend and four-year-old daughter in the car. The consequences of simultaneous criminalisation and expensive medicalisation continue to disproportionately (even fatally) affect people with lower incomes and communities of colour in Minnesota.

In this context, the Minnesota medical marijuana legislative process provides a unique case to understand drug governance and institution-building at the 'medico-legal borderlands' inasmuch as both the Minnesota Medical Association (2014) and the Minnesota Law Enforcement Coalition (2013) originally opposed medical marijuana—though both later supported the more restrictive bill. Before the legislative session, both groups' professional associations publicly rejected the medicalisation of marijuana and called for increased research and expanded use of synthetic CBD/THC (primary active chemicals in marijuana), produced by pharmaceutical companies and prescribed by physicians—toeing the AMA's line. They were not initially competing over definitions and institutional turf like the medicalisation literature would predict. Instead, the process of bringing medical marijuana to the legislative table brought to light the ways in which these authoritative institutions are overlapping and often complementary from the standpoint of governance, having mutually shaped one another's institutional practices and logics through nearly a century of criminal drug prohibition and the concurrent rise of pharmaceuticalized, evidence-based medicine. In other words, both medicine and law enforcement converge at this 'medico-legal borderland' in ways that symbiotically reinforce each institution's claim to their respective 'turfs'.

DATA AND METHODS

To analyse the institutional negotiation between medicine and law enforcement with the medical cannabis legislation in Minnesota, I conduct discourse analysis of professional position statements

and expert documents from medical and criminal justice professionals, as well as transcripts of the 2014/2015 legislative debates and hearings. Specifically, the analysis centres on the Minnesota Medical Association's (MMA) special issue journal on medical marijuana—titled 'Medicine or Menace? What We Know about Medical Marijuana'—that was published in advance for the 2014 legislative session, as well as the Minnesota Law Enforcement Coalition's (2013) public position statement. Drawing on Foucault, the discourse analysis involves identifying the various discursive elements, and the relations between them, that constitute dispositives according to which apparatuses are assembled for the institutional governance of marijuana. In that respect, my analysis centres on the 'functional overdeterminations' by which the discourses of medical and law enforcement professionals enter 'into resonance or contradiction' with one another in the construction of knowledge, and the ways in which 'strategic elaborations' from the Drug War carry over into medical policy determinations (Foucault, 1980, p. 195). Therefore, my analysis demonstrates the discursive processes involved in the 'formation of objects' (i.e. 'medical cannabis') and 'territorial distributions of truth' (i.e. institutional knowledge/turf).

At each stage I show how these discourses, knowledge claims, and definitions not only legitimise medical and law enforcement professionals' seat at the table (or 'turf') to govern marijuana and users, but also how they organise a particular biopolitical economy of 'legitimate' (read: legal, medical) and 'illegitimate' (read: criminal, non-medical) actors, resources, and conduct through the solidification of institutional boundaries. Undoubtedly, these professional associations do not represent the views of all physicians and law enforcement agents in the state (although the MMA issue solicited and published quotes from physicians across the state), but these documents are emphasised because of the analytical focus on the logics, objects, and knowledge claims put forth by both these institutions. The general ambiguity and unwillingness of medical professionals in Minnesota to incorporate cannabis into 'proper medicine' is demonstrated by the fact that in 2021 only 7% of eligible healthcare providers have enroled as medical cannabis certifiers. Moreover, in a rather rare move, the MMA publicly declined to testify in legislative hearings because of concerns with the legislation, instead publishing this special issue as their collective voice on the matter. Following the closed-door legislative compromise, then MMA president, Dr. Cindy F. Smith, publicly stated, 'Ideally, the approval of new medications for the treatment of serious conditions would remain within the scientific, not the political, arena... Given the options on the table, however, the MMA finds the House proposal to provide a more useful, measured approach.'[4] And as NPR reported, 'Law enforcement groups that opposed earlier proposals, are taking a neutral position on the new compromise. The Minnesota Medical Association also took a neutral stand.'[5] Therefore, even though it is impossible to establish their *causal* influence, both law enforcement and the MMA appeared to substantially influence the final legislation. While these documents are limited in their scope, they capture a specific historical moment in which the institutional boundaries between medicine and law enforcement were 'publicly translated'. The actual institutional processes that emerge from the legislation are part of the larger research project from which this paper is drawn.

