"Their Power Will Be Your Pain": An investigation into the discourses of medicinal cannabis users.

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DECLARATION

I certify that this work has not been accepted in substance for any degree, and is not concurrently being submitted for any degree other than that of Doctorate of Philosophy being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised another's work.

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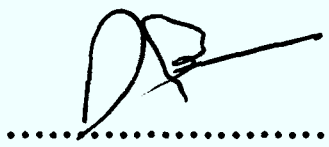

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ABSTRACT

The discourses of medicinal cannabis users are the *topic* of this thesis, examined by way of qualitative in-depth interviews with thirty-two medicinal cannabis users. The thesis focuses on four main aims: how medicinal users talk about their use of cannabis (including looking at what discursive resources and rhetorical devices they use); the prevalence and significance of talking about 'nature' and the 'natural' within these discourses; the differences between the accounts of different participants; and the potential of different 'types' of discourse in relation to contestation around the use of this substance for medicinal benefit. A discourse analysis approach is used that draws mainly on the work of Wetherell and Potter (1992) and Fairclough (1995; 2001). A Bourdieusian theoretical framework is employed that draws on the key concepts of field, habitus, linguistic habitus, cultural and linguistic capital and trajectory (1979; 1992). The main findings are that whilst participants discuss a range of issues and use a range of rhetorical strategies and discursive resources in doing so, the majority of participants discursively construct cannabis in relation to ideas about nature, with cannabis frequently being articulated as 'natural' and therefore preferable to prescribed medicines, alcohol, other illicit drugs and 'chemical' / 'man-made' substances in ways that are strongly related to various notions of 'risk' (Beck, 1992). However, there is a great deal of difference between participants' discourses and these differences are underpinned by different educational and vocational trajectories, the unequal distribution of linguistic capital and differential dispositions when using language and engaging with knowledge, and are mediated by participants' different *engagement* with the issue of medicinal cannabis use. This emphasises the importance of an awareness of how social structuration continues to affect how individuals are capacitated and disposed to talk about and understand issues and to engage in contestation in contemporary society.

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PART 1 – INTRODUCTION AND LITERATURE REVIEW

CHAPTER ONE

INTRODUCTION

For thousands of years people have used cannabis for many different reasons (Abel, 1980) and cannabis, in the form of a tincture, was very popular in Western medicine between 1840 and 1900, but after this period its use in medical practice soon declined (Grinspoon, 1994). However, recent decades have seen a revival in interest in the medicinal benefits of this substance. In the U.S. in the early 1970s, injured soldiers from the Vietnam War reported obtaining medicinal benefit from the use of cannabis (Dunn and Davis, 1974) and since the 1980s organisations seeking the legal availability of cannabis for medicinal use in the U.S., the U.K. and other parts of the world have been formed. In addition, the medicinal use of cannabis has been a prevalent theme in newspapers and on television for decades now.

There has also been a revival of interest in the medicinal potential of cannabis within scientific medicine and pharmacology. However, this interest is in relation to producing cannabis-based medicines, from the extraction or synthesising of certain active principles of cannabis, as opposed to the medicinal use of cannabis *per se*. Whilst surveys often show that general practitioners are sympathetic to the idea of cannabis being used by chronically ill and / or disabled people (Meek, 1994), governing bodies of the medical profession, for example the B.M.A in the U.K., tend to be against the idea of using cannabis itself (B.M.A., 1997).

Whilst it is difficult to estimate how many chronically ill and / or disabled people use cannabis for medicinal reasons in the U.K., a probably not insignificant number of people do so and continue to assert that cannabis is a substance of great medicinal benefit, some publicly as part of organised groups and some more privately to friends and family, as we found in Coomber, Oliver and Morris (2003). In contemporary society, with its proliferation of media and increasing inclination to critically reflect upon certain key aspects of modernity such as science, technology, government and 'expertise' (Beck, 1992), the contestation that exists around the medicinal use of cannabis occurs primarily at the level of discourse. Mainstream scientific medicine and pharmacology draw on the discourse of science in articulating cannabis as a substance of 'no medical value' and medicinal cannabis users assert opposing claims.

Previous research carried out by Coomber, Oliver and Morris (2003) had provided a broad understanding of how people came to use cannabis medicinally and the benefits and difficulties that this might have presented for them. This thesis set out to re-examine the data that was gathered and to look at the discourses of medicinal cannabis users as a topic of interest in their own right, using discourse analysis. From early on in the research process it was clear that many participants placed great emphasis on cannabis being a natural substance and that somehow this meant that it must be efficacious. Most of them were saying this, but where was this idea coming from? It was also noticeable that some participants seemed to speak about a plethora of different issues when talking about medicinal cannabis use, yet others spoke about comparatively few. The obvious question of *why* sprang to mind in relation to these observations.

During the early period, a methodological shift from the discourse analysis of social psychologists such as Wetherell and Potter towards the more sociological critical discourse analysis work of Fairclough (1995; 2001) was undertaken. Whilst Wetherell and Potter (1992) had provided the useful methodological approach of using an analytical pre-story to function as the broader social context within which to make sense of individuals' discourse, they did not seem to offer enough of an emphasis on the importance of power to discourse which Fairclough's critical discourse analysis does. This issue would also lead to a move from Foucault towards Bourdieu, although Foucault's work is still of importance to this thesis. Bourdieu's theory of practice (1979) with its emphasis on fields, habitus, capital and trajectory is at least partially compatible with Fairclough's critical discourse analysis, as Fairclough states in Chouliaraki and Fairclough (2005), and again facilitates a focus on contexts of power. In addition, unlike even the latest stage of Foucault's work (see Giddens, 1982 and Dreyfus and Rabinow, 1982), Bourdieu (1979; 1992) does so without sacrificing a model of social practice that retains human agency at its heart.

Focusing on the discourse of participants in the earlier research and on the contexts of power within which that discourse is articulated, this work can be seen as a consolidation of interest in the earliest observations about the benefits and difficulties the participants encountered in their use of cannabis as a medicinal substance. The focus of the thesis can therefore be described as one in which the ways in which the participants talk about medicinal cannabis use and related issues, what they say and what discursive resources and strategies they use to do so, takes place in a terrain of contestation over medicinal cannabis use. The great difference between participants'

accounts regarding these issues then leads to an interest in accounting for these differences, with a delineation of what became seen as different 'types' of medicinal cannabis users' discourse. The prevalence and significance of talking about 'nature' and 'the natural' when talking about medicinal cannabis use (which is a major theme in the majority of participants' interviews) is addressed specifically and the thesis also seeks to comment on the potential that different 'types' of medicinal cannabis users' discourses have in relation to the discursive struggle around medicinal cannabis use.

The thesis is structured as follows - this introduction and the literature review (Chapter Two) constitute Part One. Part Two comprises a chapter on methodology (Chapter Three) that addresses discourse analysis as an approach and a chapter on method (Chapter Four) that provides an account of the application of discourse analysis. Part Three of this thesis contains four chapters which function as an 'analytical pre-story'. Chapter Five therefore discusses the history of cannabis in relation to relevant issues including science, medicine, social anxiety, prohibition and the medicinal use of cannabis. Chapter Six considers how contemporary British society can be characterised by a 'challenge to authority' and an increasingly variable trust in certain key institutions of modernity, such as science, technology, government and 'expertise' (Beck, 1992). Chapter Seven starts by briefly discussing how scientific medicine rose to a position of dominance within the field of health, but moves on to discussing the ways in which it is now subject to critique and dissent in contemporary British society, due to issues discussed in the previous chapter, as well as issues related to chronic illness and disability. Chapter Eight addresses the ways in which medicinal cannabis use can be understood within this context as part of a challenge to the authority of scientific medicine. Part Four consists of six chapters

that 'map out' the discourses of the participants. Chapter Nine looks at various discursive constructions of cannabis articulated by the participants, both discursive constructions of the use of cannabis and discursive constructions of what a 'drug' is. Chapter Ten examines the rhetorical strategy of articulating discursive oppositions (i.e. rhetorically opposing one thing to another). Chapter Eleven considers the discursive articulation of 'nature' and 'the natural' in the participants' interviews. In Chapter Twelve, discussion by the participants about medicine, medical power, medical knowledge and other issues pertaining to issues of power are considered. Chapter Thirteen looks at the significance of vocationally derived discourse in relation to the discourses of certain participants. In Chapter Fourteen some concluding remarks are made in relation to the task of 'mapping' the participants' discourses. Part Five consists of six analytical chapters and the conclusion. Chapter Fifteen addresses how some participants undertook personal research into medicinal cannabis by reading different material and how this relates to what they draw on when talking about the issues themselves. Chapter Sixteen describes how a small number of participants are more concerned about what Goffman (1959) calls 'impression management' than others are, and what this might mean for their discourse. Chapter Seventeen addresses the significance of themes relating cannabis to nature and it being 'a natural substance'. Chapter Eighteen discusses the discourse of one participant whose articulations are understood as particularly significant regarding issues of power/knowledge. Chapter Nineteen draws on previous analysis and uses it to argue, and account for, 'types' of medicinal cannabis users' discourses. The final chapter, Chapter Twenty, concludes this thesis.

CHAPTER 2

LITERATURE REVIEW

Introduction

This review discusses literature relevant to the medicinal use of cannabis and, to a lesser extent, to the discourse of users of other drugs. In terms of positioning this thesis in relation to existing literature, it will be demonstrated that there is no existing research examining the discourse of medicinal cannabis users. This being the case, the literature discussed here will primarily illustrate the 'gap' in knowledge that this thesis hopes to make a modest contribution to filling, as well as addressing some methodological issues.

The literature discussed in this chapter is drawn from a number of areas which reflect the multi-disciplinary nature of the interest in cannabis and its medicinal potential / use. However, this review will also demonstrate the fact that the literature reflects an antagonistic relationship between different assumptions about the value and status of different kinds of knowledge in the contestation between those who see cannabis as unsuitable for medicinal purposes and those who seek to assert the opposite. This is perhaps most pronounced in institutionally determined assumptions about what constitutes valid knowledge within medical discourses and in the contested nature of the hierarchy around experimentally derived knowledge and so-called 'anecdotal' knowledge. So although the thesis focuses on the discourses of medicinal cannabis users it is also appropriate to examine the literature dealing with clinical work on

cannabis and cannabinoids. This literature is of interest in terms of how it contributes to, and demonstrates the ways in which, medical discourse contributes to the discursive contestation over medicinal cannabis use.

The literature discussed in this review encompasses the following: articles reporting clinical work on cannabis and / or cannabinoids and reviews and commentaries on clinical work; scholarly discussions on the medicinal use of cannabis; documented 'anecdotal' reports of cannabis' medicinal efficacy; 'surveys' of medicinal cannabis users; surveys of doctors about medicinal cannabis use; research on 'drugs' and discourse. Whilst an exhaustive discussion is not possible due to the amount that has been written in each of these areas, the discussion will explore both classic and more recent literature.

Articles, reviews and commentaries on clinical work

Whilst the discussion of this area of the literature is limited by the researcher's status as a sociologist and not a pharmacologist, a broad grasp of some of the issues that it raises is important to the thesis. A fuller discussion of cannabinoid efficacy can be found in Ashton (1999), Tramer *et al.* (2001) and Campbell *et al.* (2001). Similarly, a fuller discussion of raw vegetable cannabis' efficacy can be found in Musty and Rossi (2001).

Most of the clinical research that has been produced has actually examined the medical potential of cannabinoids as opposed to whole plant cannabis itself

(Coomber, Oliver and Morris, 2003) and this concentration on the former tends to obscure the existence of clinical research into the efficacy of the latter. The idea that there is no scientific evidence as to cannabis' medicinal value tends to be supported by this, as well as by its currently illegal status as a class C prohibited drug, and is perhaps one reason as to why medicinal cannabis users are still regarded with scepticism by some. However, there is plenty of literature which reports clinical work that finds favourable outcomes for using cannabis in relation to various conditions (see Zimmer and Morgan, 1995) and in some cases, cannabis was found to be more effective than cannabinoids (see Dansak, 1997).

Mechoulam and Lander (1980) discuss the fact that it was only in 1964 that the work of their research group brought about the isolation of the main active cannabinoid *tetrahydrocannabinol* (THC) and an understanding of the chemical structure of cannabis. They also argue that the majority of modern pharmacological work on the medical uses of cannabinoids has been done since then. Hollister (2001) concurs with this view but mentions that prior to the work in 1964 (Gaoni and Mechoulam, 1964; Isbell *et al.*, 1964; cited in Hollister, 2001) a small amount of work was done on a substance called synhexyl, which was believed to be similar to THC.

Since 1964, thousands of articles have been published, mainly on the efficacy of cannabinoids, but sometimes on the efficacy of cannabis itself (Hollister, 2001), as mentioned above. In a review that considers work done on both cannabinoids and cannabis, Hollister (2001) examines research using cannabinoids and, in some cases, cannabis on the anti-emetic potential for cancer sufferers undergoing chemotherapy, appetite stimulation for patients with AIDS, spasticity associated with some spinal

chord injuries, analgesic potential, glaucoma, anticonvulsant potential, bronchial asthma and insomnia. Hollister suggests that the research that has taken place so far in some of the areas that he lists justifies further investigation, but that this is mainly around the potential of THC. As most of the research that can be reviewed only looks at THC, how can the medicinal potential of cannabis itself be fully considered?

Commentaries addressing the medicinal potential of cannabinoids, and sometimes cannabis too, have been common in medical journals since the 1970s. Rose, writing in *The Lancet* in 1980, raised the question "Is it time that cannabis had a place in the official pharmacopoeia?" (Rose, 1980: 703). He notes the common medical disinclination towards the use of cannabis due to the common practice of smoking it (and the carcinogenic risks associated with this), but cites various clinical studies in an argument for more work to be done on cannabinoids. He also notes the unwillingness of the government to issue licenses for research using cannabis. Interestingly though, his initial question addresses cannabis but he then talks mainly about cannabinoids.

Similar commentaries have continued to appear. Those of Gray (1995) and Wills (1995) both appeared in *The Pharmaceutical Journal.* Gray (1995) discussed the medicinal potential of both cannabis and cannabinoids in relation to a broad range of conditions and acknowledged the existence of a double-blind trial examining the potential of cannabis in relation to spasticity that had some positive results (Petro and Ellenberger, 1981; cited in Gray, 1995). Wills (1995) discussed cannabis more particularly in relation to its potential for addressing the symptoms of spasm, muscle pain and tremors that are often associated with multiple sclerosis. Whilst he describes

accounts of people with MS who used cannabis as "subjective and anecdotal" (Wills, 1995: 237), he does also pose some critical questions at the end of his discussion.

> "The anecdotal reports of benefit in multiple sclerosis sufferers may be simply confirming the known mood altering or anxiolytic effects of cannabis. If real improvement in patient quality of life occurs, but this is due to a psychotropic rather than a neuromuscular effect, is this a justifiable reason for prescribing cannabis to multiple sclerosis patients? Should this beneficial effect, if it exists, need to be justified at all, and to whom?" (Wills, 1995: 238)

Whilst many medicinal cannabis users would, this researcher would suggest, resent the implication that it is possible that any symptomatic relief that cannabis may produce could be ascribed just to psychotropic effects, this quotation is an incidence of someone within the medical profession recognising the extant relations of power within the field of health and questioning them. This is unusual, because medicinal cannabis users do tend to have to justify themselves, due to cannabis not being officially recognised as a medicine. The quotation above hints at debates elsewhere, around the ownership of the body (Porter, 1997), of illness and of the right of the individual to consume a substance that helps them, irrespective of whether the medical profession agrees.

Three of the most influential reviews of the issue of the medicinal use of cannabis (and cannabinoids) produced in the last decade are the B.M.A.'s book entitled *Therapeutic Uses of Cannabis* (1997); a report jointly produced by The Royal Society and The U.K. Academy of Science (Lachmann *et al.*, 1998), and the House of Lords Select Committee on Science and Technology's report *Cannabis: The Scientific and Medical Evidence* (House of Lords, 1998). Reading all three raises significant questions around knowledge and power, such as what can count as valid

evidence / knowledge and who can have the power to say what another individual ought to be allowed to consume in relation to *their own* health?

The B.M.A's book (1997) (which remains their position on these issues) reviews the evidence from studies using cannabis and cannabinoids in relation to nausea and vomiting, muscular spasticity, appetite stimulation and glaucoma. However, although it acknowledges the possible effectiveness of cannabis in relation to some of these areas, it raises a number of objections to the use of cannabis in medical practice, particularly to administration by way of smoking; concerns about pesticides used in growing the hemp plant, and the possibility of microbes (being a concern for patients with compromised immune systems), and concludes that:

> "... although cannabis itself is unsuitable for medical use, individual cannabinoids have a therapeutic potential ..." (B.M.A., 1997: 77).

None of these objections to the use of cannabis as a medicinal substance are necessarily unreasonable (although the hemp plant could be grown organically without the use of pesticides), but there is another reason given which may be seen as problematic. The report argues at one point that, as cannabis is composed of various compounds consisting of over sixty cannabinoids, even if cannabis does have therapeutic benefits (which they concede it does elsewhere in the report), it would not be possible to know which constituent elements were involved:

> "... and medical knowledge would not be advanced nor treatment improved" (B.M.A., 1997: 69).

This statement could be read as indicative of a position held by the B.M.A. that although it had acknowledged the possibility that cannabis could help with some symptoms of some medical conditions, cannabis ought not to be available medicinally, as the medical profession do not really understand how it works. This possible reading is further problematised by the book's discussion of Levitt (1986, cited in B.M.A., 1997) who discuss how T.H.C.-based drugs, such as Nabilone, are used in the treatment of nausea associated with chemotherapy. The B.M.A's book describes this as the use of drugs with "relatively undefined mechanisms of action" (Nabilone), being used to treat the side effects of other drugs with "relatively undefined mechanisms of action" (chemotherapy) (B.M.A., 1997: 20). The acknowledged lack of understanding around the use of these substances does not seem to raise a concern, unlike that raised around cannabis. Interestingly, many medicinal cannabis users argue that in their experience cannabis is the only substance that is efficacious (Coomber, Oliver and Morris, 2003), but the B.M.A. is unwilling to consider cannabis in the same way as cannabinoids when it argues that:

> "The risks that some cannabinoids could pose for patients with certain conditions would need to be balanced against the benefits." (B.M.A., 1997: 71)

The joint report by The Royal Society and The U.K. Academy of Science (Lachman *et al.*, 1998) completely avoided discussion of any of the evidence from clinical experiments involving cannabis and instead spoke exclusively about research involving cannabinoids. They then concluded that:

> "We do not consider that the current medical data on efficacy and safety from randomised controlled trials are sufficient to support the medical prescribing of cannabis as yet." (Lachmann *et al.*, 1998: 4)

In its introduction it had argued that there is a clear distinction between anecdotal evidence and evidence from clinical trials and that it would base its report on the latter. Having then failed to mention any evidence of any kind in support of the medicinal use of cannabis, the document employs the credibility of a long list of contributing professors and doctors, in conjunction with that of the august institutions jointly producing the report, which may well leave less informed readers under the impression that there really is not much of an issue to consider.