As I demonstrate, 'going with the science' discourse is deployed by both medical and law enforcement professionals as a legitimising discourse. An important element of this scientific medical discourse is the imperative for and apotheosis of clinical-trial research as the ultimate source of truth for rational policymaking, upholding the FDA approval process for pharmaceutical drugs. In that sense, this discursive element serves as a dispositif of security (Wagner et al., 2020) to produce knowledge about marijuana and assess/control risk. This discourse draws on 'anti-smoking' as a mechanism for solidifying the boundaries between 'dangerous drugs' and 'proper medicine'. This mechanism privileges pharmaceutical modalities while rendering home

cultivation and whole-plant marijuana illegible as 'proper medicine', reinforcing an aesthetic distinction for policing legal-medical and criminal marijuana forms.

This discourse is deployed to distribute authoritative institutional turf and their corresponding subjects (deserving patients vs. criminal drug users). Subject formation occurs through the use of two 'functional overdeterminations'—compassionate care and criminality—that tie together particular users, use forms, and motivations for use (and their propensity for engaging in specific activities, such as crime vs. treatment). These are drawn upon to delineate subjects while firming up the institutional boundaries of both medicine and law enforcement in mutually beneficial ways. The deployment of this discursive strategy by both law enforcement and medical professionals shows how, rather than a contentious struggle, there is a *symbiotic convergence* of institutional interests between medical and criminal justice institutions over the governing of marijuana by solidifying the boundaries between 'proper medicine' and 'dangerous drugs'—thus, providing important insight into the relationship between and mechanisms deployed by medicine and law enforcement in the governing of drugs as efforts to reform criminal drug laws through medicalisation are occurring rapidly across the US.

We need more research: Scientific discourse on 'proper' medicine

In both medical and criminal justice position statements, and further elaborated during legislative hearings, scientific medicine is presented as the guardian of rational, evidence-based 'truth' with regards to health and safety, demonstrated by the frequent appeals of lawmakers, medical professionals, and criminal justice officials to 'follow the science' with medical marijuana legislation. Yet clinical research on marijuana has been severely restricted due to its DEA scheduling.[6] In this context, scientific research legitimises physicians' role as expert gatekeepers over medicine and health, as one physician (and former president of the Colorado Medical Society) involved in marijuana policy in Colorado describes:

> *What can physicians do?* That's a good question. I think we need to be very open to the science. People look to us for informed opinions and we're not as informed as we need to be. Physicians, teachers, parents, journalists, politicians, the faith community all need to come together to promote research, promote accurate information, promote access to medications. We need to keep this from becoming another Big Tobacco.
>
> (MMA, 2014, p. 13)[7]

A central element of the 'going with the science' discourse is the apotheosis of clinical trial research. A common argument of medical and criminal justice professionals—and regularly deployed by lawmakers—is that if only there were sufficient (read: more) rigorous clinical studies then experts and lawmakers could come to an objective, apolitical marijuana policy. As one physician put it, 'Why not focus on changing legislation to allow more study?' (MMA, 2014, p. 15). Additional research on marijuana would certainly be useful after nearly 50 years of research restrictions. However, when argued as a necessary prerequisite to legislative change, the imperative for more research reinforces marijuana's criminalised status. In that respect, the demand for more research is an institution-building strategy: Demanding more research reinforces the scientificity upon which medicine's legitimacy rests—physicians look to 'the science' and therefore

can be trusted to inform medical-related legislation—while, implicitly, shaping criminal drug policy.

Both medical professionals and law enforcement officials treat the FDA as the ultimate stamp of scientifically ensuring the safety and efficacy of potential treatments: 'I am a staunch defender of the rigorous process of drug approval in this country that exists to help ensure that drugs marketed are safe and effective' (Falkowski, 2014, p. 40). Terms such as 'anecdotal evidence' and 'folk medicine' are commonly deployed to discount claims about marijuana's medical efficacy by non-medical experts: 'There are no *scientifically controlled studies* that clearly demonstrate marijuana has any therapeutic effects for any psychiatric condition...Claims that marijuana improves anxiety and depression are *anecdotal*' (MMA: 25, emphasis added). The Minnesota Law Enforcement Coalition (2013), despite no rigorous scientific training, also deploy these same discursive strategies: 'The [1999 Institute of Medicine] study concluded that, at best, there in [sic] *only anecdotal information* on the medical benefits of smoked marijuana for some ailments, such as muscle spasticity. For other ailments, such as epilepsy and glaucoma, the study found no evidence of medical value and did not endorse further research' (5, emphasis added). The use of 'anecdotal evidence' to discount marijuana's efficacy is notable not only because of its malleable deployment by both medical and criminal justice professionals (i.e. 'resonance'), but especially because the vast majority of evidence is inherently 'anecdotal' in a context where research has been severely restricted. This was also deployed by lawmakers opposing the legislation, such as Rep. Kathy Lohmer's concerns expressed during legislative hearings: 'I feel like we're making decisions here based on emotional feelings instead of science, and I don't think that's a responsible governing measure' (5/16/14). As such, 'emotional feelings' and 'anecdotal evidence' are constructed as antithetical to scientifically informed policymaking.

While anecdotal claims are relegated to the non-scientific realm and controlled clinical studies serve as the ideal type, these ideals are not always reflected in physician practice. Evidence-based medicine (EBM) attempts to standardise medical practice based on rigorous empirical research (Timmermans & Mauck, 2005), for which randomized control trials (RCT) are the 'gold standard'—even though RCT results can involve 'interpretive flexibility' (Timmermans, 2011). However, while EBM offers medicine scientific legitimacy, its implementation in practice varies (Timmermans, 2005; Timmermans & Alison, 2001; Timmermans & Kolker, 2004). The following quote from a Minnesota physician (from the same article which calls for 'going with the science') demonstrates this discrepancy: 'I am not going [to prescribe] something I do not support or believe in' (17). Whose personal experiences and beliefs are 'anecdotal' or 'scientific' may appear arbitrary, yet these classifications are consequential in maintaining medicine's authoritative position. In fact, several physicians argue that medical authority is undermined when physicians are not central to medicalisation processes:

> More worrisome, *the pathway taken to legalising medical marijuana in states may change how the public views treating disease, maintaining health and approving new medicines*. The question at stake is not solely about the value of marijuana as a medicine but about *the process by which all medicines are introduced to the public*. I believe marijuana is not a good medicine, but neither is it a terrible poison. Yet I oppose medical marijuana strongly on the grounds that *it subverts our normal processes of medicine in a way that will have repercussions going forward*. I believe that medical marijuana will *corrode the doctor-patient relationship*.
>
> (Reznikoff, 2014, p. 43, emphasis added)

Medical marijuana threatens to corrode the institutional claims-making ground upon which medicine has ascended to its role of authoritatively mediating health and the body: Physicians ensure medicine's scientificity by controlling the process through which medicines are introduced to the public and, in turn, how people understand, perceive, and treat their bodies. Conversely, some physicians claim that the doctor-patient relationship is undermined by marijuana's criminal status: 'We can help a vast majority of our patients with other methods, but for some, marijuana may be the only thing that works...These patients found their own way to get relief, albeit an illegal one. In cases such as these, the law does not make sense. It interferes with my contract with the patient, and it forces me to do something that I feel is unethical (suggest they stop the sole effective therapy) or potentially illegal (suggest they break the law in order to obtain relief)' (Mirman, 2014, p. 38). In either case, marijuana's legal status is depicted as corroding the doctor-patient relationship.

At the same time that Law Enforcement calls for marijuana policy to be based on 'the science' and points to scientific medical institutions such as the FDA and the Institutes of Medicine to justify these claims, they simultaneously deploy legality dispositif in their opposition to medical marijuana:

> Marijuana is a Schedule I Controlled Substance under Federal and State Law (meaning that it has a high potential for abuse and a lack of any accepted medical use)... Consequently, those granted authority to lawfully produce and use marijuana for medical purposes under state law will still be committing a federal crime. It is not sound public policy to enact state laws which encourage law abiding citizens to commit federal crimes.
>
> (2)

Legality logic is expected from law enforcement: Marijuana is dangerous and has no medical value because the law says so. Yet the vast majority of their nine-page position statement is filled with medical discourse, citing decontextualised research that highlights either the dangers of marijuana use (especially addiction, abuse, and its potential to lead to other drugs and criminal activity) or medicine's ambiguity on its efficacy. Interestingly, the majority of 'medical evidence' they cite comes from Department of Justice and Drug Enforcement Agency reports, which are hardly 'scientific' and 'apolitical' sources.[8] In that respect, law enforcement draws on the *legitimacy* afforded to scientific medical knowledge to strategically craft its case against legal marijuana, effectively deploying these scientific discourses alongside legality dispositif. The convergence of medical science and legality reflects the intertwined dynamics of drug prohibition throughout the 20th century which both restricted research and shaped the scope of 'proper medicine'.

Smoking ≠ medicine: The gatekeepers of 'legitimate' medicine

A key mechanism through which the medical science discourse is deployed is rendering smoking illegible as an acceptable medical modality, citing its abundance of 'dirty' elements and its facile relationship to 'Big Tobacco'. As one Minnesotan physician asserted, 'I would only use the present forms of THC or cannabidiol [for patients]. The term 'medical marijuana' needs clarification. It should be understood that there's a dichotomy between smoking 'medical pot' and using pure

THC and/or cannabidiol. I do not want my patients smoking pot. Getting high is recreation, not medicine' (MMA, p. 17). Two crucial distinctions are derived: (1) *smoking* is used to *get high*, which is *not* medicine; (2) synthetic derivatives of marijuana (CBD/THC) are proper medicines because they are chemically 'pure' and not smoked—and, therefore, are not recreational. As gatekeepers of proper medicine, physicians privilege pharmaceuticalized, synthetic forms of marijuana and exclude a cheap and readily growable plant for patients.