Cannabis: The Scientific and Medical Evidence (House of Lords, 1998) was the outcome of an enquiry by the House of Lords Select Committee on Science and Technology. The report begins by saying that the enquiry was undertaken in response to a heightened interest in the medical uses of cannabis and particularly the B.M.A. (1997) report (although it also considered issues relating to the recreational use of cannabis). It was far more inclusive than the B.M.A. report (1997) and Lachmann *et al.* (1998), in the respect that it considered evidence from medicinal users themselves, as well as representative groups such as the U.K. Alliance for Cannabis Therapeutics (A.C.T.). Its recommendations were quite radical because it suggested that, whilst there was:

> "... not enough rigorous scientific evidence to prove conclusively that cannabis has, or indeed has not, medical value of any kind ... we have received enough anecdotal evidence ... to convince us that cannabis almost certainly does have genuine medical applications ... (House of Lords, 1998: paragraphs 8.1 – 8.2).

On the basis of this view, it then not only recommended that clinical trials began as a matter of urgency, but also that, at least until such research was concluded, the government should change the law on compassionate grounds to allow doctors to prescribe cannabis (whole plant) on a named-patient basis as an unlicensed medicine (House of Lords, 1998).

Whilst the government took over three years to respond to this report and did not implement its recommendations, the House of Lords report (1998) is rather novel in that, whilst it also reinforced the distinction between clinically produced evidence and 'anecdotal' evidence, it did not let what it saw as a lack of scientific evidence stop it making recommendations that it felt were for the good of thousands of medicinal cannabis users.

A decade has now passed since the B.M.A. (1997) report and the report from the House of Lords (1998) were published and, whilst commentaries (e.g. Robson, 1998; Russo, 2001; Iversen, 2001; Petro, 2001; Mather, 2001) and pharmacological research (still mainly on cannabinoids as opposed to cannabis) continue (Campbell, 2001; Tramer *et al.*, 2001; Notcutt *et al.*, 2004; ElSouhy and Slade, 2005), medicinal cannabis users are still criminalized for using a substance that they strongly assert helps them (Coomber, Oliver and Morris, 2003). The literature reviewed in this section has shown something of how the social context of the medicinal use of cannabis is strongly connected to issues of knowledge and power and how these are involved in the continued illegality of using cannabis medicinally.

Scholarly works on the medicinal use of cannabis (non-empirical)

There are a number of books, chapters in books and articles that have been written by academics and medical researchers that attempt to situate the issue of the medicinal use of cannabis within a socio-historical perspective. In a discussion of the pharmacology and toxicity of cannabis, Petro (1997) argued that a risk versus benefit assessment is relevant to all medicines, not just cannabis, and quotes the U.S. Drug Enforcement Agency's own administrative law judge from 1988 who said that cannabis was:

> "... one of the safest, therapeutically active substances known to man." (Judge Francis L. Young, quoted in Petro, 1997).

As was remarked on above, the B.M.A (1997) in their report on the medical potential of cannabis and cannabinoids only weighed the risks and benefits in relation to cannabinoids.

Grinspoon and Bakalar (1993) have also discussed this issue and argue that, whilst cannabis is less inherently risky than many of the substances that seriously ill people have to contend with on a frequent basis, e.g. chemotherapy drugs, people should have the right to weigh these risks for themselves and that this should include the right to use cannabis for medicinal purposes if necessary. They also argue that there are numerous reasons why cannabis is not available for medicinal use in the U.S. (although the issues are largely the same as in the U.K.). Grinspoon and Bakalar (1993) make the case that the arguments used to suppress recreational use have affected cannabis's potential to be taken seriously as a medicinal substance and that,

if it were to be accepted as being medically efficacious and safe, this would undermine arguments that it is a dangerous substance that ought to remain controlled (the main line of argument against 'recreational' use). Whilst the former argument is probably a fair assessment historically, medical use would not necessarily undermine continued prohibition for non-medicinal use (as can be seen in relation to morphine, for example).

Grinspoon and Bakalar (1993) also suggest (points that Grinspoon also makes elsewhere, see Grinspoon, 2000) that cannabis has a number of difficulties where approval via clinical trials is concerned. They argue that cannabis's complex chemical constitution conflicts with the ideology of controlled objective testing, an argument which is seemingly borne out by the discussion in B.M.A. (1997). Grinspoon and Bakalar (1993) argue that, as a substance chiefly administered by smoking, cannabis does not 'look' like a medicine, as no other medicine in the U.S. pharmacopoeia is administered in that way. They also suggest that, as cannabis is a plant and not a single chemical, it cannot be patented. More recent developments around particular genetically modified strains of cannabis plant being registered by the Dutch company HortaPharm B.V. - although this European registration is not the same as a patent - have seen some movement on this issue.

Grinspoon and Bakalar (1993) also encourage us to consider how medicalisation produced a strong social need to distinguish between substances that were primarily used for medical reasons and those that had 'other' uses, and the idea that this imperative came into conflict with any substances that did not neatly slot into one use or another. Whilst Berridge and Edwards (1987) have made similar points with regard

to the U.K., Grinspoon and Bakalar (1993) argue that, in the nineteenth century, the U.S. had almost no governmental controls around drug use and almost anyone was free to sell almost anything as a medicine and consumers were free to consume these products as self-prescribers. By the late nineteenth century and early twentieth century, this situation was seen as dangerous (due to fears around poisoning, addiction and other types of risk) and a trend towards centralisation, restriction and control arose. What is interesting about Grinspoon and Bakalar (1993) is that not only do they argue that the rising fears about substance consumption masked professional interests from doctors to establish a monopoly to prescribe and from pharmacists to supply, but also that substances such as cannabis in particular can been seen, historically and cross-culturally, to relate to social practice in a way that, in late modern society, we might see as spanning the areas of medicine, religion and recreation. Their argument is that, with their need to categorise (this being reflected in its formal and informal institutions – most pertinently those around health), contemporary societies like the U.S and the U.K find this ambiguity problematic.

In relation to the hierarchy between 'anecdotal' evidence (i.e. accounts of medicinal cannabis users attesting to the medicinal efficacy of cannabis) and experimentally produced knowledge (with the latter tending to be regarded more highly than the former in much public discourse and in some of the literature discussed earlier), Grinspoon and Bakalar (1993) raise a few interesting issues. They object to the assumption inherent in this hierarchy that controlled studies are an infallible route to the production of knowledge. They argue that problems can occur in such studies, e.g. inappropriate patients or the wrong dosage being used. We also know from Gilbert and Mulkay's work (1984) that the formal presentation of experiments in academic

journals tends to present an idealised version of events. Grinspoon and Bakalar (1993) also argue that controlled studies seek to establish a statistically significant effect on the group, but that surely medicine is also about the needs of the individual and, whilst cannabis might not be efficacious for everyone with a condition for which existing research suggests it could have some efficacy, it might help some.

The literature reviewed in this section clearly takes issue with a number of assumptions that appear to be inherent in some of the more medically oriented literature reviewed earlier in this chapter and this is characteristic of the numerous areas of contestation around the medicinal use of cannabis. Controversies exist within the literature already examined in relation to the risks versus the benefits of using cannabis as a medicine, whose right it is to decide whether people may be allowed to consume cannabis medicinally; the value (and even existence) of clinically derived knowledge about the efficacy and safety of cannabis as a medicinal substance, and the apparent hierarchy of clinical over 'anecdotal' knowledge.

Empirical research into the medicinal use of cannabis

Whilst numerous surveys of medicinal cannabis users exist, little qualitative research into the medicinal use of cannabis has been produced, with the exception of Coomber, Oliver and Morris (2003). This section will briefly discuss existing survey-based research from a number of countries, as well as Coomber, Oliver and Morris (2003), and will argue that this thesis, in examining the discourse of thirty-two

medicinal cannabis users, is an attempt to address something of a 'gap' in existing knowledge.

Dunn and Davis (1974) conducted an informal survey in the spinal chord injury ward of a veteran's hospital in Miami. Of those in the ward, ten patients admitted to already using cannabis in relation to their injuries. Cannabis seemed to be most effective in relation to phantom limb pain, spasticity and headaches.

In a similar survey, albeit with a larger sample group, Malec *et al.* (1982) used questionnaires from forty-three participants to gather data on the perceived effects of cannabis on spasticity associated with spinal chord injuries. Malec *et al.* (1982) found that cannabis use was associated with a decrease in spasticity and that peer group and previous use were significant influences on the decision to use cannabis medicinally.

Consroe *et al.* (1997) gathered data from fifty-three people in the U.K. and fifty-nine people in the U.S. with multiple sclerosis who used cannabis to help themselves with various symptoms associated with that condition. The research reported that:

> "From 97[%] to 30% of the subjects reported cannabis improved (in descending rank order): spasticity, chronic pain of extremities, acute paroxysmal phenomenon, tremor, emotional dysfunction, anorexia/weight loss, fatigue states, double vision, sexual dysfunction, bowel and bladder dysfunctions, vision dimness, dysfunctions of walking and balance, and memory loss." (Consroe *et al.*, 1997: 44)

In a Canadian survey of the general population, Ogbourne *et al.* (2000) conducted random telephone interviews with 2508 people (which represented 67.4% of the

households in which the telephone was answered). From this sample, forty-nine people (1.9%) admitted to using cannabis for medicinal reasons in the previous twelve months. This attempt to estimate the number of medicinal cannabis users is very interesting. Of course the estimate of 1.9% could be subject to under-reporting and / or mistruths and one can imagine that 'cold-calling' to find out about illicit drug use has all manner of methodological problems. However, *if* that figure were to be roughly correct and broadly transferable as a figure for U.K. use, this would mean that the U.K. had over one million medicinal cannabis users.

In another Canadian study, Page *et al.* (2003) posted questionnaires to adults with multiple sclerosis in Alberta. A response rate of 62% provided 420 responses and suggested that 16% of respondents had tried cannabis for medicinal purposes at some point. It also reported reasons for not trying cannabis as consisting of, among others, cannabis' illegality. Of course this is also a reason for not returning the questionnaire or not admitting to using cannabis if one were to respond.

Ware *et al.* (2005) also used a questionnaire for their U.K.-based research but, as opposed to Page *et al.* (2003), their sample had volunteered to be involved in the research (providing a far better response rate of 81%). Of the 2969 respondents, 947 (31.9%) reported having used cannabis for medicinal purposes and of these, 648 (68%) reported that cannabis made their symptoms "much better", with 256 (27%) reporting that cannabis made their symptoms "a little better". When asked to compare cannabis to prescribed medicines, 412 (45%) said it worked "much better" and 261 (28%) said it was "somewhat better" (Ware *et al.*, 2005: 293).

Swift *et al.* (2005) recruited 147 respondents by way of a media advertising campaign in their Australian research. They used a questionnaire that was administered by post and found that most medicinal users described cannabis as providing "great relief" (86%) and that their biggest concern was cannabis' illegality. It was also found that 62% of respondents reported discontinuing or decreasing use of prescribed medicines when they started to use cannabis medicinally, which seems to relate well to the findings in relation to prescribed medicine found by Ware *et al.* (2005).

Reiman (2007) surveyed medicinal cannabis users who used medical cannabis facilities in Berkeley and San Francisco in the United States, obtaining questionnaires from 130 participants. Of her sample, Reiman reports that, whilst nearly half reported using cannabis as a substitute for alcohol and / or other illicit drugs, 74% reported using cannabis as a substitute for prescribed medicines in relation to a broad range of health conditions. The research also reports similar findings to those discussed above – high levels of satisfaction with cannabis with regard to its effectiveness in addressing symptoms and a highly reported preference for cannabis over prescribed medicines.

Whilst the research discussed so far is interesting, it is also limited. Taken together, it produces a very limited profile of individuals who choose to use and continue using a substance and then, unsurprisingly, report that they are very happy with it! Whilst it is a commonly acknowledged limitation to quantitative research that it often lacks depth, these various studies taken together do little to produce a more in-depth understanding of the experience of medicinal cannabis use.

In Coomber, Oliver and Morris (2003) we attempted to address this. Thirty-three medicinal cannabis users (one more than was used in this thesis, due to one participant having a severe level of speech impairment that made the particularly close reading that discourse analysis requires impossible) were recruited by way of initial advertising in the magazine *Disability Now* and the newsletters of a number of disabled people's groups. From an initial sample of recruits a snowball-sample was then used to recruit more participants. In-depth, semi-structured qualitative interviews were undertaken, mainly at the homes of the participants, with interviews lasting for between 90 and 180 minutes. The research sought to address a number of aims:

> (a) To investigate the reasons why people decided to use cannabis for therapeutic purposes.
>
> (b) To describe the ways in which people came to decide to use an illegal drug.
>
> (c) To estimate levels of self-reported satisfaction with the drug and any difficulties as well as benefits experienced.
>
> (d) To evaluate the effect on negotiated health care.
>
> (e) To inform current debates about the use of cannabis for therapeutic purposes.

In addition to the usual findings of medicinal cannabis users reporting cannabis to be effective, safe and preferable to prescribed substances, a far deeper understanding of medicinal cannabis use was produced. An understanding of how much cannabis participants used and how often they used it was gained. The benefits obtained were also fully described by participants, as was how they came to use cannabis medicinally in the first place. Discussion involving participants comparing cannabis to prescribed substances revealed that, not only did they find cannabis to be more effective, and often to have fewer side effects, but that many also preferred it because

they felt that it was somehow more 'natural.' This kind of understanding is rarely, if ever, achieved by using a questionnaire. The impact of cannabis use on relationships (friends, neighbours, family, healthcare professionals) was also investigated.

The current thesis uses data from the interviews produced for Coomber, Oliver and Morris (2003). The richness and depth of this qualitative data lent itself to further analysis in terms of the interest sparked by the discourses used by the medicinal cannabis users themselves. The focus is now on the articulation of these discourses and various rhetorical strategies used by participants when talking about the medicinal use of cannabis and the issues described directly above. The analysis of the discourse of medicinal cannabis users is an area that has not been examined by previous research and this thesis hopes to make a modest contribution to addressing this gap in knowledge.

Discourse and other aspects of illicit drug use

However, whilst the discourse of medicinal cannabis users is something that has not been examined before, plenty of research on the discourses of users of illicit drugs has been produced. A brief, non-exhaustive, discussion of some of the more interesting and relevant pieces of research within this area will now be undertaken. The review will relate the research discussed to the present thesis in terms of areas of shared interest and some methodological issues.

One of the main themes found in the discourse of medicinal cannabis users, as was briefly noted in Coomber, Oliver and Morris (2003), is the construction of cannabis in relation to ideas about it being 'natural'. Hellum (2005) is a narrative analysis of interviews with young Swedish backpackers talking about their experiences of travelling and drug use (or for some their non-drug use). This research produces an account of how those who did not use drugs produce narratives that draw on the 'official' Swedish discourse on drugs, whereas those who did use drugs produce what Hellum describes as an anti-discourse (a discourse which in some ways is in opposition to the 'official' discourse). The author argues that in Sweden, alcohol is not usually described as a 'drug' (which is also true in the U.K.) and indicates that those substances which are usually discussed using this term may be understood as a social 'other' to alcohol, the accepted 'drug'. The accounts of those who did use drugs during their travels are understood as constructions of an anti-discourse, contrasting with the 'official' Swedish discourse on drugs and featuring the construction of various contrasts. The drug-using backpackers' accounts feature, among other things, a preference for the use of cannabis because of its construction as 'natural' and therefore inherently preferable, with this construction often forming part of a contrast with other substances, such as alcohol or other drugs. In these contrasts, alcohol was constructed as problematic and ecstasy, for example, as a 'chemical' drug and therefore 'dirty.' This preference for the 'natural' is understood by Hellum (2005) in relation to the idea that backpacking emerged out of the hippie lifestyle from which it also took a cultural preference for the 'natural'.

However, there is something uncomfortably neat about the way in which examining discourse in relation to drug-using backpackers and non-drug using backpackers

produces two sets of almost homogeneous discourses. What about attending to the differences between individuals' discourses? The explanatory use of the concepts 'clean' and 'dirty', borrowed from Douglas (1966; cited in Hellum, 2005), are somewhat limiting in their use. The concern here is not with the work of Douglas, but with its application. The idea that the 'official' Swedish discourse constructs 'drugs' as 'dirty' and that in constructing cannabis as 'natural' the anti-discourse draws on connotations of purity and so constructs cannabis as 'clean' is a useful starting point. However, in constructing cannabis as 'natural' the meanings of cannabis as articulated need to be seen within a broader and deeper context of late modernity in which the 'natural' is contrasted with the 'man-made', 'chemical', 'artificial' or however else this might be articulated within numerous social debates, lifestyles and patterns of consumption. The link between backpacking and a hippie lifestyle of the 1970's is just one small part of this broader context within which these rhetorical constructions must be understood.

Omel'chenko (2006) discusses data from semi-structured interviews with young Russians discussing illicit drug use, with a view to understanding the varied language and narratives used by young people and how the differences between this and official discourses limit the effectiveness of drug-prevention programmes and drug education. In addressing 'official' discourse and alternative discourses, it is similar to Hellum (2005). However, unlike Hellum (2005), Omel'chenko (2006) does attend to the differences between different youth discourses on drugs.

In relation to the discourse of those participants who were drug users, Omel'chenko (2006) produces an interesting discussion about the way in which the everyday use of

language by young people plays a role within the 'normalisation' of certain practices, in this case that of substance use. When combined with a discussion of what is articulated by young people as *narkotik* (drugs) and *ne narkotik* (not drugs) it becomes evident that the shifting boundary of what is and what is not articulated as being a drug plays an important role in the participants justifying certain practices. Omel'chenko (2006) describes how *narkotik* can be used as a term to describe all illicit drugs, or by others (or in different circumstances) to talk about 'hard' drugs (itself a shifting category). She describes how cannabis is frequently spoken about, particularly by users, as *ne narkotik* and is seen as comparable to legal 'drugs' such as cigarettes and alcohol. These articulations are always contextual, as Omel'chenko (2006) argues, and people can be understood as doing particular things with discourse at particular times. It is important to attend to how individuals are using discourse to *do* things (i.e. the idea that the articulation of discourse is a form of social action) (Gill, 1996).

Interestingly, neither Hellum (2005) nor Omel'chenko (2006) reflect methodologically on how gathering data on drug use, particularly from drug users, is what Lee (1993) calls a 'sensitive subject' and how this may relate to the ways that participants' accounts might, at least in relation to particularly sensitive issues, involve what Goffman (1959) describes as a concern to protect the positive moral standing of the self. In a piece of research that employs a discourse analysis approach in relation to interviews with injecting drug users (IDU's) in New Zealand, Plumridge and Chetwynd (1998) consider such issues. The authors were interested in how participants portrayed themselves as social and moral actors and justifications used for behaviours related to sharing injecting equipment so as to attempt to

maintain the positive moral standing within which they attempted to portray themselves. This research also focussed on the discursive resources, the discursive practices and the rhetorical strategies employed. Lenders of injecting equipment tended to produce narratives in which any decision to borrow placed responsibility on the borrower. Borrowers tended to depict borrowing as a matter of desperation and therefore one of 'powerlessness' (Plumridge and Chetwynd, 1998).

Rødner (2005) analysed existing interview data with socially 'integrated' Swedish drug users, with a particular focus on how they drew on shared discursive resources in constructing their identities and would contrast themselves with those they saw as drug 'abusers' (seemingly those perceived as dependent drug users). Much of this is understood by Rødner (2005) as involving a process of 'polarisation', when participants compared themselves to this 'other' and can be seen to be emphasising their own 'good' points and under-representing their own 'bad' points. Conversely, they can also be seen to be emphasising the 'bad' behaviour and under-representing the 'good' behaviour of the 'other.' This is of course classic self-presentational strategy and, as Rødner (2005) also discusses, much of what the 'integrated' users draw on when discussing the 'other' is 'official' Swedish discourse about 'problem' drug users (i.e. discourse that problematises them and their drug use). However, as 'official' drug discourses tend to have little if anything positive to say about illicit drug use, one would expect to hear few positive things being said about 'problem' drug users by those with only 'official' drug discourse to draw on (i.e. no other sources of meaning, such as personal experience which might 're-humanise' the prevalent notion of the passive 'junkie' stripped of morality and will). The

'polarisation' view of in-group and out-group constructions is explanatorily useful, though, as such constructions often do tend to resemble binary oppositions.