Because of physicians' concerns and imperative for rationally dosed, 'cleanly' administered, and well-regulated medicine, smoking was immediately disqualified almost unanimously by physicians on several grounds. First, smoking contains too many chemicals:

> Admittedly, the medical marijuana product that's currently available challenges our ideas about what constitutes a legitimate medication. First, it is a raw plant containing at least 60 distinct cannabinoids among nearly 500 discrete chemical compounds, the vast majority of which are uncharacterised, let alone studied. Moreover, the concentrations of THC and cannabidiol (CBD), marijuana's two known active ingredients, are essentially idiosyncratic, depending on the strain... Thus, marijuana buyers have little guarantee of what they are purchasing, whether the drug comes from a dealer or a state-authorised distributor.
>
> (Bostwick, 2014a, p. 36)

Second, medical marijuana is depicted as inherently unpredictable in flower form, and thus does not meet the rational qualification for legitimate medicine: 'Marijuana's effects differ greatly among individuals. Where it may make one person happy, it may make another sad. Where one person feels relaxed after smoking it, another may feel anxious. Sometimes, it causes all of these in the same person at different times, and its use often makes normal everyday functioning difficult' (25). The phenomenon of varying effects of smoked marijuana is not specific to marijuana—all substances, to some extent, vary in effects by user (Zinberg, 1984). Rather, this quote demonstrates how smoking undermines physicians' role in determining precise, rationally dosed prescription and consumption procedures—a fundamental basis of physicians' gatekeeper role over patients' medicine.

Third, law enforcement and medical professionals regularly cite concerns that legitimising smoking as a medical modality will undermine the 'success' of health professionals' crusade against cigarettes—conflating the two substances based on shared modality.

> It is also important to note that the FDA has never approved the delivery of a medication through smoking. This is because not only is it difficult if not impossible to administer safe and regulated dosages of medicine in a smoked form, the harmful chemicals and carcinogens that are by-products of smoking create an entirely new set of health problems.
>
> (MN Law Enforcement Coalition, 2013, p. 7)

Despite law enforcement's lack of medical expertise, they draw on medical discourse and the FDA to argue smoking is inherently antithetical to medicine. This facile, common-sense argumentation against smoking is justified by the decades-long public health crusade against cigarette smoking and 'Big Tobacco'. Similarly, a Minnesotan physician pointed out how not only is smoking antithetical to physicians' professional sensitivities, but also undermines the traditional gatekeeper role of the physician with medical administration:

> Unlike any other medication, medical marijuana is typically smoked, invoking intense concern in a profession sensitised to the health consequences of exposure to tobacco smoke. Moreover, users decide for themselves how much is the right amount, titrating their inhalation to their symptoms, thereby challenging a system premised on the prescriber—usually a physician—decreeing the amount and frequency of dosing based on approved standards derived from a series of FDA-ordained trials designed to establish that the benefits of a proposed medication outweigh its risks. All of this occurs against the reality that cannabis is the most popular illicit drug in the United States.
>
> (Bostwick, 2014a, p. 36)

The argument, used by both law enforcement and medical professionals, that smoking is antithetical to medicine reflects and reinforces the institutional claims-making and turf-grabbing by the medical professional field, as a whole, *and* reinforces marijuana's inherent criminality.

In addition to excluding smoking as a legitimate medical modality, medical experts and criminal justice officials regularly cite the availability of synthetic cannabinoid products, such as Marinol (dronabinol), as adequate alternative forms of medical 'marijuana', justifying marijuana flower's criminalised status: 'We already have 'medical marijuana' in two forms: dronabinol and nabilone. Their usage should be expanded for many other problems: chronic pain, neuropathic pain, migraine, chronic headache, etc. Smokable marijuana should not be legalised for medical purposes' (MMA, p. 17). Not only does this privilege pharmaceutical companies, but it does so at the ongoing expense of those (potentially) under the auspices of the criminal justice system for marijuana-related charges. For physicians, legality is a moral necessity for medical legitimacy: 'There are legal alternatives for the diseases that marijuana could help. It's a gateway drug. I don't believe it should be used' (MMA, p. 14). In other words, pharmaceuticalized synthetic CBD/THC is a safe (FDA approved) and legitimate *medicine* when prescribed by a physician for patients suffering with severe conditions; marijuana flower grown by anyone else is a *dangerous drug*.