One of the problems with Rødner (2005), as well as with Hellum (2005) and Plumridge and Chetwynd (1998), and much other research that employs discourse analysis to investigate small aspects of accounting for, or talking about, a given topic, is that they tend to homogenise how their participants use discourse and neglect attending to differences between the discourses of participants, an important part of discourse analysis (Tonkiss, 1998). The reader may take the view that this is perfectly legitimate, as such questions are not pertinent to the aims of much of this type of research, but surely analysis must seek to avoid homogenising participants simply as 'backpackers' (Hellum, 2005), 'injecting drug users' (Plumridge and Chetwynd, 1998) or 'integrated drug users' (Rødner, 2005)?

Let us consider Rødner (2005) in relation to this point (mainly because she explicitly discusses her methodological assumptions). Rødner (2005) states that in her piece of research:

> "... it is assumed that people are self-conscious in their everyday lives. Hence, people's linguistic mode of presenting themselves and others is paid close attention to, as it is the manner in which people in a spontaneous and resourceful manner create social order. The second point of this article is that discourses form the background of individuals' reality construction. ... Interpreting the informants' own perspectives is important ... [as] ... it might also lead to an understanding of the social processes and contexts in which social meanings of drugs are created, reinforced and produced. Understanding these processes is a necessary prerequisite for developing successful interventions." (Rødner, 2005: 334).

People's "spontaneous and resourceful" discursive constructions are actually the product of individuals with differentially capacitated discursive resources and rhetorical strategies at their disposal, as well as socially constituted and habituated dispositions around the use of discourse. Discourses certainly do "form the background of individuals' reality construction" but the discursive resources they draw on, how they draw on them and how they articulate them are not the same and are the outcome of socially constituted and habituated dispositions around the use of discourse, or a linguistic habitus (Bourdieu, 1992). To not consider such issues leads to a homogenisation and over-abstraction of individuals' accounts. Finally, surely "developing successful interventions", as is often one of the aims of much of this type of research, so that its findings will be fed into intervention-related practice, will be better served by a research generated awareness of inter-participant differences regarding understandings and practical ideologies. So this criticism is not necessarily just related to questions of methodology, but may also have 'real world' import.

Conclusion

This literature review has discussed work from a range of areas that all contribute to the debates that this thesis will engage with and position itself in relation to. However, as was mentioned in the introduction, some of the literature (i.e. the non-sociological research) is more relevant to the thesis in terms of illustrating how some of the more significant issues inherent within medical discourse contribute to the discursive contestation around the medicinal use of cannabis. Whilst most of the medically oriented writing tends to employ its own discursive criteria uncritically as

regards what substances might or might not be suitable as medicinal substances and what forms of knowledge should be seen as valid, or it simply chooses not to review existing clinical research on whole-plant cannabis at all, some commentary from the medical profession does ask more critical questions. Other literature on the issue has adopted a position of critically engaging with this medicalised view of cannabis, in subjecting the objections to, and exclusion of cannabis from being considered as medicinally efficacious to scrutiny. Grinspoon and Bakalar (1993) have been particularly critical, asserting essentially that cannabis is a safe and effective substance and that objections from the medical profession are an outcome of their own inability to separate cannabis from the mythologizing, moralising and bureaucratically medicalised and commercial objections that stop it from helping patients.

The more 'sociological' research that has been reviewed is, in fact, rather limited and is mainly survey work, offering shallow knowledge on the issue. Whilst Coomber, Oliver and Morris (2003) represents a contribution towards a more in-depth qualitative understanding of medicinal cannabis use within the context of the U.K., the current thesis is alone in attempting to investigate the discourse of medicinal cannabis users. Yet there is a body of discourse analysis-related work that has been undertaken in relation to the discourse of other types of drug use, and this presents a helpful context within which to also place the current thesis. Discussing constructions of the 'natural' in relation to cannabis (Hellum, 2005), the shifting articulations of what is and is not seen as a 'drug' (Omel'chenko, 2006), how drug users' accounts must be seen as being influenced by the individual's need to attend to issues of self-presentation when articulating accounts (Plumridge and Chetwynd, 1998) and the

rhetorical processes of polarisation within the contextual construction of identities (Rødner, 2005) are all of import to this thesis. Yet most of these pieces of research raise methodological concerns that this thesis seeks to build on and contribute to. These issues will be discussed further in the next chapter.

PART 2 – METHODOLOGY AND METHOD

CHAPTER 3

METHODOLOGY – DISCOURSE ANALYSIS

Introduction

The previous chapter reviewed the literature on the medicinal use of cannabis as well as some discourse analysis on other drugs. This chapter will outline the methodological approach being adopted in this thesis in relation to a number of key issues. The following chapter will address the application of this set of approaches.

This chapter will address:

- What are the intellectual 'roots', and main themes, of discourse analysis?
- What methodological approaches does discourse analysis adopt to language and meaning?
- What approaches to language and meaning will be adopted in this piece of research?

It will encompass sections discussing:

i) The things that participants do with language in interviews.

ii) The analytic status of the interview.

iii) The methodological validity of 'referencing out' meanings that arise in the interview to the broader social context of therapeutic cannabis use.

iv) The 'analytical pre-story'.

The intellectual 'roots' of discourse analysis

In this section, the intellectual 'roots' of discourse analysis will be discussed. In order to do this, some general descriptive comments about discourse analysis as a methodological approach will be useful. The type of discourse analysis undertaken in this thesis is that which attends to the ways in which individuals produce spoken discourse within particular contexts of social interaction and which understands such discourse as the outcome of construction, articulation and the rhetorical use of language (Potter *et al.*, 1990; Potter, 1997) with language use being seen as a form of social action in its own right.

In a summary of the four main themes of discourse analysis, Gill (1996: 141-143) describes these as:

1. Discourse is the **topic** of discourse analysis. That is to say that talk and texts are of interest to discourse analysts in their own right, as opposed to being interested in them as a way of accessing some reality, which is assumed to lie behind the discourse. That is to say, discourse is of interest in itself, not as a resource (as would be the case in most other social science disciplines).

2. Language is viewed as being **constructive.** This metaphor of construction highlights three issues:

   i) Discourse is manufactured from pre-existing linguistic resources (this will be dealt with further below).

   ii) The assembly of an account involves selection from various possibilities.

   iii) As individuals, we deal with a world that is constructed by discourse, not one accessed in some unmediated or direct way.

3. Discourse analysts see discourse as a **social practice** in its own right. "People use discourse in order to *do* things: to offer blame, to make excuses, to present themselves in a positive light and so on." (1996: 142).

4. Discourse analysts view discourse as being organized **rhetorically**. "Unlike conversation analysis, [which does not typically contextualise discourse within the broader social context, outside of the immediate context in which it occurs – the talk or text] discourse analysis regards social life as being characterised by conflicts of various kinds. As such,

much discourse is involved in establishing one version of the world in the face of competing versions." (1996: 143).

Having illustrated what are arguably the four main themes of discourse analysis, it is now useful to contextualise these in relation to discourse analysis' intellectual 'roots'.

Language as a topic of intellectual inquiry is to be found in the work of Saussure (1974) and Wittgenstein (1976), and first within the sociology (leaving aside debates over whether it is sociology or not), of Garfinkel (1967). Garfinkel's interests in people's mundane behaviour brought language use to the forefront as a topic in its own right (Filmer *et al.*, 1998). Conversation analysis evolved within ethnomethodology as an approach to the analysis of discourse, and there are similarities between this approach and discourse analysis (although they will not be discussed here).

The intellectual heritage of treating discourse as a topic also relates strongly to the structuralist and post-structuralist traditions. Drawing on the work of Saussure (1974), writers such as Foucault (1974), Derrida (1977) and Lyotard (1987) are part of a tradition that decentred human agency as the central focus of their inquiry. The intellectual 'roots' of a constructivist view of language, as found in discourse analysis, are to be located in a number of areas. Gill's (1996) comment contains a reference to the idea that talk and text are produced by individuals, but from existing linguistic resources. This aspect of discourse analysis needs to be seen in the context of the structuralist and post-structuralist views of language in which it is conceptualised as having powerful structuring effects. These ideas also relate to the

notion that the world (at least in our perception of it) is constructed within various discourses.

The idea that accounts are assembled from linguistic resources by people also stresses the active involvement of individuals in this process and is a part of one of the other points made by Gill (1996), that people use discourse to *do* things. Seeing language as a social practice itself draws on the work of Wittgenstein (1976), Austin (1962) - with the idea that language is performative - and Garfinkel (1967) who, as mentioned above, made peoples' use of language a topic in itself.

In the narrower context of people actively using pre-existing linguistic resources, discourse analysis draws on the work of Gilbert and Mulkay (1984), and their concept of the interpretative repertoire, or linguistic repertoire – work which is to be located within the sociology of science. Gilbert and Mulkay (1984) conducted interviews with biochemists, and also amassed various other documents to be used as data. The authors found differences in the ways in which the scientists produced accounts of their work depending on the context - these being formal accounts such as those found in journal articles, and informal accounts, such as those produced in the interviews. Overall, Gilbert and Mulkay argued for the existence of two *interpretative repertoires* on which scientists would draw to construct accounts of their work - depending on the context in which they were doing so. Interpretative repertoires can be defined as:

> "... broadly discernible clusters of terms, descriptions, common-places ... and figures of speech often clustered around metaphors or vivid images and often using distinct grammatical constructions ... (Potter *et al.* 1990: 213).

Interpretative repertoires are employed in ways specific to each situation - that is to say that accounts produced are specific to the situation within which they were produced. Repertoires are drawn on in order to not just describe, but also to do things. Accounts may contain language that is performative (Austin, 1962), for example the end of a wedding ceremony in which the phrase uttered by the officiator "I pronounce you ..." is also the action of marrying them.

The notion that discourse is organised rhetorically, that it is often concerned with establishing one version of something over others (as well as this obviously being one of the things that people *do* with discourse) is to be found within the post-structuralist tradition of text analysis, and more generally its theoretical position on discourse. Adopting a relativist position towards all discourse (including itself), post-structuralist approaches view any attempt to assert one version of something over another as an act of power. Discourse analysis adopts the same approach to text and talk. Questions of truth are suspended, and all discourse is regarded as being organised to potentially have certain outcomes. This interest, not only in how discourse is organised, but also in the possible outcomes of this organisation, takes discourse analysis into the realm of questions of power and forces discourse analysts to examine talk and text in relation to the broader social context as well as the immediate context in which it occurs (interview, conversation, written text and so on).

Discourse analysis and language

Having identified the intellectual 'roots' of discourse analysis, what methodological position does it adopt in relation to language, meaning and the individual? In the previous section, the methodological positions that have been adopted in various approaches to language, meaning and the individual were divided into two broad groups. In the first of the two groups, human agency can be seen as being methodologically central, and in what is perhaps the most significant consideration of language and meaning in this broad position, Wittgenstein (1976) views meaning as the product of peoples' use of language. In this first group would also be Weber (1980), Schutz (1982) and phenomenology, Wittgenstein (1976), Austin (1962), Garfinkel (1967) and ethnomethodology. What is shared by all of these is the centrality of the active social agent. In the second of these two groups, the social agent is 'decentred' by language itself. The argument that language is central to the production of meaning is first found in the work of Saussure (1974), and later in structuralism and post-structuralism, as was indicated earlier. Central to this position is the methodological centrality of discourse, not the human agent. With its interest in "how people use discourse and how discourse uses people" (McKinlay *et al.*, 1993: 143), both the agency of the individual *and* the structuring effects of language are at the centre of the discourse analysis stance.

As was discussed in the previous section, discourse analysis has been strongly influenced by a range of intellectual disciplines in different ways, which may be grouped in this way. This inter-disciplinary set of influences must also be seen within the context of the growth of discourse analysis in the 1980's as, for a number of

decades now, the boundaries between academic disciplines have been eroding, with new areas arising at the junctures of traditionally recognised disciplines.

However, whilst this inter-disciplinary development is clearly evident, the discourse analysis of writers such as Potter, Wetherell, Reicher, Gill, Burman, Parker, Abrams, Hogg and others has evolved within social psychology, initially as an alternative methodological stance to that represented by the concept of 'attitude'. Whilst a full discussion of this is not possible here, this movement can be understood within the context of the response of some psychologists to the qualitative critique of quantitative methods, as well as what has been labelled by commentators as the 'linguistic turn' within the human sciences. However, whilst the work of some of these writers offers great insight (and is drawn on to some degree in this thesis) it tends - although far more in some cases than in others - to retain an inherent focus on the primary interests of social psychology (individual and group interactions) as opposed to a more sociological take on the social construction of social life, with a focus on issues of power.

In this respect, the movement that has come to be labelled 'Critical Discourse Analysis' (C.D.A.) offers what might crudely be described as a more sociological approach to discourse analysis, with a particular interest in the ways in which discourse and power interact within the social world of everyday lived experience (although there are some writers from a social psychology background who employ a C.D.A type approach too, for example van Dijk. Talking about this approach to discourse analysis, Fairclough says:

> "I view social institutions as containing diverse 'ideological-discursive formations' (IDFs) associated with different groups within the institution. There is usually one IDF which is clearly dominant ... . A characteristic of a dominant IDF is the capacity to 'naturalise' ideologies, i.e. to win acceptance for them as non-ideological 'common-sense' ... . To 'denaturalise' them is the objective of a discourse analysis which adopts 'critical' goals. I suggest that denaturalisation involves showing how social structures determine properties of discourse, and how discourse in turn determines social structures ..." (Fairclough, 1995: 27).

This statement is something of a manifesto for C.D.A. It implores the researcher to be critically involved, to be involved in the exposure of the 'play' of power and discourse. It suggests an interplay between social structure and discourse and a social world composed of 'institutions' that are populated by different groups (and individuals, many having opposing interests – although he goes not go so far as to say this here) associated with different I.D.Fs, some of which are dominant (in correspondence with, or as part of the dominance of, dominant social groups). In terms of power and discourse, for Fairclough (1995), these dominant I.D.Fs are often able to pass what is actually no more than one of a number of competing versions of the 'truth' off as *the* truth and to make this appear unquestionable – as "common-sense". It is this that Fairclough (1995) wants us to expose and, in making transparent these 'acts of obfuscation', Fairclough (1995) and other practitioners of C.D.A. hope to render social change more possible. To emphasise this end, Fairclough (2001) quotes the anthropologist Franz Boas:

> "How do we recognize the shackles that tradition has placed upon us? For if we can recognize them, we are also able to break them" (Boas, n.d., quoted in Fairclough, 2001).

Whilst it is arguable whether the 'breaking of shackles' is as simple as being able to recognise them, Fairclough makes the intention of a critical discourse analysis clear –

like Marx, the 'critical theorists' of the Frankfurt School, Feminism(s), Foucault, Derrida, Lyotard and many others, for Fairclough, the analysis of the social is inherently political.

The approach to language to be employed in this piece of research.

The approach to language held by this researcher has many influences, but the main ones relevant to this thesis are the critical discourse analysis approach briefly outlined above (with reference to the ideas of its founder, Fairclough), as well as the work of Foucault on the contestation of 'truth', but more than anyone else, the work of Pierre Bourdieu on language as a form of socially constituted social practice.

Drawing on the work of Bourdieu, Lee (2000), in a fascinating paper on practical meaning in everyday life, argues that meaning can be seen as:

> " ... the outcome of symbolic struggles waged on an individual and collective level. ... symbolic systems ... should be located within specific institutional spaces that become arenas for symbolic competitions among individuals and groups. Following this approach, cultural objects gain meaning foremost as objects of practical, contested usage and not as objects of pure contemplation ..." (Lee, 2000: 46).

Adopting this type of position, the 'meaning' of cannabis is an outcome of contestation between different individuals and groups and the parallels with Fairclough's view are clear – competing groups within institutions with diverse I.D.Fs, some of which are able to pass as dominant. Later chapters will describe the context or field of power relations (Bourdieu, 1979) within which this discursive

contestation takes place (the field of health provision and regulation). For the moment, a brief sketch of Bourdieu's main ideas on social practice and language will be undertaken.

Bourdieu on social practice and language

The concept of *field* (Bourdieu, 1979) is used within this thesis to understand the social sphere or field of health and, within it, how the medical profession as an institution and its associated discourses and practices have become dominant, and to understand how other individuals and groups within that *field* are positioned. It is employed in the analysis of the participants' discourses, relating it to the dominant medical discourses, primarily of course the discourse that constructs medicines as a set of valid objects and constructs cannabis as an object that is not of medicinal value.

For Bourdieu (1979), the transition from traditional (pre-modern) society to modernity is characterised, in terms of social structural change, by the emergence of numerous relatively autonomous *fields* – of which the field of health is just one. The concept of field is central to how Bourdieu distances himself from seeing all of society as occupying just one dimension or plane that is in the last instance superstructural in relation to the economic mode of production. It also allows him to account for and to provide an analysis informed by the observation that modern societies are composed of various parts that seem to exhibit a relative degree of autonomy from the state and prevailing economic relations of production. The concept of field allows Bourdieu (and others who use the concept) to analyse social

practices that occur within certain spheres of social life in relation to a more specific understanding of the prevailing relations that exist within that particular area (which, due to the assumption of relative autonomy, may be different to other areas of social life) and the more localised details of the discursive and material conflicts that characterise that sphere or field at any given moment.

Bourdieu's concept of field allows exploration of specific conflicts, such as the discursive contestation around the medicinal use of cannabis that takes place within the health *field*, by offering an explanation of how individuals and social groups are positioned within such contestations; what is at stake, and how the distribution of the resources that are contested and are the basis for participation within such contestation can be seen to shape a given *field of relations* (for this is what the term really means) and to explain the practices that take place within it. For Bourdieu, fields are characteristically about symbolic and material struggles and therefore antagonistic relations and self-interest, the first notion being Marxian in origin, the second, part of Bourdieu's less often considered Nietzschean inheritance (Webb *et al.*, 2002).

In this thesis, medicinal cannabis users can be seen to assert the medicinal usefulness of cannabis, drawing on their everyday experience, but also in some cases drawing on personal research on the subject too (some read all manner of material on the topic). However, due to the dominance of the medical profession in the field of health, assertions as to cannabis' medicinal efficacy by chronically ill and disabled users (including those participants in this research) come to be constructed by the dominant discourse as merely anecdotal. This of course reflects the hierarchy of types of

knowledge inherent within scientific discourse on which medicine draws – in which the form of knowledge prized by science, i.e. that which is clinically produced, is the only form that is recognised.

Also key to the use of Bourdieu's ideas about discourse as social practice is his work on the habitus, the "*dialectic of the internalisation of externality and the externalisation of internality*" (Bourdieu, 1979: 72), which is defined by Bourdieu when he argues that:

> "The structures constitutive of a particular type of environment (e.g. the material conditions of existence characteristic of a class condition) produce *habitus,* systems of durable, transposable *dispositions,* structured structures predisposed to function as structuring structures, that is as principles of the generation and structuring practices and representations which can be objectively "regulated" and "regular" without in any way being the product of obedience to rules …" (Bourdieu, 1979: 72).

More briefly, he also defines habitus as:

> " … the durably installed generative principle of regulated improvisations …" (Bourdieu, 1979: 78).