The overt privileging of pharmaceutically produced synthetic THC/CBD products (over marijuana) is particularly salient among law enforcement professionals, and as such points to, at the very least, the de facto constitutive relationship between law enforcement and pharmaceutical companies in the War on Drugs. As the MN Law Enforcement Coalition (2013) put it:

> Advocates for the medical use of marijuana would have the public and policy makers incorrectly believe that crude marijuana is the only effective treatment alternative for masses of cancer sufferers who are going untreated for the nausea associated with chemotherapy, and for those who suffer from glaucoma, multiple sclerosis, and other serious ailments. Numerous effective medications, however, are currently available for these conditions... Also of importance is the fact that there already exists an approved form of marijuana for medical use in America – it's called Marinol... Unlike marijuana which also contains more than 400 different chemicals (including most of the cancer-causing chemicals found in tobacco smoke), Marinol delivers therapeutic doses of THC in a manner that has been studied and approved by the medical community and the Food and Drug Administration. *There is, therefore, no medical need to substitute a dangerous and addictive drug like marijuana for an approved prescriptive drug like Marinol that can provide a synthetic form of THC treatment with safe and controlled amounts.*
>
> (5–6, emphasis added)

Law Enforcement depicts medical marijuana advocates as ignorant of these legal, pharmaceutically produced alternatives—while ignoring their wide range of commonly reported adverse effects (see Lee, 2012). Despite no pharmacological training, law enforcement depicts Marinol as the normative FDA-approved medicine that renders marijuana obsolete. According to their logic, the suffering patient who may benefit from marijuana does not deserve access because legal pharmaceutical synthetics exist.

It is worth noting that not all physicians agree with this assessment (e.g. Mirman, 2014) and acknowledge the limitations of Marinol. Nonetheless, most physicians' accounts depict smoking as a non-normative modality, and their call for more research into synthetic pharmaceutical alternatives moralises smoking as backwards vis-à-vis the telos of scientific medical-technological progress:

> By rescheduling cannabis, the past and the future could be reconciled. Schedule II status would facilitate development of additional cannabinoid-derived medications with novel formulations and delivery strategies to improve efficacy and minimise side effects. Research could go forward with the goal of deriving cannabis-based pharmaceuticals that would in all likelihood render medical marijuana in its current crude, smoked-form obsolete.
>
> (Bostwick, 2014a, p. 37)

The use of 'crude' here implies a telos: 'crude' being a primitive modality which medical technological advances can 'improve' by removing the 'smoke' with pharmaceutical synthetics. Not only does this privilege pharmaceutical production, but it also provides a material distinction onto which two identifiable subjects are mapped: the deserving medical patient (with oil-based products) and the criminal user (with smokable marijuana flower).

The deserving medical patient and criminal user subjects

Marijuana is not only seen as dirty and unscientific, and thus needs a clean and rationally dosed alternative, but marijuana's 'legitimate use' versus 'dangerous abuse' is demarcated by the moralised user subjects produced by medical and criminal justice professionals' use of 'compassionate care' (Lancaster et al., 2017) as a 'functional overdetermination'. The patient *deserves* medical marijuana not because it's necessarily the most scientifically objective thing to do, but because it is the *compassionate* thing to do. As Sen. Charles Wiger argued, 'For God's sake, if people are suffering and we have the ability to provide a way to alleviate that pain – let's hear their concern, let's hear their prayer.' Such 'compassionate care' logic was not only invoked by patient advocates and lawmakers, but also provided the moralised basis to differentiate deserving patients from criminal users.

In their letter's opening statement, the MN Law Enforcement Coalition attempted to undermine any differentiation between a deserving medical patient and an undeserving criminal user by arguing that the real suffering is the collective suffering from life in a marijuana-filled world:

> Minnesota law enforcement officers and prosecutors sympathize with individuals and their family members and friends who suffer from pain and other ill effects associated with serious medical diseases and conditions...However, as law enforcement officers and prosecutors we also experience on a daily basis the pain and suffering

> that is directly and indirectly attributable to the illegal cultivation, distribution, and possession of marijuana.
>
> (1)

Despite their attempt to sympathise with those who may be morally deserving of medical marijuana, they instead assert that the suffering of patients requesting access to medical marijuana pales in comparison to the daily 'pain and suffering that is directly and indirectly attributable to the illegal cultivation, distribution, and possession of marijuana.'