For Bourdieu, the habitus is the internalisation, through socialisation, of certain *dispositions* or tendencies – ways of being, of understanding, of relating to the world and ways of acting. These tendencies explain the likelihood, commonly observed in everyday life, of people from certain social groups being more likely to behave in certain ways in certain situations. This does not mean that all members of a given social group will always or inevitably act in a given way, but simply that it is more probable that they will, due to the internally durable dispositions that they possess.

Sometimes accused of determinism, Bourdieu's habitus is about tendencies, dispositions and likelihoods (from behaviours to tastes), but is in no way simply deterministic.

Bourdieu's concept of habitus is able to explain change within the individual over time. Whilst Bourdieu emphasises the "durable" character of the internalised structures (1979: 72) this does not make the habitus rigid or fixed in any simple way. Discussing this point, Bourdieu argues that:

> "... the habitus acquired in the family underlies the structuring of school experiences ... and the habitus transformed by schooling, itself diversified, in turn underlies the structuring of all subsequent experiences ... and so on, from restructuring to restructuring." (1979: 87).

So, for Bourdieu, the habitus is flexible in the respect that it can undergo what he describes as restructuring. This, of course, is important because otherwise something akin to determinism would take place, whereby a given social class habitus, for example, would simply be internalised and fixed. Whilst this is not the case in Bourdieu's conceptualisation, the precise nature of that restructuring is complex and probably contributes to the perception that Bourdieu's theorisation of social life is rather conservative.

In one of the most famous works by Bourdieu (Bourdieu and Passeron, 1977), for example, the authors argue that, through the process of early socialisation in the family, children acquire different levels and types of cultural capital (subject to the social class of their family) and that on entering formal education, the cultural capital of the middle-class child is regarded more highly than that of the working-class child,

through day-to-day interaction. Viewing education as a relatively autonomous field, in which the value of different capital (cultural in this case) is contested, the authors argue that education tends to act as a legitimator and reproducer of class-based inequality. This being the case, whilst Bourdieu's habitus is capable of restructuring, the unequal distribution of capital and the education system's tendency to act in accordance with this means that the restructuring tends to act to confirm rather than challenge existing habituated tendencies in terms of the *trajectory* of an individual (their biographical direction through life, in terms of fields traversed and cultural capital-related positioning within these fields, which tends to reflect dispositions within the habitus but also contribute to the restructuring of the habitus). However, accusations of conservatism or even determinism ought to consider that Bourdieu is not arguing that reproduction of class inequality *will always* happen, simply that, through the transmission of capital and the process of socialisation encouraging social group similarities in disposition, that it is *likely* to reproduce social class inequality.

Of particular importance to this thesis is Bourdieu's concept of the *linguistic habitus.* Just as Bourdieu's understanding of language use (see below) is the outcome of his broader conception of practice (because he understands language use to be a form of practice) so he sees what he describes as a linguistic habitus as a part of the overall habitus (Bourdieu, 1992). Linguistic habitus is a key part of accounting for the differences between different participant's discourses about medicinal cannabis use in this thesis and is key to being able to understand individual participant's accounts as the outcome of what they are habitually inclined to say (i.e. disposed to talk about certain issues in certain ways) and capacitated as able to say (because linguistic capital is not equally distributed and people can only use the discursive capabilities

that they are socially constituted as possessing). Thus, in the later chapters of this thesis, types of discourse are identified and are related to issues of social class, education and vocation to account for observable tendencies in terms of different ways of talking about medicinal cannabis use.

Bourdieu understands the linguistic habitus to be a sub-set of the dispositions that characterise the overall habitus, which are acquired whilst language is acquired during childhood and subsequently developed within the family, peer group and school over a series of restructurations. This linguistic capital is transmitted in the same way that cultural capital is (and arguably the former could be seen as a sub-set of the latter). Bourdieu's related concept of *hexis* is also relevant, as speech is also an embodied practice that is socially constructed but embodied in durable ways (e.g. accents as certain ways of moving the mouth and other speech-related parts of the body) (1992).

However, Bourdieu also notes that language use is not simply a product of a particularly socially constituted habitus and hexis, but that practice always takes place in context (a point which concurs with the discourse analytic importance of seeing discourse as contextual and situated). He sees linguistic practice as the product of a relationship between the linguistic habitus and a linguistic market. The notion of linguistic market not only reflects the idea that language is always used contextually, but also that different 'speech situations' may value certain ways of speaking more highly than others (the value of capital is always contested for Bourdieu). For example, within the context of formal speaking, the 'fit' between linguistic habitus and linguistic field will be best with the linguistic habitus that has the most linguistic

capital best disposed towards having a practical 'feel for the game' of formal speech. One would expect something akin to a social class hierarchy being strongly in accordance with a formal speaking hierarchy (1992).

As linguistic capital is also (as with all forms of capital) unequally distributed, it is no surprise that Bourdieu links this to the role of the education system in reproducing inequality (or to playing a role within the distribution of cultural capital which is in effect the same thing). On this issue, Bourdieu argues that:

> " ... different agents' linguistic strategies are strictly dependent on their positions in the structure of the distribution of linguistic capital which can in turn be shown to depend, via the structure of chances of access to the educational system, on the structure of class relations." (Bourdieu, 1992: 64).

However, the most important point raised by this quote is that the strategies that different agents may be able to employ or mobilise within instances of discursive contestation depend upon their position in relation to the distribution of linguistic capital. This means that, discursively, individuals can only say what they are equipped to be able to say. They can only use the linguistic capital or resources that are at their disposal. This seemingly obvious point in fact becomes vitally significant in relation to this thesis, as it aims to analyse the discourse of individuals from different backgrounds and how they talk about cannabis, its use and associated issues. With medicinal cannabis use being discursively contested in all sorts of ways, but seemingly the capacity to participate in it being socially (and therefore unequally) capacitated, the research will focus upon examining different participants' discourses in terms of the differentially constituted capacity to engage with discursive struggle,

or otherwise. In terms of explaining discursive differences, educational background, vocational experience and social class will be key explanatory concepts.

The interview: analytic status

Within the context of a discussion of how 'the interview' has been regarded from a number of methodological perspectives, this section will therefore address the following issues:

i) The things that participants do in interviews.

ii) The analytic status of 'the interview'.

iii) An argument for 'referencing out' the meanings which arise within the interviews to the broader social context of medicinal cannabis use.

Realism and the paradox of the contextual

The interview, in one form or another, has been a central method in social research for a considerable period of time. The developments in the use of this tool need to be seen in the context of wider changes within sociology; the belief in the unity of methods, the rise of the interpretative tradition and developing positions within the

corresponding philosophical debates around realism and idealism, as well as theoretical debates about language.

Mishler (1979) notes the paradox, which shall be considered here in particular relevance to the interview as a methodological means, in which the everyday knowledge that meaning is context-dependent has been

> " ... excluded from the main tradition of theory and research in the social and psychological sciences ... . As theorists and researchers, we tend to behave as if context were the enemy of understanding rather than the resource for understanding which it is in our everyday lives" (Mishler, 1979: 2).

As Mishler goes on to argue, and as is referred to in the phrase 'main tradition of theory and research', this 'approach' to context and meaning is to be situated within the historical appropriation of the methodological principles of the natural sciences (1979: 3). Within this tradition it has been assumed that a singular objective reality could be known by the application of the scientific principles of objectivity and neutrality. It has also been assumed within this tradition, argues Mishler, that an interview is a behavioural event rather than a discursive event (i.e. that the speech taking place within an interview is conceptually reduced to the level of stimulus and response, thereby losing all the complexities found within speech). The consequences of this are that technical methods are employed which obscure the relationship between discourse and meaning. Further to this use of the stimulus-response model, thinking around interviews has tended to concentrate on the phrasing and ordering of questions, and the characteristics of the person asking them, in the belief that attention to standardisation, distortion and bias will deliver the 'true' opinions and beliefs of those being interviewed (1993: 10-15). This conception of the interview

fails to grasp the complexity of language and interaction within such social interactions, and serves to strip meaning of its context.

The critique of the quantitative methodology implicit in the interpretivist stance (whilst recognising the diversity present in the latter) centres on three main issues. First, that interviewees do not always behave outside of interviews as they say they do in them (an argument often raised by ethnographers in support of participant observation). Secondly, the variability of meaning as a criticism of standardised meanings in, for example, fixed choice answers in questionnaires. Thirdly, the inequitable power of the research relationship, in which interviewers usually direct everything within the encounter (Seale, 1998).

Those committed to the view that interviews could serve as a 'window to the world' within the qualitative approaches followed the belief that certain types of interview were more likely to provide subjectively authentic accounts than others (Seale, 1998). Such 'in-depth' interviews allow more flexibility around questioning, having questions which could be departed from if interesting topics not foreseen arose and topic guides instead of set questions, or perhaps no structuring elements at all, inviting the participants to simply speak about what they felt to be the relevant issues (Seale, 1998). Whilst there are strong 'political' arguments for adopting such approaches, which are importantly reflexive about the role of social sciences and its' part in the production of knowledge / power, the commitment to such realist epistemologies promotes what Seale calls a "somewhat romantic" belief that certain approaches to interviewing can guarantee data which contains 'how it really is' (1998: 209). To a degree, this belief is similar to that found in the quantitative

approach in the respect that both broadly contain such a realist view, in which following certain steps will lead to 'how it really is'. Objective and distanced or subjective and involved, *the* truth about a topic of interest can be known by following steps to solicit accounts which are simply reflective of 'reality'.

Realism, context and moral standing

This position contrasts with one in which people's talk is involved in presenting and preserving certain views of themselves, others, and the social world in which they are involved. Goffman suggested that one feature of behaviour within interactions is a concern to protect the positive moral standing of the self and of others (1959). This is one of the tasks that may be located within the performative conceptualisation of language, in which people use language to *do* things, i.e. language as a form of social action. Within this view, interview responses are no longer simply true or false reports on reality, but are also, or only (depending on the position that a researcher adopts within this debate), displays of the interviewee's 'reality' constructed and spoken of. Interviews, as well as other types of interaction between people, may therefore be seen as 'moral arenas', in which the standing of the speaker is on display and is being maintained (Seale, 1998). People's talk is conceived of as achieving certain aims, in this case the maintenance of a certain moral standing. This is one of the things that people *do* with language and is one of the four themes of discourse analysis that Gill (1996) discussed earlier in this chapter. Interestingly, a small number of participants exhibited quite a lot of 'impression management', as Goffman

(1959) called it, perhaps because of the sensitivity of the topic, i.e. that they might be perceived as 'immoral' drug users (see Chapter Sixteen).

This view of language and what happens in interviews has a number of corresponding positions with regard to the analytic status of interview data. One position is that interviews are displays of subjective realities and 'moral arenas', but also contain references to a reality outside of them, a position in which realism has not been abandoned, at least not totally. Another position that may be adopted is that interviews can only, unproblematically, have the analytical status of topic rather than resource. Talk, it is argued, must become the topic of interest, not a means to finding out about activities beyond the interview from research participants. Seale argues that Potter and Mulkay, for example, adopt this position, when they state that:

> "For the most part interviews are used as a technique for obtaining information that will enable the analyst to describe, explain and / or predict social actions that occur outside the interview ... this approach to interviews makes the analyst's conclusions heavily dependent on the interpretations of social action carried out by participants ... a radical revision is therefore required in our use of interview material ... interview data should be used to reveal the interpretative practices through which participants come to construct versions of their social world ... accounts cannot be read as a literal depiction of social action ... there are no unproblematic means for separating those accounts that are literal descriptions from those that are not ... accounts can only be properly understood in relation to the specific interactional and discursive occasion ... ." (Potter and Mulkay, 1985; quoted in Seale, 1998: 212 – 213).

However, whilst Potter and Mulkay argue that the data obtained from interviews cannot be regarded unproblematically as insight into events beyond the interview itself, it is debatable as to whether Seale's interpretation that they also mean that

interviews can *only* be used as insight into how individual's discursively construct *versions* of events is also meant by the authors. Less problematically, Seale (1998) then argues that interviews may potentially be treated as both topic *and* resource. Seale adopts this position whilst also acknowledging that some discursive articulations, made in relation to the world outside of the immediate context within which they were made, might be less problematic than others - i.e. the gender of a child may be more easily seen as an issue of 'fact' (though this 'fact' is a social construction itself) than questions with a concern to elucidate a participants' attitudes on some given subject.

As an example of the position which Seale (1998) is arguing for, Glassner and Loughlin (n.d., cited in Silverman, 1994) took the view that interview responses could be treated as culturally defined narratives *and* also possibly as reports on reality. The authors discuss an example in which, when a participant says that she uses cannabis because her friends do, they take this to suggest two things. First that she has employed a culturally prevalent way of understanding and talking about this topic (narrative), and secondly that this is evidence that cannabis use is part of peer gatherings. In this example, the authors can be seen as having taken Garfinkel's advice, that accounts are a part of the world that they describe (1967). The participant in the example may be seen as displaying the way she makes sense of something that she does, as well as referring to something she does, i.e. smoking cannabis in some social gathering. The point to be made here is that Glassner and Loughlin (n.d., cited in Silverman, 1994) may take this data as evidence of cannabis being used at peer gatherings, and use it questioningly, tentatively and critically. It is not necessary to

merely accept what is being said, and the way this 'revelation' is being constructed, in an unquestioning and literal fashion.

However, the participant in Glassner and Loughlin's example (n.d., cited in Silverman, 1994) is also arguably doing something else when she says that she uses cannabis because her friends do. Is she simply employing a culturally prevalent way of making sense of what she does? Such a conception does not take account of the possibility that this is an example of moral display, as well as evidence of some scheme by which she understands her behaviour. Glassner and Loughlin's (n.d., cited in Silverman, 1994) research is about adolescent drug-use, and drug-use is morally a highly charged issue. In a society in which illicit drug-use is heavily associated with social 'problems', surely the analytic status of participants' accounts is, in places and to a degree, not just referentially true or false, not just insightful with regard to the linguistic resources which are part of peoples' discourse, but also manifestations of moral display. With this in mind, the response that she uses cannabis because her friends do serves a further rhetorical end. One possible reading is that her response has a performative function, that of devolving responsibility, i.e. to be able to assert that 'I use it because others do too'.

In another discussion of what Goffman called 'impression management' (1959) Silverman (1994) uses the example of a patient in conversation with a doctor, in which the patient can be seen to construct her responses to what the doctor says with the outcome of maintaining the conception of being a 'good' mother. Silverman is discussing this conversation in terms of what he refers to as a 'charge-rebuttal' analysis (1994). It is in just such a way that one may also regard the example

discussed from Glassner and Loughlin (n.d., cited in Silverman, 1994). The additional attention to self-presentational concerns within interview accounts need not mean that we must, for example in Glassner and Loughlin's (n.d., cited in Silverman, 1994) example, abandon the idea that she uses cannabis because her friends do as in some way referential to actual events, or abandon this idea because it may not happen as she says it does. It is surely a case of acknowledging that accounts of events are not literal and may well be composed to attend to certain moral / self-presentational concerns. Used in a critical and speculative way, such an account can still be referentially useful - for example corroborating evidence of cannabis use at social gatherings would add to the confidence of making such claims in a piece of research.

The broader social context

What has been argued for so far is a conceptualisation of the interview as a resource for the apprehension of the linguistic means used by people to speak about and make sense of the world and their lives, and, to some degree, for finding out about events outside of the interview. Interviews, like other discursive encounters, may be regarded as having particular interpersonal elements, such as self-presentational concerns. They are also encounters which on one analytical level must be regarded as contextually specific, with regard to any attempt to apprehend the meanings articulated within them, because what is said is of course said within the particular context of the discussion / interview. However, whilst the specificity of the meanings being produced and the aspects of 'impression management' (Goffman, 1959) are on one level contextual to the interview, it is essential to realise that broader social

contexts also apply to what is being talked about within the interview. McKinlay *et al.* (1993) argue that a continuum runs from the local and immediate discursive context within which talk occurs, to the wider purposes that discourse may serve, for example as an ideological effect (1993). This being the case, it is necessary to *reference out* to the larger 'macro-social' context within which talk also occurs.

Tonkiss discusses this issue when stating that discourse analysis aims to analyse language use in its larger social context by reference to external (that is external to the interaction producing the account) social relations (1998: 249). One such example is Wetherell and Potter's work on the language of racism (1992) in which the accounts of White New Zealanders on topics related to issues such as 'race', 'nation' and 'community' are analysed not only in relation to the local discursive context of the interviews, but also in relation to the broader socio-economic context and related discourses, both historically and contemporaneously (e.g. colonial discourses of 'race' or the 'new' racism based on cultural rather than biological constructions of difference). So the analysis of the articulation of discourse not only requires attention to the immediate 'micro-social' context (in the research, the interviews) but also an awareness of the larger socio-historical context within which we might situate such an interaction and properly understand it. By this process the local and broader contexts within which interviews occur may be connected. To ignore this would be to, as Parker and Burman citing Bowers and Iwi (1991) comment, neglect:

> "... the way that language always does things, always reproduces or transforms social relationships. The analysis threatens to avoid the 'performative' aspect of language" (Parker and Burman, 1993).

By contextualising people's accounts within the broader discursive context, we are able to properly attend to what is happening. Analytical attention to the local and broader discursive contexts within which interviews take place allows us to " ... study how people use discourse and how discourse uses people" (McKinlay *et al.*, 1993: 143). It is particularly crucial that this position is taken in relation to this research, as participants' talk about medicinal cannabis use is part of a broader symbolic contestation around the issue.

The 'Analytical Pre-Story'

One way that the discourse analyst can place discourse within its broader socio-historical context is to produce an 'analytical pre-story'. Discourse analysis, unlike conversation analysis, attempts to analyse discourse not only in the immediate context within which it is articulated, but also in relation to the broader contexts of the social fields of interest. For example, discourse analysis looking at homophobic discourse would seek to analyse a spoken account on this topic not only in the context of the conversation within which it arose but also in the broader social context (for example historical and contemporary discourses on sexuality, relevant institutional practices and relations of power, and so on). Wetherell and Potter have described this practice within discourse analysis as the attempt to connect patterns 'read' in research data with those 'read' into the social context in question (1992:105).

How can this be done? Thompson (1984, cited in Wetherell and Potter, 1992) argued that the analysis should involve three stages:

i) A description of the social field, history and social relations relevant to the area of investigation.

ii) Systematic linguistic analysis of the pattern of discourse,

iii) A hermeneutic connection of the former with the latter.

Discourse can be analysed in relation to such a description, this description being called an analytical 'pre-story' and an example of this can be found in Wetherell and Potter (1992). The authors attempt to connect the discursive patterns they 'read' in their data with the patterns they 'read' in the social context. This 'reading' of the social context results in the construction of what they call a 'pre-story'. In the case of Wetherell and Potter (1992), this 'pre-story' is an account of New Zealand's colonial history and specifically of White New Zealander - Maori relations. This functions analytically as the context within which to locate the analysis of White New Zealanders' discourse on matters such as 'race', nation and community relations.

Drawing on this approach, the analytical pre-story to the analysis of medicinal cannabis users' accounts will involve discussing the history of cannabis in relation to relevant issues including science, medicine, social anxiety, prohibition and the medicinal use of cannabis (Chapter Five), considering how contemporary British society can be characterised by a 'challenge to authority' and an increasingly variable trust in certain key institutions of modernity, such as science, technology, government and 'expertise' (Beck, 1992) (Chapter Six) and a brief discussion of how scientific

medicine rose to a position of dominance within the field of health and how it is now subject to critique and dissent in contemporary British society, as well as issues related to chronic illness and disability (Chapter Seven). Chapter Eight addresses how medicinal cannabis use can be understood within this context as part of a challenge to the authority of scientific medicine.

Conclusion

This chapter has distinguished precisely which type of discourse analysis was performed in this piece of research (an approach known as critical discourse analysis). In the second section, the intellectual 'roots' of discourse analysis were explored in relation to its main themes and assumptions. In the third section, it was argued that, as a consequence of its' intellectual 'roots', discourse analysis adopts a methodological accommodation between the orthodox 'human-centred' social science position and the decentred position found within structuralist and post-structuralist social theory in relation to language and meaning. The fourth section contained an argument for the methodological position on language and meaning to be adopted in this piece of research. The fifth and final section discussed what participants do with language in interviews, the analytical status of the interview and made an argument for the methodological validity of 'referencing out' and the use of an 'analytical pre-story'. The next chapter will discuss how the issues of methodological importance were applied.

CHAPTER 4

METHOD

Research 'within' research

In describing and discussing the method that was used in this thesis, certain restrictions need to be recognised. This piece of research uses data that was obtained for another project, which eventually led to the production of Coomber, Oliver and Morris (2003). The details of this project were as follows:

CANNABIS, IMPAIRMENT, DISABLED PEOPLE AND CHRONICALLY ILL PEOPLE: An evaluation of the therapeutic uses of a controlled substance.

The study will describe and evaluate the use of cannabis in the lives of a sample of chronically ill people and disabled people. It will seek to establish the therapeutic purpose of taking the drug, the pathway to its use, the broad consequences of its use for disabled people and chronically ill people, and its effectiveness.

Aims

(a) To investigate the reasons why people decide to use cannabis for therapeutic purposes.

(b) To describe the ways in which people came to decide to use an illegal drug.

(c) To estimate levels of self-reported satisfaction with the drug and any difficulties as well as benefits experienced.

(d) To evaluate the effect on negotiated health care.

(e) To inform current debates about the use of cannabis for therapeutic purposes.

In discussing various issues related to the method, it is important to bear in mind that certain decisions about the approach taken were primarily made with regard to the aims of the research project reproduced above. This PhD thesis has had to fit within these constraints, and discussion of this follows. Ethical approval for both the original research and thesis were obtained from the University of Greenwich Research Ethics Committee.

Recruitment of participants and sampling.

Participants were initially recruited by way of advertisements placed in the monthly magazine *Disability Now* and in the newsletters of a number of disabled peoples' groups in and around the London area. The central criteria that were used to decide upon the suitability of participants were that they were chronically ill and / or disabled people who had used cannabis for therapeutic purposes within the preceding two years.

When interested individuals telephoned the office of the researcher (myself), they tended to want to discuss the study to varying degrees before deciding whether or not to participate. In part, these telephone discussions may also have served the purpose of establishing that the research project was genuine and not an attempt by the police to identify medicinal cannabis users, possibly with a view to prosecution (a very real possibility). During these telephone conversations, the researcher described the aims of the study, how it had come about, the method of gathering data (that the researcher would come to their home to interview them and why this was the proposed

arrangement), the purpose of the study, the type of questions they would be asked and that the data would also be used for the researcher's PhD thesis. The researcher also established how long they had used cannabis medicinally for and details of their impairment and / or chronic illness, to assess suitability under the participation criteria. Some individuals wanted to have some time to think about whether or not to participate in the study, but most simply agreed to participate during the first telephone conversation. Contact details were recorded and the participants were told that they would be contacted at a later date to arrange an interview.

After interviewing the initial contacts that this advertising had produced, these participants were asked if they knew of anyone else who would be suitable to participate in the research, which yielded a number of other participants. These individuals contacted the office by telephone and the procedure described immediately above took place. In all, twenty-six of the participants came from original contacts and six came from 'snowballing'.

This type of 'snowball' sampling procedure (Becker, 1963) is most useful in pieces of research that are purposive (that seek to recruit non-random participants on the basis of some particular characteristics), and in which the participants sought are part of a 'hidden' group. For example, medicinal cannabis users as a group are something of an unknown entity in terms of numbers and social characteristics due to the illegality of this type of behaviour. Using this sampling technique, a small initial sample can be turned into a larger sample, even when the research is dealing with a sensitive research topic.

The details of the sample are as follows (and a more detailed description of the participants is contained in Appendix C). Thirty-three participants were recruited and interviewed (the interviews of only thirty-two of these participants are used in this thesis as one interview was unsuitable for in-depth discourse analysis due to the participant having a severe speech impairment). Of the thirty-two participants whose data was used, thirteen were male and nineteen were female. In terms of ethnicity, all thirty-two were white. Whilst this was a concern, it is hard to gauge how much of a problem it was because of the aforementioned lack of awareness of the characteristics of medicinal cannabis users overall (although the researcher feels relatively safe in estimating that they are not an exclusively white group). Of the thirty-two participants, by way of occupation or previous occupation, six were working-class, consisting of three lower working-class (unskilled or semi-skilled manual) and three upper working-class (skilled manual labour); twenty-six were middle-class, consisting of ten who were lower middle-class (routine non-manual), fourteen middle middle-class (occupations intermediate between the routine non-manual and the professional) and two upper middle-class (professional). Similar concerns and lack of knowledge about the overall characteristics of the social class constituency of medicinal cannabis users exist as were discussed above in relation to the ethnicity of the sample.

Of the thirty-two participants, two were aged below thirty, eight were aged between thirty and forty, fourteen were aged between forty and fifty, six were aged between fifty and sixty and two were aged over sixty, the mean age of participants being 44.5 years of age. Of the thirty-two participants, one had not completed compulsory education, eleven had completed compulsory education only, eight had some post-

compulsory education, nine were university graduates and three had post-graduate qualifications. The sample also covered a broad range of forms of chronic illness (some of which may or may not lead to impairment) and types of impairment. The most common forms of chronic illness were multiple sclerosis (fourteen participants) and various forms of arthritis (eight). Other chronic illnesses and / or forms of impairment that participants had included myalgic encephalopathy (chronic fatigue syndrome), respiratory and muscle weakness, orthopaedic problems, congenital fibromyalgia, spondylitis, cerrebellar ataxia and spinal chord injuries.

The interviews

Thirty-three participants were interviewed. After this point, no more participants were sought as it was felt by the researcher, and the directors of the research, that 'saturation' had been reached (participants were no longer telling us anything new). At this point recruitment was discontinued.

Of the thirty-three participants interviewed, all but two were interviewed in their homes. There were various reasons for this, some of a more practical nature, some more ethical concerns and some methodological. The practical reasons related to the obvious mobility issues that many of the participants had, which made it easier for the researcher to go to them rather than vice versa. The ethical reasons were related to this, in that it would be ethically questionable to expect some participants to make what could be an unreasonably difficult journey. It would also be ethically questionable on the grounds of expense. Whilst expenses can always be refunded, this

assumes that the money is easily available in the first place; however, the majority of participants were unable to work, so this might not have been the case. It is also a fair question to ask why the participants should have been expected to spend their time travelling when it was ultimately the research team who would benefit most from the research. In methodological terms, the broad principle that people feel more comfortable in their own homes and would therefore make better interviewees was employed. As some of the questions could be seen as being reasonably 'sensitive' (for a very interesting discussion on 'sensitive research' see Lee (1993)) it was also assumed that fuller and franker discussion would be likely to occur wherever participants felt most comfortable (Lee, 1993).

The interviews lasted between 90 and 180 minutes and were conducted in a relaxed and friendly manner in an attempt to make the participants feel as relaxed as possible. Typically these interviews were conducted in a living room with a cup of tea or coffee. The interview schedule was constructed in relation to the aims of the original research project described above. It was a semi-structured, in-depth, qualitative interview schedule, a copy of which can be seen in Appendix A. Interviews were tape-recorded (after participants had been asked if they were comfortable with this). In line with ethical requirements, participants were told that they had every right not to answer any particular question or to terminate the interview at any point and were told that personal details would be held securely and used in an anonymous way.

It is possible that, to some extent, the initial telephone conversations with participants could have shaped expectations about the research and influenced what was or was not said in the interviews. It is also possible that individuals who were recruited by

way of the 'snowball' sample could also have had their expectations influenced by conversations with those that referred them to the study. The discourses produced in the interviews may have been influenced by this to some extent, but the researcher did attempt, during the initial pre-interview telephone conversations, to avoid expressing opinions about the issue of medicinal cannabis use where possible, although at the time this was more in relation to the interests of the original research project as opposed to a concern about shaping discourses in relation to the PhD thesis (the focus of which, at that point in time, was yet to be determined).

It is also the case that the social dynamics of the actual interview itself would have had some influence in shaping the discourses of the participants. However, the same friendly and relaxed approach to interviewing was employed with all participants and the same questions were asked in each interview. Where the semi-structured approach does allow for elaboration in the interviews (something which is of significance in later chapters) and elaboration is at times the outcome of the co-construction of interviews between interviewer and interviewees, such elaboration is initiated by the interviewee having something to elaborate on in the first place. It is also important to note that elaboration does not just occur by way of unplanned questions being asked by the interviewer, it most often simply occurs in more elaborated answers to questions that are planned as part of the interview schedule.

In addition to the possible influences, on the discourses produced during the interviews, of the pre-interview telephone conversations and the actual social dynamics of the interview itself, the 'snowball' sampling approach also influences the discourses of participants in terms of *who* is potentially recruited to the sample and

therefore whose discourse is being produced. Participants who were recruited by way of 'snowballing' often tended, unsurprisingly, to be similar in terms of demographics to those who had referred them to the study. However, of the thirty-two participants, only six were recruited by way of 'snowballing', with four original participants referring one participant each and one referring two. This being the case, there are no large subgroups of participants all recruited having been referred by one participant.

Discourse analysis as method

Having discussed discourse analysis methodologically in the previous chapter and having made certain methodological arguments with regard to this particular piece of research, it is now necessary to discuss the *method,* i.e. the actual 'nuts and bolts' of analysis that will be employed in this piece of research. Discourse analysis does not follow any rigid step-by-step method and in this respect it is similar to other qualitative methods and contrasts with the more fixed and formalised stages of quantitative methods. One commentator on this subject has described discourse analysis as being:

> " ... a fluid, interpretive process which relies on close analysis of specific texts and which therefore does not lend itself to setting up hard-and-fast 'rules' of analysis" (Tonkiss, 1998: 254).

This, however, does not mean that discourse analysis does not or should not seek to be methodologically rigorous. What it does mean is that, like other qualitative approaches, there is often some degree of interplay between data analysis and the formation of research questions, i.e. the process of data analysis itself may lead to

some changes to the research question(s). It is the case that, in this thesis, early areas of interest around why so many participants spoke about 'nature' and 'the natural' so often and the pronounced differences between different participants' discourses increasingly solidified as two of the four major aims of the research.

Transcription

As numerous discourse analysts, e.g. Potter (1996) and Gee (1999), have emphasised, transcription is not a neutral activity. Rather, it is part (often the first part) of the analysis. Transcription is often misunderstood as the act of listening to what is held on some form of audio storage and simply reproducing it by way of typing. However, transcription actually *produces* the object of analysis as it involves the production in text of a particular version of the data, previously stored in audio form. The decision about whether to transcribe in full or in part and whether to employ a complex transcription system, such as Jefferson transcription (named after Gail Jefferson who developed it) or not, is, as Gee (1999) argues, a matter of the aims of the researcher. Generally speaking, the finer the analysis needs to be, the more transcription detail is required. If a researcher were interested in the most minute details of speech then a complex system like the Jefferson transcription system would be beneficial. However, this does tend to lead to a loss, or at least slowing down, of readability. This is evident in the following example, taken from Hepburn (2004):

1. CPO: Is that o[↑ka:y.]
2. Caller: [Fine.] =yes.
3. [°that's fine.°]
4. CPO: [↓Brilliant] okay,
5. Caller: °.Hh° (0.2) u:m (0.1) >I'm sorry

6. I'm a little bit< emo:~tional

This example gives information about intonation, rising and falling pitch, pauses and emphasis and all of this information would be very useful if the researcher's aims necessitated knowing all of this, but it is not easy to read. Many discourse analysts are more usually interested in a far broader analysis and for these purposes this amount of detail is unnecessary. This research is interested, or slowly became interested, in how participants talked about medicinal cannabis use, accounting for the differences between different participants' accounts, in the significance of discussing 'nature' and 'the natural' when talking about cannabis and considering the consequences of this for the contestation that occurs around medicinal cannabis use and the potential of different types of discourse for affecting some level of policy change. This being the case, the decision was taken to adopt a simple approach to transcription that maximised readability. The researcher takes the view that this produced the most usable version of what was said in the interviews in relation to the particular aims of this thesis. At times, excerpts from participants' interviews will also be reproduced in a way that highlights certain parts of the account using italicisation. This is done to draw the reader's attention to the parts of most interest and does not indicate any aspect of intonation, volume or any technical aspect of speech.

Analysis

Perhaps the first point to make about the analysis was that the researcher took the decision not to use one of the many pieces of software available for qualitative

analysis. Having undertaken some training on their use, the researcher was of the opinion that whilst they are valuable in many ways, they do tend to distance the researcher from the data. With discourse analysis relying on a deep immersion in the data, this seemed to be a disadvantage that outweighed the advantages of computer-aided analysis. The decision was therefore made to employ a paper-based approach.

The first stage of analysis (transcription) has been described already. As was argued above, this process of *production* cannot be viewed as a neutral exercise. It involves certain choices about how to represent data and to some degree decisions about content. In this respect, a certain *version* has already been *produced* (because with different decisions the transcripts could be different in various ways). Reflexivity is therefore required at this stage, as at others, because such choices may have important implications for the research even at this stage, when none of the later analysis (described below) has been done.

After the transcription had been done, it was important to familiarise oneself with the data by reading and re-reading it. Immersion in the data is common to discourse analysis (Gill, 1996) and is an integral part of the analytical process. An 'initial pass' over the transcripts was conducted, which involved reading and re-reading them, listening to the tapes again and starting to form some initial ideas about what participants were saying and any patterns that might exist within and between accounts.

The next stage of the analysis involved the production of 'participant categorisation information' forms (see Appendix B). The single side of A4 forms acted as a

summary of the most significant biographical information about each participant. This was the first step in terms of engaging with a huge amount of data and a reasonable number of participants and being able to produce a sense of who was saying what and differences between the participants that might help to understand their accounts. This stage also involved listening to the recordings of the interviews again, whilst also reading through the corresponding transcripts and noting down anything that seemed particularly interesting. At this stage, the thesis' aims were still quite open, so this noting process was fairly inclusive.

This 'initial pass' through the data drew attention to the presence of certain areas that the researcher found interesting and, in turn, this helped to begin the precise solidification of research aims (although it was clear from fairly early on in the process that medicinal cannabis use involved issues of power and contestation and that the ways in which medicinal cannabis users spoke about it must be of significance to this in certain ways). Notes from this point of the analysis show an early interest in the presence of the following issues within the participant's accounts:

> Talking about 'nature', the 'natural', 'chemical', 'man-made', 'synthetic' and so on.

> The rhetorical importance of articulating discursive oppositions, e.g. emphasizing the 'naturalness' of cannabis as opposed to the 'chemical' constitution of prescribed medicines and the positive – negative connotations that this held for many participants, respectively.

Talking about all manner of issues not immediately and solely relating to personal experience (van Dijk, 2003) of cannabis use.

Given the significant differences in what was said and how it was said between many participant's accounts, these differences seemed initially to relate, in some way, to issues related to social class, educational background, vocational experiences and the general trajectory (Bourdieu, 1979, 1992) of the individual's life, but with complexity and interesting exceptions that would warrant care and reflexivity.

By the end of this initial phase of analysis there was a 'participant categorisation information' form for each participant and a fairly inclusive summary of anything that seemed significant, usually two or three sides of written notes with corresponding transcript page numbers from the relevant transcript which was attached to the form. As well as this, there was also a list of initial areas of interest, as described above.

The next stage of the analysis involved selecting which parts of the data would be analysed. Selection was largely inclusive, reflecting the first aim of the research – how medicinal cannabis users talk about their use of cannabis and related issues (which includes examining what they spoke about in terms of themes and issues raised, as well as how they spoke about it, i.e. an interest in what discursive resources were articulated and which rhetorical strategies were used). This inclusive selection of data was of course made possible by having fully transcribed the interviews, as transcription also has an aspect of selection involved in it (i.e. if full transcription has

not been performed then the data available will be limited to what has been transcribed).

Coding the data also reflected this inclusive approach to the data, in relation to the first aim of the research (the other three aims emerged later, hence the importance of the first aim to the initial analysis). The actual coding was performed using a traditional paper-based approach using printed copies of each participant's transcript and numerous highlighting marker pens. Once the coding of data had been completed, the codes generated, the participants to whom they applied and the location of the passages to which they related within each transcript were recorded on summary sheets. The codes were then organised into clusters of related themes, thereby bringing order to the process of analysis.

The next phase of the analysis was the 'mapping out' phase. 'Mapping out' discourse involves the idea that spoken discourse is particular, occasioned and momentary, but if it is recorded in some way and thereby given (or constructed into) permanence, is something that can be 'mapped.' This methodological view is taken from the influential work of Wetherell and Potter (1992), who argue that:

> " ... discourse does have substance, it is a material which can be explored and charted" (Wetherell and Potter, 1992: 1-2).

The practice of 'mapping out' discourse attempts, as one might expect from the cartographic analogy, to produce a largely inclusive 'map' or an account of what is said by which participants, and to place these within categories that enable the reader (and the analyst themselves) to make sense of the data. This was done by way of

another re-reading of the transcripts as well as the summary notes from each transcript, which led to the production of a list of who talked about what. This in turn was organised by way of its content into chapters that described and discussed what the participants talked about (see Chapters Nine to Fourteen).

Whilst producing this account of the discourses of participants, some guiding principles were employed in the form of questions that the researcher kept asking himself as the analysis progressed. These were:

> How do participants' discourses differ and why?
>
> What are the discourses *doing* (this draws on the notion of discourse as action-oriented, with discourse seen as practice)?
>
> How do the discourses of participants achieve what they appear to be trying to do?
>
> What discursive resources and rhetorical strategies are used to do this (an aspect of this thesis that became increasingly important in an attempt to explain the differences between the accounts of different participants)?

The latter stages of the analysis involved taking the main findings of the 'mapping out' chapters forward into a further, with the solidification of the three further aims:

To account for the prevalence and significance of talking about 'nature' and the 'natural' within medicinal cannabis users' discourses.

To account for the differences between the accounts of different participants.

To address the potential of different 'types' of medicinal cannabis users' discourses in relation to contestation around the use of this substance for medicinal benefit

This stage of the analysis was more inductive than the previous stages, particularly in relation to the emerging understanding of the differences between the discourses of different participants, where the emerging understanding had to be modified on a number of occasions to account for what were 'deviant' cases (i.e. cases that did not 'fit' the understanding at that given point).

The next part of the thesis consists of four chapters that collectively function as a description of the contexts within which the discourses of medicinal cannabis users must be understood.

PART 3 – THE ANALYTIC PRE-STORY

The next four chapters collectively function as an 'analytic pre-story'. Whilst this has been discussed in far greater depth in the methodology chapter (Chapter Three) this draws on Thompson's argument (1984, cited in Wetherell and Potter, 1992) that the analysis should involve three stages, the first of which being:

> " ... a description of the social field, history and social relations relevant to the area of investigation ..." (Wetherell and Potter, 1992).