Despite this initial opposition, law enforcement's emphasis on marijuana's criminality provided the moralised backdrop during legislative hearings for justifying marijuana use for specific patients based on disproportionate suffering. Criminal marijuana users are depicted as dangerous and antithetical to the upstanding, law-abiding citizen. The 'marijuana addict' threatens public safety by getting behind the wheel of a car and causing an accident or breaking into homes and mugging innocent people:

> We are alarmed at reports that marijuana is the most widely abused controlled substance in our state and nation. We are alarmed at surveys that indicate over 30% of 12th grade students in our state have used marijuana within the past year. We see firsthand the property crimes, assaults, child neglect and endangerment, robberies, and homicides that are related to illegal drug activity, including marijuana. In some cases, the incidents are directly related, such as when an innocent person is seriously injured or killed during a robbery attempt of a marijuana dealer or if someone impaired by marijuana causes a motor vehicle crash which kills or injures innocent persons. In other cases the impact of marijuana abuse is less apparent, such as the high percentage of methamphetamine or cocaine users who began their illegal drug experiences with marijuana. Regardless, evidence is clear that marijuana is an addictive and dangerous substance which has significant detrimental effects upon public safety.
>
> (2)

First, law enforcement officials claim marijuana is a problem because youths use it (less than a third of 17–18 year olds). This 'protect the youth' discourse again situates marijuana use along a moralised telos whereby it is inherently criminal and dangerous not only for our present moment but also our collective future which youths embody (Edelman, 2004). Second, law enforcement officials list an otherwise unrelated series of morally charged crimes and social ills which they loosely link to marijuana, including issues of private property, proper parenting, and personal safety. For law enforcement, the relationship between marijuana and criminality is presented as obvious, such as a robbery attempt by a dealer or the 'gateway theory' that marijuana use leads to use of 'harder drugs'—despite volumes of evidence to the contrary.[9]

Law enforcement depicts potential criminality and danger as embedded in the very fibres of marijuana: 'Marijuana is a dangerous drug that is associated with violent crimes including assaults, robberies, and murder and its use impairs driving skills and endangers public safety' (7). They also cite crime statistics to argue that 'nationwide, 41% of males tested positive for marijuana at the time of their arrest' (ibid). These statistics do not account for the fact that one could test positive for marijuana over a month after use. Law enforcement seamlessly deploys medical-scientific discourses to discount marijuana's medical efficacy (in a context where

research has been restricted), legality dispositif to refute its juridical legitimacy, and criminality (or security) dispositif to distinguish morally deserving patients from the threat of criminal abusers.

Differentiating users into discernible, governable subjects operates as a moralised strategy for distributing institutional turf between law enforcement and medical professionals for governing marijuana users (as a 'strategic elaboration'), while maintaining marijuana's deviant status. As Kevin Sabet, a former senior adviser at the White House Office of National Drug Control Policy, said in reference to Minnesota's legislation:

> There's going to be heightened awareness about *what kind of people are legitimately allowed to have marijuana, and what aren't* according *to what their conditions are*... Keeping it in a non-smoked form, I think law enforcement is going to have to be really watching this.[10]

Inasmuch as law enforcement depicted marijuana use as intimately tied to addiction and abuse, supportive medical experts distanced themselves from this moral judgement by arguing that these patients have tried everything else, that marijuana is a medicine of last resort for otherwise hopeless victims of disease: 'I see marijuana as one more potential complementary therapy. We can help a vast majority of our patients with other methods, but for some, marijuana may be the only thing that works' (Mirman, 2014, p. 38). These patients are *deserving* not only because of their suffering condition, but also because they are not trying to take advantage of the system to score dope. Had other medications been effective, perhaps they would not need marijuana.

Given some physicians' desire to make marijuana accessible as a 'medicine of last resort', controlling the qualifying conditions provides a moral and medical justification for certain deserving patients' access to marijuana as compassionate care in a context of restricted clinical research:

> You need to have a baseline list of conditions that a referral can be written for. If there are too many or if the definition is too loose, it's a problem. In Colorado, 94 percent of the more than 150,000 referrals made were for chronic or severe pain. Only 2 percent were for cancer, 1 percent for HIV and 1 percent for glaucoma. People would say "I have pain" and get a referral. You need to make the condition very legitimate and really make it about compassionate care.
>
> (MMA, 2014, p. 13)