In doing so, the discourses of individual medicinal cannabis users can be understood not just in the context of the interviews themselves, but also in the broader social context of the discursive contestation around the medicinal use of cannabis. This context involves a particular field (Bourdieu, 1979) of social relations in which the efficacy of cannabis as a medicinally useful substance is contested through different media that represent the arguments by representative bodies of the medical profession, the U.K. government and medicinal cannabis users themselves. Through understanding how the medical field (Bourdieu, 1979) came to be structured as it is, how late modernity is characterised by vastly increased levels of variation of faith and trust in science, technology, government and 'expertise' (Beck, 1992) and how medicinal cannabis use might be seen as part of this, the participants' discourses can be more adequately understood.

CHAPTER 5

A BRIEF HISTORY OF CANNABIS: 'SCIENCE', MEDICINE, SOCIAL ANXIETY, PROHIBITION AND MEDICINAL USE

Of the seemingly multitudinous historical accounts of cannabis use, many cite a long history of cannabis being used in a medicinal way. Some accounts trace cannabis cultivation by humans back to at least 4000 B.C. (China) and medicinal use (China) to 3000 B.C. (Grinspoon and Bakalar, 1993). Other accounts trace cannabis cultivation and use back to a less precise " ... dawn of history ..." (Abel, 1980: 4). Whilst the academic 'quality' of some of these accounts may be debatable, it would appear reasonable to argue that humans have used various parts of the hemp plant for thousands of years (Ashton, 1999) and perhaps as long as five thousand years (Notcutt *et al.*, 2004; ElSohly and Slade, 2005).

Such accounts may be seen as articulating a narrative about an ancient relationship between humanity and the hemp plant, a plant that is seen as a provider of many of pre-modern man's needs, with a certain degree of naïve idealisation around this. Above all, such accounts often suggest that there is something 'natural' about the cannabis-human relationship and that there is an 'ancient wisdom' that has since been lost – see Herer (1995) in particular. This narrative about 'what people knew but have since forgotten' can be understood as part of what Brand (1990) calls the 'modernization critique'. Later chapters will discuss this idea further and will argue that contemporary concerns around conventional medicine, science and 'man-made', 'chemical', 'artificial' (and numerous other ways of articulating what individuals understand to be 'non-natural' products), are in fact part of just the most recent wave

of scepticism and anxiety about modernization and so form a significant part of the social context within which the medicinal use of cannabis by contemporary chronically ill and disabled people must be understood.

From these 'ancient beginnings', histories of the medicinal use of cannabis then cite the *Materia Medica* of the Greek physician Dioscorides in 70 A.D. (Abel, 1980) and later use in folk medicine by the poor of medieval Europe. The church at this time suspected the use of cannabis as an ingredient in the *black mass,* a belief that led to the issuing of a papal fiat by Pope Innocent VIII (Abel, 1980). Accounts also record the use of cannabis by the noted medieval herbalist Nicholas Culpepper (1616-1654) (Blanchard and Atha, 1997) and an inclusion within the *New English Dispensatory* of 1764 and the *Edinburgh New Dispensatory* of 1794 (Abel, 1980).

However, it was not until the middle of the nineteenth century that cannabis became popularly used as a medicinal substance in the West. Prior to this point in time, it was not used with any real popularity (Abel, 1980). The heyday of the medicinal use of cannabis in the West occurred between 1840 and 1900. In this period more than one hundred articles were published detailing its use for various ailments (Grinspoon, 1994). William Brook O'Shaugnessy, an Irish physician, is widely credited as the person who introduced cannabis into Western medicine. In 1843 O'Shaugnessy reported a summary of his observations on the drug during his time in India. This report quickly captured the interest of his medical colleagues in England, who were eager to be supplied with the substance. On his return to England he supplied a quantity of cannabis to the pharmacist Peter Squire. Squire's extract (a tincture) quickly became popular among physicians who began to prescribe it for almost any

physical difficulty, including childbirth, loss of appetite, insomnia, migraine, pain, involuntary twitching, excessive coughing, and menstrual bleeding (Grinspoon, 1994). Queen Victoria's personal physician, J.R. Reynolds, commented, "Indian hemp ... is one of the most valuable medicines we possess" (Reynolds, n.d, quoted in Mather, 2001).

Yet whilst it was very popular with some doctors, others were already experiencing doubt on the basis of its variability of action (Abel, 1980). By 1890 the medical use of cannabis-based medicines was already in decline. Factors contributing to this were; an unacceptable level of the variation of potency in preparations and in responses, the introduction of the hypodermic syringe signalling a rise in the use of opiates in medicine (they are water soluble and cannabis is not), also the development of alternatives such as aspirin and barbiturates hastened the decline of cannabis-based medicines still further (Grinspoon and Bakalar, 1993). Indeed, during the late nineteenth century the attitude towards cannabis-based medicine held by the medical profession was rather ambiguous. Blanchard and Atha comment that some saw it as very useful, some as a form of poison, and some as likely to cause insanity (1997).

Crucial to understanding the waning popularity of cannabis tincture as a medicinal substance in the late 1800's, are the developments of a scientifically based pharmacology over the period of the nineteenth century. In 1800, as Cartwright (1977) remarks, the pharmacopoeia was a mixture of the ancient and the modern. It contained substances such as opium, but also " ... arabs' eyes, pearls, and the 'sacred elixir'" (1977: 134). However, modern pharmacology arose in the early 1800's and transformed drug-therapy from what Porter (1997) describes as the jumble of the

apothecary's backroom to an organised experimental science involving the extraction of active principles from vegetable substances. By 1850, laboratory work had produced a science based around the microscope, vivisection, chemical investigation " ... and everything else measurable, weighable and testable in its uniquely controlled environment" (1997: 320). The scientific principles of precise experimentation seeking causal relationships had been brought to bear on drug-therapy. It will later be argued that it is these discourses and practices that are at least partially responsible for the dominant discursive notion of what can and cannot be seen as a 'medicine' – with cannabis in its raw vegetable form simply not corresponding to dominant contemporary notions of what a medicine is. As an example of this, ElSohly and Slade (2005), who are both research pharmacists, describe marihuana as the "crude drug derived from the plant *cannabis sativa* ..." (2005: 540).

Prior to O'Shaugnessey reporting on his work with cannabis in 1843, the active principles of many of the vegetable substances used in medicine had already been isolated and extracted. Between 1803 and 1804 the crystaline substance later named morphine was refined from raw opium and between 1818 and 1821, strychnine, brucine, veratrine, cinchonine, quinine and caffeine had been refined (Porter, 1997). Within this context of a discourse that formulated the way forward for medicine as being through the discovery and isolation of active therapeutic agents of vegetable substances, the concerns about cannabis tinctures' variations of potency and effect must have made it seem anachronistic by the late nineteenth century. This discourse about medicinal substances having consistent purity, strength and dosage was reflected in the development of pharmacopoeias themselves, as these documents came to have details of preparation, testing and standardised dose (Singer and

Ashworth-Underwood, 1962). In not being able to fulfil the requirements of standardisation that became of increasing significance in scientific pharmacology, it was perhaps inevitable that the use of cannabis tincture by the medical profession would decline.

By 1890, cannabis tincture was already less popular with the medical profession. Whilst in more recent times the legal status of cannabis as a medicine itself and cannabis-based medicines is perhaps more significantly related to social anxieties around the use of cannabis in non-medical ways, as well as racialised and sexualised discourses, it would seem that the waning popularity of cannabis tincture in the late 1800's was less significantly connected to such factors. One of the perceptions on the part of physicians at around this time, that cannabis caused insanity (Blanchard and Atha, 1997), could be related to concerns that its non-medical use in India was having just such a result, even though this concern was disputed by the Indian Hemp Drugs Commission, published in 1890 (Blanchard and Atha, 1997).

At the turn of the twentieth century, recreational cannabis use was simply not an issue of any notable concern in Britain (Shapiro, 1998). During the early 1800's, *The Thousand and One Nights* had been a best seller, and contained *The Tale of the Hashish Eater* that later inspired interest among small groups of romantic artists and poets in France and later England (Abel, 1980), but the prevalence of cannabis use did not reach significant levels until the latter part of the twentieth century in Europe, and the early twentieth century in the U.S. (Bloomquist, 1971). It seems likely, therefore, that the fall from favour of cannabis tincture in medicine during the late 1800's was primarily an issue of it not being able to meet the increasingly important

requirements of predictability and standardization as opposed to it being an outcome of fears around 'recreational' use.

However, social anxieties would come to play a more significant role in cannabis' more recent history. Although it has been argued that such concerns had played a negligible role until the latter half of the nineteenth century, this point in time witnessed an important conceptual change in relation to psychoactive substances. By the end of the nineteenth century, the previously non-existent distinction between drug 'use' and drug 'abuse' had arisen. Moralised discourses about 'addiction' had appeared, and the solution to this 'problem' was the growing trend towards clearer and more enforceable categories and legislation around pharmaceutical substances (Grinspoon and Bakalar, 1993; Morris, 2004). Such concerns and changes in practice need to be seen in relation to the broader changes taking place within the field of health at this time. This period saw the consolidation of the medical professions' near monopoly in the field of health and trends towards the control of drugs were just one part of the overall assertion of control by this profession in the field of health (this is discussed further in Chapter Seven).

However, fears around drug 'abuse' at this time also need to be seen in an increasingly international context (Shapiro, 1998) and in terms of discourses of concern around violence, sex, 'racial' minorities and drug 'abuse'. The common denominator of these themes is of course morality, and it would seem that the advanced industrial nations were struggling to deal with the rapid pace of social change and drug 'abuse' increasingly came to play a central role in the moral anxieties of the day (Kohn, 1992). As the twentieth century unfolded, cannabis would

increasingly become a means by which society, or more specifically parts of society, expressed their social and moral anxieties. As Grinspoon and Bakalar have poignantly commented, "drugs are symbols charged with cultural tension" (1993: 163) a point that has also been made by Szasz (1975). With the passing of international drug treaties, the discourse on drugs in the U.S. was to have a considerable effect on the situation elsewhere. Abel argues that with the advent of large scale Mexican immigration to the U.S., around 1910, ethnic tensions developed, with these immigrants often depicted as being thieves, savages, lazy and irresponsible. When economic depression hit the U.S. in the 1930's, Mexicans were frequently made the scapegoats, and cannabis (or *marihuana* as it became known), became deeply involved in symbolic ways in this persecution. Mexicans were the most conspicuous users of marihuana at this time and sensationalist stories in the American media of how it made them behave insanely and violently were frequent and influential (1980).

The appearance in the U.S. of the heavily racialised term *marihuana* between the late 1800's and the early 1900's is of particular consequence. Mathre argues that cannabis was renamed in order that it could appear as a new scourge (1997). Indeed one may speculate as to whether most Americans knew that this 'new' and 'terrible' threat was in fact the very same cannabis that formed the basis of some medicinal products. Yet O'Leary has argued that it was this 'reefer madness' discourse that successfully eliminated the concept of cannabis as a medicine in the United States (1980).

In the U.K., cannabis became a prohibited substance under the Dangerous Drugs Act in 1928 (due largely to the 1925 Geneva International Convention on Narcotics Control) (Blanchard and Atha, 1997). However, as a crude measure of the prevalence

of cannabis use in the U.K., prosecutions for cannabis-related offences did not surpass those for opium and manufactured drugs in the U.K. until 1950 (Blanchard and Atha, 1997; Shapiro, 1998). Abel comments how at the 1925 convention, pressure principally emanating from the U.S., Egyptian, and South African delegates eventually resulted in the restriction of international trafficking in cannabis except for licensed medical or scientific purposes. Ironically, not all the nations signed the final agreement, among them the U.S. and Egypt (1980). At this point cannabis was rarely used in Europe and Parliament passed the Act more in the interest of opiates and other drugs that it also covered than in relation to a concern about cannabis use in the U.K. (Gossop, 1993).

In the U.S., the Marijuana Tax Act of 1937 imposed a tax of $100 per ounce on any use of the hemp plant other than certain industrial and medical uses. Whilst medical uses were only taxed at $1 per ounce, vast amounts of paperwork were required for such uses, effectively putting an end to the use of cannabis-based medicines in the United States, despite 'protestation' from the American Medical Association. In 1941 cannabis was removed from the U.S. Pharmacopoeia and National Formulary (Grinspoon and Bakalar, 1993). The level of protest by the A.M.A. appears to be disputed in various historical accounts. Whilst Herer (1995) argues (in a rather conspiracy-oriented account) that the A.M.A. had not realised that the 'killer weed' marijuana was the same thing as the medically benign cannabis and had therefore failed to submit adequate protestation, Aldrich (1997) quotes the written protest of the A.M.A., which argued that:

> "Cannabis at the present time is *slightly used* for medicinal purposes, but it would seem worthwhile to maintain its status as a medicinal agent ... . There is a possibility that a restudy of the drug by modern means may show other advantages to be derived from its medicinal use [my emphasis] (A.M.A. quoted in Grinspoon, 1971; quoted in Aldrich, 1997).

Whilst cannabis tincture was finally removed from the US pharmacopoeia as a result of political action seemingly brought about by racialised *marihuana* 'moral panics', it would appear that by this point in time cannabis tincture was not significantly used by physicians anyway. The fall from popularity of this medicinal product has its roots in the late nineteenth century (as has been discussed above), and during the twentieth century the trend was towards synthetic organic compounds and away from crude vegetable drugs and "old-fashioned tinctures and mixtures [that] have become obsolete" (Singer and Ashworth-Underwood, 1962: 679). Such non-synthetic, less predictable medicinal substances were simply seen as old-fashioned, as they did not conform to ideas of what a medicinal substance ought to be. As regards the British context, however, cannabis was still available to the British physician, at this point, in the form of cannabis tincture.

It was not until 1964 that pharmacological research isolated the active principle and elucidated the chemical structure of cannabis (Mechoulam and Lander, 1980). However, although thousands of research papers have been published on the pharmacology of cannabis and cannabinoids since then (Mechoulam and Lander, 1980), it is likely that research in this area has been severely impeded by the social anxieties and legal restrictions that have arisen around cannabis. It is not only the comparatively late scientific pharmacological work on cannabis (remember that the active principles of many other vegetable drugs had been isolated in the first half of

the nineteenth century) that needs to be considered in attempting to make sense of cannabis *vis-à-vis* medicine in contemporary society but also the broader social context of this period. It has been argued above that although cannabis tincture was dropped from the U.S. pharmacopoeia due to legal measures that were a response to social anxieties around its use as a recreational drug, the tincture based medicines were waning in popularity with physicians anyway. Yet whilst the pharmacological work of 1964 allowed the potential for new research into cannabis, cannabinoids and cannabis-based medicines, the 1960's were also a time of considerable social change, and cannabis came to be seen as playing a significant role in these events.

As Bloomquist (1971) argues, cannabis became an important symbol in the clash of values during the 1960's in the U.S. and came to symbolise 'counter-cultural' values and behaviour. One may argue that this is also true to some degree of other advanced industrialised nations at this time as well. Leech (1973) notes how some of those involved in this 'counter-culture' rejected, to some degree, the dominant values of Western capitalism, and turned their backs on violence and wealth. It is interesting to note that the *marijuana* that had previously been constructed within discourses that (mis)understood cannabis to incite violent and sexually deviant behaviour was now seen as a catalyst in the rejection of violence. This 'counter-culture' as it became known may be viewed as one wave of what Brand (1990) has referred to as a modernization critique. The questioning of Western capitalism's values of wealth accumulation and violence (as used by the state) may be seen here. More specifically, in relation to a history of medicinal cannabis use, this wave of modernization critique also ushered in a social mood which increasingly came to value and embrace products and lifestyles that are regarded as being in some way more 'natural'. This social

mood has affected the area of healthcare in the respect that people have increasingly come to embrace alternative approaches to healthcare (Siapush, 1998; Siapush, 1999), approaches that are frequently understood by their advocates as being more 'natural'.

Since the 1960's, research into the medicinal potential of cannabis and its constituent cannabinoids has been hampered by legislation, both in the U.S. and in the U.K. In the U.K., cannabis was classified under schedule 1 of the Misuse of Drugs Act 1971, at which point its' current legal status as having no therapeutic value was reached (B.M.A., 1997: 3), the status it also holds in the United States. As has been argued above, cannabis tincture was viewed as old anachronistic far before this point in time, so the use of cannabis tincture was probably not greatly affected by this legislation anyway. However, research into synthesized pharmaceutical cannabis-based products has been impeded by this legal status, as, in the U.K., medical research involving cannabinoids has required a special licence from the Home Office since 1971. Notcutt *et al.* (2004) have argued that it is only recently that the two issues of medicinal cannabis use and recreational cannabis use have been separated in the minds of the public, the medical profession and politicians and that this has acted to impede medical research into cannabis and cannabinoids.

Unsurprisingly, the predominant form of medical research into the medicinal potential of cannabis and cannabinoids has focussed on producing synthetic medicines that contain one or a number of cannabinoids. This type of research is in line with the general trends that have been discussed above, whereby tincture type medicines and crude vegetable drugs have gradually been replaced by synthetic drugs containing only the active principles (Singer and Ashworth-Underwood, 1962). In

this respect, one could view the more recent development of synthesized cannabinoid drugs as simply being in line with this trend. Whilst morphine had been produced from the raw vegetable material opium at the start of the nineteenth century, synthetic cannabinoid drugs have only been produced post-1964, as this was when the chemical structure of cannabis was finally understood. Admittedly, one might argue, one reason that it has taken longer for cannabinoid-based medicines to 'catch up' with general trends in pharmacology is that legislation has impeded research (perhaps the initial understanding of the chemical structure and work since then made possible by this may both have been possible earlier without such legal obstacles).

Of the synthetic cannabis-based drugs currently manufactured, nabilone can be prescribed to patients in the U.K. with nausea or vomiting caused by chemotherapy if these side effects have proved unresponsive to other drugs. Dronabidol (also known as Marinol in the US) is unlicensed in the U.K. and would require importation on a named patient basis. So the prescription of nabilone for any other purpose than that stated above or dronabidol for any purpose is problematic for the doctor involved as regards avoiding possible charges of negligence (B.M.A., 1997). It is also the case, however, that some studies suggest that cannabis is often more effective than the synthetic T.H.C. medicines which are available in the U.K. and United States (T.H.C. is just one of the many cannabinoids to be found within the hemp plant). Zimmer and Morgan discuss the example of a synthetic T.H.C. capsule called Marinol, which was first marketed in the U.S. in 1986 as an anti-emetic. The authors argue that despite some utility, Marinol had serious disadvantages. It would have cost $5000 for one patient to use it for one year. It also has shortcomings when opposed to natural cannabis when administered by smoking. Orally delivered T.H.C. is slower to take

effect, more likely to yield unpleasant psychoactive effects and for patients who are suffering from nausea and vomiting it is often difficult to swallow capsules without vomiting them back up again (1995). So, whilst this trend towards synthesised cannabis-based medicines seems to be simply in line with contemporary ideas within pharmacology about what medicines ought to be, the synthetic T.H.C. medicines have seemingly made little impact and may be less effective than naturally occurring cannabis.

The last few decades have seen a rise in the number of people using cannabis as a medicinal substance on a self-prescribing basis (Coomber, Oliver and Morris, 2003). This rise in use has been accompanied by a growing public debate around whether or not it should be legalised for medicinal uses. However, responses from the government and the B.M.A. in the U.K. have centred around an alleged lack of 'evidence' as to cannabis' efficacy and safety (Boateng quoted in Nando.net, 1998), the view that cannabis would have to be subject to clinical trials for legalisation to even be considered (Lachman *et al.*, 1998) and various arguments which may be summarised as saying that it is simply inappropriate to consider a plant that people may administer by smoking as a legitimate medicinal substance (B.M.A., 1997).