'Compassionate care' can only be determined by its differentiation, by it being for a select group of subjects based on degree of suffering and relative availability of effective treatments. Medical professionals are therefore enlisted in the project of discerning the deserving from the undeserving users. It is noteworthy how medical professionals also draw on 'functional overdeterminations' of criminality and delinquency in what otherwise would appear to be a medical-scientific endeavour of identifying conditions for which marijuana could be efficacious: 'It has similar effects as alcohol as a depressant, and it is addictive. *It will just add to the general malaise in society*' (Terese Shearer, M.D.; 17, emphasis added). By depicting marijuana as an addictive drug that increases the 'general malaise of society', medical experts must ensure that only the truly deserving access it so that *society* is properly healthy (i.e. not addicted) and productive (i.e. not malaised, criminal users). As such, the 'criminal user' and the 'deserving patient' become identifiable and loaded categories which provide the basis for organising the biopolitical economy of

marijuana use: the deserving medical patients prove their suffering to a physician, who certifies the patient's claims for marijuana based on qualifying conditions after undergoing ineffective treatments, and then obtains legitimate (i.e. pharmaceuticalized, oil-based) medical marijuana through a state-sanctioned dispensary; the criminal user proves their criminality by possessing and smoking marijuana flower. The medical patient subject receives therapeutic intervention; the criminal is (potentially) punished.

CONCLUSIONS

The symbiotic convergence of medicalisation and criminalisation emerges from over a century of criminalised drug prohibition where medicine has regularly ceded turf to criminal justice institutions, shaping one another's definitions and legitimising practices in accordance with the Drug War—with enduring effects in the current drug reform era. This case demonstrates how both criminal justice and medical professionals draw upon scientific medical discourses that privilege knowledge derived from (restricted) clinical trial research for determining the uses of marijuana—despite criminal justice institutions not participating in nor having any specialised knowledge of clinical research. These discourses justify the need for further research before supporting legislative change, reinforcing marijuana's criminal status.

Similarly, law enforcement and medical professionals both argue that existing synthetic marijuana pharmaceutical products provide an adequate basis to preserve the status quo of criminalised marijuana—privileging pharmaceuticalized medicine. Furthermore, both draw upon moralised claims that smokable flower presents a danger to health, with medical and criminal justice professionals simultaneously drawing on notions of criminality and health, and both deploying largely irrelevant scare tactics tying marijuana to 'Big Tobacco'—and, in so doing, situate smokable marijuana as 'backwards' along the institutional telos of advancements in health, medical technology, and public safety.

Finally, both criminal justice and medical professionals deploy criminal, medical, and moralised discursive elements to delineate between deserving patients and criminal abusers based on both a lack of clinical evidence and prevailing notions of criminality and abuse. In so doing, they draw boundaries by which both medicine and law enforcement govern marijuana use—while positing the contradictory notion that marijuana has both medical and criminal (i.e. no medical value) applications. In that regard, 'scientific medicine' discourse, within a restricted research context, provides a point for both medicine and law enforcement to converge and expand their corresponding authority to govern drugs and drug-using bodies in ways that are mutually beneficial (i.e. symbiotic). This convergence is mutually beneficial to the extent it distributes authoritative institutional turf to each through the solidification of institutional boundaries by their shared deployment of discourses that reflect the historical intertwining of the two through the delineation between 'proper medicine' and 'dangerous drugs'—and the authority to govern each accordingly.

Overall, there is no neat delineation between the logics and knowledge-claims proffered by criminal justice and medical institutions' discourses. Instead, both mutually draw upon one another in their justifications for determining how marijuana should be governed in Minnesota, while providing distinct institutional circuits for each to govern certain users and forms. Rather than authority being derived from institutional turf-grabbing processes, from the standpoint of governance, both operate in overlapping and mutually constitutive manners. It is only through the drawing and solidifying of boundaries between medical and criminal justice institutions that

each derive and maintain particular forms of legitimate authority and jurisdiction. Yet both ultimately operate in mutually constitutive ways in governing bodies by mediating their relationships to a plant, which both deploy the law to accomplish.

While this analysis pertains to a specific case, it nonetheless suggests that moments of (re) defining deviance between medicalisation and criminalisation is not necessarily a zero-sum contestation over institutional definitions and turf, but rather serve to reinforce the imperative for authoritative institutional control, in general, while negotiating the distribution of specific governing jurisdictions and institutional boundaries. In that way the 'symbiotic convergence' is both *symbiotic* and *productive*: both institutions retain the authority to govern by reproducing marijuana as deviant and therefore in need of authoritative control, while allowing each to negotiate the boundaries (along their points of convergence) between their authorities. With the resulting legislation, almost every patient I interviewed could not afford as much cannabis as they need, while the racialised policing of marijuana in Minnesota continues unabated (ACLU, 2020). The medicalisation of illicit substances, more broadly, presents these complications because of the ways in which the proper turf of medicine has been so deeply shaped by the Drug War. As evidenced by harm reduction efforts, this is likely to show up in drug reform efforts beyond marijuana, as movements to medicalise 'psychedelics' gain steam.

AUTHOR CONTRIBUTIONS

Ryan T. Steel: Conceptualisation (Equal); Data curation (Equal); Formal analysis (Equal); Funding acquisition (Equal); Investigation (Equal); Methodology (Equal); Project administration (Equal); Resources (Equal); Software (Equal); Writing – review & editing (Equal).

ACKNOWLEDGEMENTS

The author would like to thank Josh Page, Teresa Gowan, Victoria Piehowski, Jane Steel, and the anonymous reviewers for their guidance and constructive feedback. This study was funded by College of Liberal Arts, University of Minnesota.

DATA AVAILABILITY STATEMENT

All data in this paper are derived from publicly available documents and are accordingly cited for anyone to readily access.

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ENDNOTES

[1] As part of a broader research project on the medical cannabis program in Minnesota, I conducted 27 in-depth interviews with patients who had participated in the program, which addressed their cannabis use practices and experiences, experiences navigating the healthcare system and the medical cannabis program, managing program-related costs, and attitudes about the current program/policy, among others.

[2] Notably, included within an omnibus bill, the Minnesota legislature recently (5/18/21) passed a measure allowing the use of whole-plant flower for medical cannabis patients. This important change, however, does not go into effect until at least March 2022—and does not allow patients to cultivate their own medical cannabis products

at home, and also does not expand the number of companies allowed to produce and distribute medical cannabis. Thus, while this change will undoubtedly reduce the cost of medical cannabis in the state while providing access to smokable, whole plant cannabis, it still requires patients to purchase their products through one of two manufacturers, and thus does not provide the most equitable and affordable access to cannabis, which is home cultivation and a diversity of cannabis manufacturers. For these reasons, even with this recent change, the analyses and arguments below are still applicable and theoretically relevant. For more on the legislative change, see Pugmire (18 May 2021), 'Major change to Minnesota medical cannabis law approved.' *Minnesota Public Radio*. https://www.mprnews.org/story/2021/05/18/major-change-to-minnesota-medical-cannabis-law-approved.

[3] It is worth noting that as the program has expanded conditions and program enrollment has increased, the costs for medical cannabis products in Minnesota have decreased, and now are fairly similar to equivalent state programs—even though they still tend to be on the higher end for most products. For instance, compare: https://www.health.state.mn.us/people/cannabis/docs/about/firstyearreport.pdf, and https://www.health.state.mn.us/people/cannabis/docs/rulemaking/pricereport.pdf.

[4] Snowbeck (7 May 2014), 'Minnesota Medical Association favors House medical marijuana bill.' *Twin Cities Pioneer Press*. https://www.twincities.com/2014/05/07/minnesota-medical-association-favors-house-medical-marijuana-bill/.

[5] Neuman (15 May 2014), 'Minnesota's Legislature OKs Medical Marijuana.' *National Public Radio*. https://www.npr.org/sections/thetwo-way/2014/05/15/312474443/minnesotas-legislature-oks-medical-marijuana.

[6] For a detailed accounting of the arduous restrictions and laborious bureaucratic processes involved with conducting marijuana-related research in the US, see Bostwick (2014b).

[7] This same physician also argued that prioritizing legalization to reduce arrests was not 'going with the science' and therefore beyond the purview of 'proper medicine'.

[8] The vast majority of sources cited by the Minnesota Law Enforcement Coalition come from publications by the Drug Enforcement Administration, the Department of Justice, the National Institute of Drug Abuse, and the Office of National Drug Control Policy. In fact, the majority of their citations to medical journals are often indirect citations taken directly from DOJ, DEA, NIDA, and ONDCP publications. For example, some of the most frequently cited sources are: U.S. Dept. of Justice's *Exposing the Myth of Medical Marijuana*; U.S. Drug Enforcement Administration's *Say It Straight: The Medical Myths of Marijuana* and the DEA's *Speaking Out Against Drug Legalization*; the Office of National Drug Control Policy's *What Americans Need to Know about Marijuana (Important facts about our nation's most misunderstood illegal drug*). Their quote from a Columbia University study on the effects of smoking marijuana on white blood cell count comes from an op-ed written by televangelist James Dobson, founder of the conservative 'Focus on the Family' group.

[9] For an overview of the refutation of logic and evidence for the gateway drug theory, see Lenson (1995), Lee (2012) and Robinson and Scherlen (2014).

[10] Collins (21 April 2015), 'Police on guard as MN gears up for medical marijuana program.' *Minnesota Public Radio*. http://www.mprnews.org/story/2015/04/21/medical-marijuana, emphasis added.

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How to cite this article: Steel, R. T. (2022). Medicalising the menace? The symbiotic convergence of medicine and law enforcement in the medicalisation of marijuana in Minnesota. *Sociology of Health & Illness*, *44*(8), 1324–1343. https://doi.org/10.1111/1467-9566.13513