Whilst in the U.S. in recent years a number of states have voted to allow the medicinal use of cannabis (although such moves have been continually impeded by federal government), there has been no serious consideration of changing the law to allow chronically ill and disabled people to use cannabis legally in the U.K. The only real progress in recent years in the U.K. towards exploring the potential of cannabis and / or cannabis-based medicines has been a renewed interest in producing cannabis-based

pharmaceutical products. Such moves are in line with scientific-medicine's discourse about what medicines should be like and, in line with the trend towards realising this that has occurred over the last two hundred years. This view is exhibited in the B.M.A.'s consideration of cannabis and cannabinoids, which stated that

> " ... it can be concluded that although cannabis itself is unsuitable for medical use, individual cannabinoids have a therapeutic potential ... " (BMA, 1997: 77).

The G.W. Pharmaceuticals research, which began in 1997, produced a patented cannabis-based medicine (a sub-lingual spray) through clinical trials using cloned hemp plants which thereby allowed it to deal with the formerly problematic issues of cannabis' lack of predictability regarding dose, potency and so on. This is merely the latest attempt to produce a cannabis-based medicine that also subscribes to medical discourse's dominant notions of what a medicinal substance should be. The development of this cannabis-based medicine involved acquiring the worldwide rights to cannabis varieties developed by the Dutch company HortaPharm B.V. and the experimental use of cloned plants in the attempt to discover which cannabinoid compositions are more effective. Whilst still not approved in the U.K., the substance, known commercially as Sativex Oromucosal Spray, obtained approval in Canada in 2005 and can be prescribed by a U.K. doctor on an individually named patient basis.

The question now is whether the illegal use of cannabis as a medicinal substance and the attempts to assert the legitimacy of this in a public debate on the subject, have led to a medicalisation of medicinal cannabis use? Have the 'anecdotes' of users, denied as ample evidence to bring about a medical legalisation of cannabis in raw vegetable form, led to a renewed interest in medical research in the area? Has resistance in the

field of health led to the extension of medicalisation? Does the renewal of research into cannabis-based medicines mean that a medical legalisation of cannabis itself is actually now even less likely?

In an editorial of the British Medical Journal in 1998, Robson argued that:

> "The active components of a plant which has been prized as a medicine for thousands of years should not be discarded lightly, and certainly not through political expediency ..." (Robson, 1998: 1035).

This quote is interesting because discursively it employs cannabis' long medicinal history, something which is common to accounts of cannabis' medicinal use that are broadly in favour of its' legalisation for medicinal purposes. However, there is a twist. This argument is not in favour of the whole plant, but only its' *active components,* and Robson (1998) is Director of the Cannabis Research Institute, set up by G.W. Pharmaceuticals (G.W. Pharmaceuticals, 2007). It would seem that those in favour of developing cannabis-based pharmaceutical products have begun to employ similar rhetorical strategies to those who are apologists for cannabis in its raw vegetable form as a medicine. In fact, it would appear that a discourse in favour of synthesized cannabinoid-based pharmaceutical products under the prescriptive control of the medical profession has also drawn inter-textually on certain areas of the discourse of the medicinal cannabis users. However, this is not a one-way scenario, as certain medicinal cannabis users also draw on the discourse of medicine at certain times too (as will be discussed in later chapters).

The current situation regarding medicinal cannabis use in the U.K.

In the United Kingdom, cannabis is controlled as a class C drug under the Misuse of Drugs Act 1971 and research involving the use of cannabis requires a special licence from the Home Office. It is speculated that cannabis is by far the most popular of the illegal drugs used in Britain. It is estimated that nine million people in the U.K. aged 16-59 have tried it at least once in their lives (Roe, 2005). However, a growing number of people also report obtaining medicinal benefits from its use. Anecdotal reports, and in some instances scientific 'evidence', indicate that it may be used as an appetite stimulant, as an anti-emetic, as an anti-spasmodic, to relieve intraocular pressure, and to relieve pain. Among the users are:

People with spinal cord injuries. Anecdotal reports indicate that cannabis is effective, for some people, in reducing muscle spasticity and that it may also improve bladder control and bowel movements (McBee, 1988; Bransetter, 1988).

Cancer patients. Cannabis reduces nausea and vomiting associated with chemotherapy (Chang *et al.*, 1979, cited in Zimmer and Morgan: 1995) and stimulates appetite, thereby helping the patient to combat weight loss and to retain strength (Dunsmore III, 1990).

People with multiple sclerosis. Cannabis has been reported to be successful in relieving, in varying degrees, vomiting, headaches, fatigue, muscular spasm, convulsions, and weight collapse (Cover, 1988; Ware *et al.*, 2005).

Glaucoma sufferers. Cannabis has been shown to be effective in lowering intraocular pressure in the eye (Hepler and Frank, 1971, cited in Zimmer and Morgan, 1995).

HIV / AIDS patients. It has been argued that cannabis is effective in combating nausea and vomiting associated with both the disease and AZT drug therapy and that it stimulates appetite, thereby allowing patients to gain weight and strength (Zimmer and Morgan, 1995; Ware *et al.*, 2005).

Accounts of the experiences of therapeutic users are actually fairly numerous. Such accounts, from American users, have been central to a number of publications edited by R.C. Randall of the Alliance for Cannabis Therapeutics. Many of the accounts were actually affidavits for court hearings connected to attempts to make cannabis available as a medicinal substance in the United States. So far, it seems that the experiences of British users are mainly documented on the internet, in newspapers (see also Chapter Fifteen) and in magazine articles.

As has also happened in the United States, some medicinal cannabis users in the U.K. have organised themselves into co-operatives to organise the supply of cannabis and to approach medicinal cannabis use as a political issue. It would appear that at least some of these groups have drawn on the experience of similar groups in the U.S. and one such U.K. based group, the Alliance for Cannabis Therapeutics, has named itself after and aligned itself with the group of the same name that was started in the U.S. Members of such groups in the U.K. have appeared on various television programmes as well as having written and featured in numerous newspaper and magazine articles. As a result of this, the issue of medicinal cannabis use has become more visible.

There is also some evidence to suggest that the medicinal use of cannabis by chronically ill and disabled people is viewed sympathetically by many members of the general public and interestingly by many doctors as well. Whilst cannabis is legally defined as a drug with no therapeutic value, many members of the public clearly have a very different view of the subject. On July 27th 1998, the B.B.C. television programme *Watchdog Healthcheck* conducted a telephone poll asking whether or not cannabis should be legalised for medical purposes. Of 42,000 callers, 96% said yes (BBC Online, 1998). In a survey of U.K. hospital doctors, Meek found that 74.4% of those asked believed that:

> "cannabis should be available on prescription ... for proven therapeutic reasons such as the relief of pain or the side-effects of clinical treatment such as chemotherapy." (1994: 15).

Whilst initially this could be interpreted as indicating that doctors are also becoming more sympathetic to the medicinal use of cannabis in certain specific instances, Gray cites a B.M.A. survey conducted in 1974 which also found 74% of doctors asked to be in favour of cannabis being available for "proven therapeutic reasons" (cited in Gray, 1995: 773). On the basis of these two polls it would, at least initially, appear that British doctors have largely been in favour of cannabis as a medicinal substance, since it was removed from the formulary in the U.K. in 1971 (Ashton, 1999; Notcutt *et al.*, 2004). The attitude of doctors towards the therapeutic use of cannabis may be a complex one, with formal and informal facets, but there may be good reason to believe that many are in favour of its use at least in certain specific situations. However, the B.M.A. does not share this position and neither does the British

government. Interest in cannabis' medicinal potential elicited the response, in 1998, from the minister for home affairs, Paul Boateng, that:

> "to allow any substance, not just cannabis, to be prescribed without adequate proof of its effectiveness and safety would be a highly irresponsible and retrograde step." (quoted in Nando.net, 1998: 1).

The government has also shown no signs of changing its mind since then. Representative bodies of the medical profession also share this position. A joint report by the Royal Society and the Academy of Medical Sciences (written for the 1998 House of Lords Science and Technology Select Committee inquiry into the use of cannabis and its derivatives in both medical and recreational settings) also notes that:

> "the risks and benefits of using cannabis ... need to be properly evaluated. ... Until such studies have been made, there is no persuasive case for the non-experimental medical use of cannabis." (Lachman *et al.*, 1998: 4).

Yet conducting studies into the safety and efficacy of cannabis as a medicinal substance has been hampered by its schedule 1 classification, under which a special licence is required from the Home Office before pharmacological research may be carried out (Gray, 1995). This is also the situation in the U.S. with the Food and Drug Administration (Grinspoon and Bakalar, 1995). It is therefore the case that the type of research which would be required in order to change this situation is less likely to be carried out and a 'catch twenty-two' situation exists whereby cannabis' legal status hampers the research which could change its legal status. The B.M.A. recognises this and even notes that this has probably led many people to break the law out of desperation (B.M.A., 1997). As of February 1998, six Home Office licences were in

existence permitting research using cannabis or prohibited cannabinoids. Three had lapsed, one had no ongoing work and two were testing cannabinoids. None were testing cannabis (GMCDP, 1998). As of June 2007, there were still only six licences in existence in the U.K., again with none of them testing cannabis itself for medical usage (personal communication with Home Office, 2007).

Whilst research into synthetic cannabinoids and cannabis-based medicines continues, the medicinal use of illicit cannabis remains illegal. Such cannabis is still regarded as having no medical use by the B.M.A., who recommended further research into synthetic cannabinoids and cannabis-based medicines but not into the medicinal use of cannabis itself (B.M.A., 1997). The Alliance for Cannabis Therapeutics has called for:

> "medical preparations of natural cannabis ... to be made available on a doctor's prescription whilst research is going ahead" (A.C.T., quoted in House of Lords, 1998: paragraph 7.11).

However, this has not transpired and medicinal cannabis users are still potentially subject to prosecution. Between 1996 and 1998, at least fifteen people were charged with cultivation, possession and / or supply (House of Lords, 1998: paragraph 7.2) and numerous other cases have since been taken to court (typically for cultivation and intent to supply).

Many disabled people and chronically ill people who use cannabis medicinally argue that it is not only the case that cannabis is effective in helping them (Coomber, Oliver and Morris, 2003; Ware *et al.*, 2005) but also that cannabis is the only substance which they find to be effective (Coomber, Oliver and Morris, 2003). In contemporary

Britain, as in many other parts of the world, healthcare is administered by various professionals and professional bodies. With obvious exceptions (e.g. paracetamol for headaches, cough mixtures, and so on), individuals do not self-administer medicinal substances. It is, however, the case that this is a relatively recent state of affairs. Medicinal users of cannabis self-administer a substance which they believe to be highly effective, but which they possess and obtain / cultivate under the threat of criminal prosecution. This situation, in which individuals in contemporary British society are barred from self-administering what they see as a medicinally efficacious substance, is a consequence of certain historical developments around the professionalisation of healthcare.

A brief analysis of these developments and the social and power relations that they have brought about will be undertaken in Chapter Seven, as this is the macro-context within which the struggle around the medicinal use of cannabis takes place. Meanwhile the next chapter will discuss how contemporary society is increasingly characterised by a tendency to critically reflect upon various forms of authority, that are key to modernity, and to exhibit an increasing variability in the trust that it places in them. Subsequent chapters will argue that this critique manifests particularly strongly in the field of health and that such issues are a key part of the context within which the medicinal use of cannabis must be understood.

CHAPTER 6

THE MODERNISATION CRITIQUE AND THE 'CHALLENGE TO AUTHORITY'

Introduction

This chapter will argue that contemporary late modern society is characterised by a heterogeneous challenge to authority, in which many in society have an increasingly variable faith in many of the key institutions of modernity such as science, technology, government and 'expertise'. The two chapters that immediately follow this one will employ these ideas in a more specific discussion of the field of health and the medicinal use of cannabis.

Contemporary society and the critique of modernization

In the post-WW2 period, industrial (and later post-industrial) societies have undergone significant changes in the social, cultural, political and economic spheres. Different social theorists have taken these changes to suggest different things, with some arguing that such societies have entered, or are about to enter, a qualitatively different stage in their histories and others arguing that the contemporary period simply represents a maturing of tendencies inherent within capitalism and modernity. As Miles (2001) observes, different theorists sometimes note the same or similar aspects of change (effectively talking about the same thing), but understand them differently, leading to a gross lack of consensus about how we might understand

contemporary societies like the U.K. and societies at a similar point of their development. Leaving debates around this to one side, recent decades in these societies have exhibited trends towards greater diversity, new lines of social fragmentation, changes in the 'roots' of social conflict, and a more pluralist context in general (Barnes, 1996).

These changes in such societies are reflected in (as well as also being the product of) changes in the nature of political participation (Ainley, 1993). In Britain, as in other nations, the last few decades have seen a 'new' kind of politics in which a heterogeneous collection of social issues have become the basis for 'new' forms of political action. Many people have become less interested in mainstream politics, whilst some have become more interested in a 'new' single-issue politics (Byrne, 1997). Unconventional forms of political action have accompanied 'new' political issues. The post-WW2 period has seen student movements occupy university campuses, peace camps near to nuclear weapons bases, environmentalists protesting the destruction of woodlands by staging tree 'sit-ins' and medicinal cannabis users presenting the Queen with a cannabis plant posy. These movements are not revolutionary, but may be seen as being part of a growing demand that democracies open up the political process to a wider set of interests and issues (Dalton *et al.*, 1990).

Whether the civil rights movement in the U.S. or the student movements of the 1960's are seen as the first social movements of the latter part of the twentieth century (and opinion here is divided on issues of definition which need not detain us), the most industrialised nations had reached a position of relative affluence and

economic security by the early 1960's. However, a significant sized minority did not embrace this situation but began to question it. They wanted more involvement in politics without deferring to established leaders and institutions and they also came to question some of the outcomes of economic growth (Beck, 1992; Byrne, 1997). Having said this, there were also social groups who engaged in forms of political action because they were still marginalized from this increasingly affluent society in one way or another (e.g. black people, women, disabled people).

The rapid expansion of higher education in the Western democracies since the early 1960's seems to have played a role in these events. Much of the protest against the Vietnam War coalesced around universities and the protests and unrest of May 1968 in France involved students first of all (Byrne, 1997). It may also be argued that the growth of higher education within society may lead to a growth of critical thinking and questioning of authority (with the relationship between educational background and discursive capital being important to later analytical chapters of this thesis).

Whilst the student movement began to fade within a fairly short period and had been less radical in Britain (Byrne, 1997), it may be seen as significant in having instigated a broader wave of social change within nearly all of the advanced industrial nations (Dalton *et al.*, 1990). In its wake, a range of new social issues arose as the basis for social movements. These movements were able to draw on a mixture of radical ideology and 'new' forms of political action, which had arisen within the protests of the student movement and other movements of this period (Byrne, 1997) and these ingredients have been employed by numerous movements since then. However, the novelty of these social movements, and to a degree the novelty of the forms of action

that they have employed, is questionable. The concept of New Social Movements (N.S.M.'s) originated among German social scientists in the 1980's (Brand, 1982; Brand *et al.*, 1983; cited in Dalton *et al.*, 1990), but whether there is anything particularly 'new' about them has been a matter of some debate.

In some respects, the sharp break in terms of 'the political' that is located somewhere between 1945 and the 1968 (and is therefore not so 'sharp') may be over-emphasised. Brand (1990) has argued that three waves of cultural criticism swept Europe and the U.S. in the nineteenth and twentieth centuries, and cites English and American peace societies of the early 1800's and the women's movement of the late nineteenth and early twentieth centuries as examples of non class-based social movements that employed non-conventional forms of political action. Having questioned the novelty of these N.S.M.'s (at least in absolute terms), Brand (1990) argues that different social moods suit different social movements and that the 1960's witnessed a revival of the social mood that had twice previously swept the U.S. and Europe in the nineteenth and twentieth centuries. Speaking of this 'social mood', Brand (1990) has employed the term 'modernization critique', and has described it as:

> " ... a heterogeneous pattern of critique of fundamental aspects of modern life ..." (1990: 28).

This critique has been heterogeneous in pattern as it has involved various issues and various social groups and would appear to be consistent with many of the recent social trends that have led theorists to argue that advanced industrialised nations are entering a qualitatively different period.

In summary then, advanced industrial nations have witnessed significant changes in their social, cultural, economic and, as discussed above, political spheres. Some theoretical questions remain about the novelty of what have been labelled as New Social Movements, but these need not concern us here. What is important is that these advanced industrial nations, including Britain, have witnessed broad, as well as specific, challenges to authority and to its associated discourses. People have increasingly wanted a say in how society has been run and have increasingly felt confident in pursuing it around a variety of issues and in a variety of ways.

Brand (1990) has argued that the revival of social movements since the 1960's (new or otherwise) that was born out of a revival of currents of modernization critique which:

> "... shattered the technocratic consensus of the post-war decades" (1990: 33).

Byrne (1997) notes that by 1970, people in Britain had become significantly less deferential towards established institutions and practices, wanting more opportunities to participate in decision-making. What is apparent is that a significant part of the population were asking critical questions about various issues in society and that authority in whatever shape was increasingly subject to questioning.

One of the obvious questions that relates to this discussion, as far as this researcher is concerned, is to what degree are individuals from different social backgrounds capacitated and disposed to critically engage with dominant institutions and their discourses? What is the relationship between the unequal distribution of material and

discursive resources and the ways in which people might be able to engage with talking about an issue that affects them? This is a very important question in relation to one approach to how societies, such as the U.K., are now changing, which is associated most strongly with the work of Beck (1992) and Giddens (1990; 1991; 1999) and which is very insightful in relation to the issue of medicinal cannabis use and how individual users might reflect upon and talk about the issue.

Whilst Brand (1990) has argued that there have been 'waves' of modernisation critique during the nineteenth and twentieth centuries, Beck (1992) and Giddens (1999) take such ideas much further and have argued that such critical reflection upon the affects of modernisation now characterises a new and distinct form of modernity. They argue that this is not a post-modern age, but an age of reflexive modernity (Giddens, 1990; Beck, 1992) in which the risks produced by modernisation increasingly come to preoccupy the thinking and behaviour of individuals. In terms of the issues that the two authors engage with that are more relevant to this thesis they have argued that:

- Such societies are not necessarily riskier than those that preceded them (Beck, 1992; Giddens, 1999), but the risks that are increasingly reflected upon by such societies tend to be of a different kind, i.e. manufactured risks (e.g. iatrogenic medicine, pollution, global warming) as opposed to external risks (although manufactured and external risks are sometimes related, e.g. external risks such as hurricanes may be increasingly common because of environmental damage).

- There has been erosion of faith in the modernisation project, a similar argument of course to that made by Lyotard (1987), and an erosion of trust in science, technology, government and 'expertise' (with the erosion of faith in all of these being exhibited in talking about the medicinal use of cannabis by the participants in this thesis).

- The media play an important role in the circulation of meaning in relation to such issues with stories about B.S.E., cloning, dangerous medicines, how the latest foot-and-mouth outbreak originated from a government research laboratory and so on. In what is argued to be a reflexive modernity, much of this reflecting occurs in the media and Beck (1992) argues that because most manufactured risks generally remain invisible (although not all do) they tend to be visible only in knowledge; hence science and the media construct and contest risk.

- Both authors see such reflection on the consequences of modernisation as not in opposition to it but as part of a new reflexive modernity. For Giddens:

> "... reflexive modernisation ... implies coming to terms with the limits and contradictions of the modern order (1999: 6).

For Beck, critiques of science, technology and 'progress' are not contradictory to modernity but are expressions of the risk society and of reflexive modernisation (1992), since different people occupy different risk positions. These risk positions can be related to class positions but can also be independent of them, with risk having the potential to affect everyone and anyone (this being a part of his

argument for individualisation). This thesis will explore how different participants articulate risk type ideas in relation to medicinal cannabis use.

- Both Beck and Giddens argue that reflexive modernisation involves a significant change in relation to the nature – society relationship, in the respect that it is this relationship that increasingly involves more reflection. For Giddens, the risk society involves a change from thinking about 'what nature might do to us' in terms of harms, to 'what we might have done / might still be doing to nature' in terms of harms (and of course in turn, what this damage to nature might end up meaning for humanity) (1999). Beck (1992) discusses how nature has gone from being the 'other' of nineteenth century thought (something to be subdued) to a situation in which:

> "... violations of the natural conditions of life turn into global social, economic and medical threats to people ..." (1992: 80).

Conclusion

Later chapters will explore how these issues are articulated within the discourses of the participants, although this happens in far from uniform ways. Whilst, as Savage has argued, the notion of the individual within reflexive modernisation is probably more accurately a representation of a particular social class fraction, the cosmopolitan university educated new middle classes (2000) (and discussion in later chapters will provide empirical support for this belief), it should be remembered that Beck (1992) often appears to be talking about the risk society as a set of still emerging tendencies.

a dawning epoch, not one that we as yet occupy. However, in differing degrees, participants who reflect upon the risks of prescribed medicines, may be sceptical about the medical profession, science and the government and those who argue for a 'natural' substance (cannabis) as being innately efficacious in addressing their symptoms are most definitely to be found in the analytical chapters of this thesis. The ideas of Giddens (1990; 1991; 1999) and Beck (1992) are certainly not unproblematic, but they provide a helpful context to this work. The next chapter considers these ideas within contexts particular to the field of health.

CHAPTER 7

THE MODERNISATION CRITIQUE AND THE FIELD OF HEALTH

Introduction

This chapter will argue that the increasingly variable trust in institutions such as science, technology and 'expertise' that is characteristic of the contemporary period (Beck, 1992; Giddens, 1999), as well as the broader tendency in society to challenge authority, are both strongly manifested within the field of health. The reasons for this are fairly simple; scientific medicine is an area in which science, technology and 'expertise' are all involved, it is an area on which many media-produced stories concentrate and it is through encounters with the practice of medicine that the public are most likely to come into contact with science, technology and 'expertise' the most and experience them most immediately as they act on the body. This chapter will also discuss some of the more particular issues that relate to the participants in this research (chronically ill and / or disabled people who use cannabis medicinally) in terms of their positioning in relation to the medical profession and other related issues.

Health as a field of power relations

In order to provide a satisfactory account of the rise of scientific-medicine as a profession that has come to establish itself in a dominant position within the area of

health provision and to adequately situate social practices within their broader social contexts, some level of theorisation about how that field is structured is required.

This thesis draws on the work of Bourdieu (1979) who saw the transition from traditional (pre-modern) society to modernity as characterised, in terms of social structural change, by the emergence of numerous relatively autonomous *fields* (fields of power relations) (Bourdieu, 1979). This conceptualisation allowed Bourdieu to account for, and to provide an analysis informed by, the observation that modern societies are composed of various spheres (or fields) that seem to exhibit a relative degree of autonomy from the state and prevailing economic relations of production. The concept of field allowed Bourdieu to analyse social practices that occur within certain spheres of social life in relation to a more specific understanding of the prevailing relations that exist within a specific sphere (which, due to the assumption of relative autonomy, may be different to other areas of social life) and the more localised details of the symbolic and material conflicts that characterise that particular field at any given moment.

This thesis uses these ideas to understand the contestation around medicinal cannabis use as taking place within a particular field of relations (the field of health) that is dominated by the medical profession in terms of dominant discourses and practices, although, as in all fields, domination is not uncontested (Bourdieu, 1979). The next section will briefly describe how the scientific-medicine profession came to occupy a position of near monopoly in terms of its dominance within the field of health, but more importantly how this position is increasingly subject to considerable critique.

The Rise of the Medical Profession ...

The near monopolisation of health by the scientific-medical profession, which is a feature of contemporary British society (and large parts of the rest of the world) and probably appears to be a given to most members of society, is actually a comparatively recent development. In his book *Medical Ethics*, Dr. Thomas Percival presents a picture of medicine in the early nineteenth century that Porter describes as:

> " ... traditionally small-scale, disaggregated, restricted, and piecemeal in its operations" (Porter, 1997: 628).

Porter then comments on just how much the scientific-medical profession has grown within the last two hundred years by comparing medicine to the military 'machine' or the civil service (Porter, 1997). It is in fact only since the late nineteenth century that it has held a near monopoly over health.

Public healthcare arose in England as a response to the concerns around rapid industrialisation (Fee and Porter, 1994), and it is the case that as late as the eighteenth century most people self-medicated or simply changed their lifestyle when ill, but did not seek the help of medical practitioners (Porter, 1992; cited in Lypton, 1995). It has been argued (Freidson, 1970; Lypton, 1995; Porter, 1997) that the relationship between the state and the medical profession is one of the major factors in an explanation of its rise to the near monopolization of health. The medical profession had been patronized by the social elite from the time of the middle ages (Freidson, 1970), and with the rise of the state in the seventeenth and eighteenth centuries,

medicine's influence began to grow (Lypton, 1995). This influence grew because of concerns around rapid industrialisation and the accompanying social changes (Fee and Porter, 1994), the belief among the social elite and the state that the medical profession were the most skilled of the competing groups in health provision (Freidson, 1970), and legislation around who may practice within the area of health which effectively enshrined the near monopoly that we see today in law, but which did not occur in Europe and North America until the twentieth century (Freidson, 1970).

In the nineteenth century, national associations of the medical profession were established in England and in other countries (Freidson, 1970). In England, The Provincial Medical and Surgical Association was founded in 1832, and in 1855 this organisation became the British Medical Association (Porter, 1997), the organisation that presides over the medical profession in the U.K. to this day. However, whilst state legislation gave the medical profession its monopoly and the occupation's representative body played an active role in this, if the medical profession had not been seen as scrupulous and effective within the area of healthcare then one might reasonably wonder how their position of dominance was obtained. It has been argued above that the medical profession was patronised by social elites since the middle ages, but this does not explain why, even with a monopoly, they would suddenly become patronised by the population in general, because if they were not believed to be effective then, alternative choices or not, why would people have consulted them?

The answer to this question is to be found in the medical profession's increasingly scientific basis over the nineteenth century and since. It can be argued on two levels

that this was of great significance in its rise to power. On the one level, medicine, it can be argued, became vastly more effective in treating illness when it 'discovered', or came to see, that diseases have specific causes that can be treated. On the other, and perhaps more significant level for this analysis, the growing scientific basis of medicine is important because people came to believe that it was more effective. The point here is that whether it was more effective or not, or whether we might believe that it was more effective or not, the population and the powerful within society came to see it as such, and behaved accordingly – with the latter legislating in its favour.

During the nineteenth century, medicine came increasingly to have a scientific basis. Examples of such changes are the discovery of the cellular structure of plant and animal life in 1838, by Schleider and Schwann, the origins of antiseptic surgery in the 1860's and of bacteriology in the 1870's (Weindling, 1994). During this period, illness and the body were reconceptualised. Symptomatic treatment was replaced by the knowledge and treatment of causes (Freidson, 1970). The doctor of 1800 could relieve the symptoms of some illnesses but could not treat the causes of them, as at this point they were unknown (Cartwright, 1977). With the invention of the microscope came the discovery of the cause of diseases such as cholera, tuberculosis and typhoid. Such discoveries, understandably, glorified the progress of scientific-medicine (Rosenberg, 1988, cited in Lypton, 1995). As Freidson comments, the:

> " ... distinction between physician and so-called quack needed no longer to rest on the academic certification of the superiority of one superstition over another (1970: 16).

Scientific medicine could now offer evidence, or make the argument, that it was superior to its competitors.

What must have appeared to be the unlocking of the secrets of scourges such as typhoid, tuberculosis and cholera, must surely have contributed to the belief that scientific-medicine was not only superior to its competition, as well as contributing to the narrative of medical-science and its personnel as heroes, and occasionally heroines (when the contribution of women was recognised) in the 'fight' against disease. To repeat the point made previously, whilst scientific-medicine with a causative model may be argued to be more effective, it is perhaps of more significance that, whether or not this is true, it came to be *seen* as such. One of the central factors within an explanation of the rise of the medical profession has to be the perception that it was the superior provider of healthcare and that it was effective in this role.

Mass education, which was arising at a similar historical point, was also an important factor in the rise of the medical profession, because it was through mass education that the general population developed knowledge and beliefs that were more similar to those held by physicians (Freidson, 1970) and that, presumably, the public were therefore more likely to see them as credible.

... and struggle within the field of health

However, the field of health has not escaped the increasingly variable levels of trust in key institutions of modernity such as science, technology and 'expertise' that are characteristic of the contemporary period (Beck, 1992; Giddens, 1999), as well as the

broader tendency in society to challenge authority that is strongly manifested within the field of health. As Porter (1997) notes, from the inter-war years until about 1970 patients (broadly speaking) regarded the medical profession as benign and the populace generally wanted more of the profession. Yet this was to change from about 1970 onwards. As Porter comments, the twentieth century closed

> " ... with the ownership of the body and the right to speak on sickness **profoundly contested** [my emphasis]" (1997: 708).

By the 1970's there was a growing part of the population who were no longer convinced that scientific-medicine was the best, or only, approach for dealing with illness (Porter, 1997). It is perhaps the case that the population, or at least the better educated fraction of it, living in a media-saturated society that was becoming increasingly sceptical about medicine as one aspect of science, was unlikely to remain as enthralled with scientific medicine as they perhaps once were. Their scepticism was heightened by the growth of pharmaceutical monopolies and associated scandals from thalidomide onwards. This is even more likely to be true of those who suffer from some form of chronic illness, in relation to which the limitations of scientific-medicine are more apparent.

However, this questioning of scientific-medicine is nothing new. Porter (1997) argues that nineteenth century religious non-conformity and political radicalism often meant an allegiance to alternative medicine. He also notes how such tendencies were mirrored in the counter-culture of the 1960's and 1970's, in an argument reminiscent of Brand's (1990) idea that waves of modernisation critique can be detected in Western history of the last two hundred years. Yet the more recent 'wave of critique' (Brand, 1990) may perhaps be distinguished due to its more intense critique around

the iatrogenic effects of scientific medicine's pharmacological products. Illich (1995) comments on the change in attitude to scientific-medicine in the U.S. in the 1970's, but also touches on something broader, which may be contextualised in relation to reflexive modernisation's trend towards increased questioning around science and 'expertise' (Beck, 1992) as manifested in the medical profession. Illich comments that:

> "A generation ago, children in kindergarten had painted the doctor as a white-coated father-figure. Today, however, they will just as ready paint him as a man from Mars or a Frankenstein. ... a new mood of wariness among patients has caused medical and pharmaceutical companies to triple expenses for public relations. ... Americans have come to accept the idea that they are threatened by pesticides, additives, and mycotoxins and other health risks due to environmental degradation" (Illich, 1995: 225-226).

It seems clear from this description of changing attitudes that faith in science and scientific-medicine has been subject to increased criticism for several decades. Whereas the medical profession had previously been discursively constructed in narratives of heroes and heroines fighting illness for the good of humanity (one variant of the progress through rationality grand narrative of modernity), Illich describes how children might now be just as likely to portray them within some dystopian vision of science and medicine. Illich ties this to concerns around the environment in his comment above and science is now seen as 'meddling with nature' and as being a danger, rather than a benefit, to humanity. Beck's argument (1992) about modernity coming to reflect upon the consequences of its own developments is relevant here, because scientific medicine as a 'benefit' of modernisation appears to have come increasingly into question from around the 1970's onwards. This coincides with the end of the post-war boom and the growing crisis of the welfare state, the

most significant feature of which in the U.K. was the N.H.S. The dystopian discourse that Illich refers to above is also interesting, as it is a prominent feature of the way in which contemporary concerns around G.M. foods and cloning have come to be represented, by some. It will later be argued that critiques around scientific-medicine, cloning, G.M. foods, and any number of other contemporary concerns of advanced industrialised nations, draw on common discursive resources that may be located within the increasingly fraught nature-society public debate (Beck, 1992; Nerlich *et al.*, 1999; Sutton, 1999).

Since the 1970's, 'alternative' therapies have been resorted to by growing numbers of people who have had reservations about scientific-medicine or who have conditions that 'conventional' medicine is unable to successfully treat (Lypton, 1995). In Britain, as long ago as 1981, an estimated thirteen million visits were made to medical 'irregulars' (Porter, 1997). Whilst in functional terms it is true that scientific-medicine has been unsuccessful in the 'war' (to employ its own imagery) on illness, as patterns of illness have changed from acute to chronic (e.g. it has not been successful with chronic illnesses such as arthritis and multiple sclerosis), other changes in society since the 1960's, affluence, education, commercialisation and individualism, must also be part of an explanation for changing attitudes towards scientific-medicine (Beck, 1992; Porter, 1997). Increasingly people are no longer prepared to accept what scientific medicine has to offer, and only that. It may also be the case that whereas once the rise in mass education socialised people into a general outlook (*weltenschuang*) that was more conducive to accepting medicine's scientific basis as a benefit, it may now be more conducive, in its role in facilitating critical

reflection, to bringing about a critical questioning of scientific medicine (among at least *some* members of society).

It has also been argued (Coward, 1989; cited in Lypton, 1995) that people are attracted to 'alternative' therapies because of their representation as being in some way more *natural*. Coward argues that 'nature' has powerful associations with notions of virtue, morality, cleanliness, purity, renewal, vigour and goodness in late modern society (Coward, 1989; cited in Lypton, 1995) and the opposition between this and the representations of 'Frankenstein' scientific-medicine, with its iatrogenic effects (Illich, 1995) is obvious and understandably appealing. Coward continues to argue that:

> " ... nature by implication is that which is safe, gentle and has inherent properties which will benefit individuals" (1989: 19; quoted in Lypton, 1995).

This must also be seen in the context of Beck (1992) and Giddens' (1999) ideas about the changing relationship between society and nature in contemporary society, in which nature is increasingly seen as not just something to be protected and treasured but also as an alternative to the inherent manufactured risks of non-natural products.

Within this context, in terms of considering representations within language as a 'game' (Wittgenstein, 1976; Lyotard, 1987) or simply to understand this as a rhetorical strategy, to draw on 'nature' to assert notions of efficacy and safety is a truly effective discursive move. When constituted in opposition to dystopian visions of 'conventional' medicine dominated by private corporations, this is even more effective. As will be shown later, many of the participants in this research do this, and do so frequently. However, this does not mean that the near monopoly of scientific-

medicine is necessarily in mortal danger. Lypton (1995) notes that the late twentieth century was characterised by disillusionment with scientific medicine, but also by an *increased dependence on it*. Porter notes that in the nineteenth century a backlash against conventional medicine was observed, leading some to favour alternative approaches (1997), and such previous challenges to the authority of scientific-medicine fit well with the idea that waves of 'modernization critique' have swept Europe and the U.S. before. However, scientific-medicine still holds the dominant, if contested, position within the field of health.

Lypton (1995) and Armstrong (1987) have both noted criticisms that doctors who 'listen' to patients as opposed to employing more 'objectifying' practices, as in the earlier half of the twentieth century, simply served to extend the medical 'gaze' (Foucault, 1973) further into people's lives. Lypton (1995) has asked, with regard to the growth of 'alternative' medicine, whether the argument that practitioners must treat the whole person, the 'holistic' approach, simply extends the medical 'gaze' further still, perhaps to the maximum possible extent? The referral of two in five patients to 'alternative' therapists by G.P.'s (Porter, 1997) has been accompanied by a discursive 'repositioning' of alternative therapists as *complementary* therapists (i.e. *complementary* in relation to scientific-medicine as *conventional*). Foucauldian approaches note that power requires resistance in order to expand and resistance to medicalisation has had this outcome before, as these examples would appear to demonstrate.

In summary, whilst the field of health is presently open to contestation in terms of who may speak with authority and the ways in which they are perceived, it would be

unwise to view scientific-medicine and more broadly the phenomenon of medicalisation as in decline. *It is this complex situation of contestation that is one of the major contexts in which the issues of interest within this thesis must be located.*

Disability and chronic illness within the context of a profoundly contested field of health

As well as a broadly discernible change in attitude towards scientific-medicine since the 1970's, there have also been changes in the relationship between certain social groups and the medical profession. Two such groups are disabled people and chronically ill people (although the distinction between these two groups is not simple). However, before this can be discussed, there are some conceptual issues that must be addressed. In recent decades, those writing in the field of disability studies have challenged the conceptual 'nature' of disability. It has been argued that contrary to the medical or individual model of disability, which views impairment and disability as synonymous, disability is the product of social not biological factors (Oliver, 1996). The argument, simply put, is that disabled people are not disabled by physical impairment, but by a range of social factors. This 'social model of disability' sees the exclusion of disabled people as having been socially constructed, as the outcome of social factors ranging from individual prejudice to institutional discrimination, from public buildings that are inaccessible and public transport systems that are unusable by disabled people, from segregated education to exclusion from employment and so on (Oliver, 1996). The main point as far as this discussion is concerned is that disability does not equate to impairment.

The second issue to be addressed here is that in some cases people with some forms of chronic illness may at some point in their lives become impaired and then be thrust into the social relations, discourses and practices that constitute disability. The main point for this discussion is that there is some degree of crossover between disability and chronic illness (e.g. a person who has multiple sclerosis and at some point is unable to walk due to physical impairment resulting from the illness). This is an important point as it has been argued that the majority of impairments in the late twentieth century (and at the start of the twenty-first century) are linked to chronic illness (Barnes *et al.*, 1999).

The disability movement

Dissatisfaction among some disabled people with attempts to make provision for them by charitable organisations and the welfare state, and with attempts to pursue disability-related issues through the means of conventional politics, led some disabled people to establish their own organisations from around the late 1960's onwards (Oliver, 1990). Such groups run 'by and for' disabled people, as opposed to 'for' disabled people by non-disabled 'experts', have pursued civil rights and social integration from their position of social exclusion, but integration for disabled people as they are, not through some process of 'normalisation', the medicalised notion of 'cure.'

The disability movement initially arose during a period of considerable challenge to authority on many social fronts and at a time when the nature of politics and political action were becoming considerably more diverse (as has been discussed above). Oliver has argued that the disability movement should be seen as a new social movement and that it was influenced by the civil rights movement in the U.S. (1990). In terms of seeing the disability movement as a new social movement, Scott (1990) has argued that such movements arise as a result of the exclusion of groups and issues from the existing political and cultural system, a view consistent with that expressed by some disability studies theorists (Oliver, 1990; Barnes *et al.*, 1999) on the rise of the disability movement. A number of the participants in this research were members of disabled peoples' groups and it will later be argued that their discourses often reflect this politicised tendency, with many seeing the medicinal use of cannabis as a disability issue.

The conceptualisation of the relationship between the medical profession and disabled people

The Disability Movement has come to challenge the predominant conceptualisation of the relationship between disabled people and the medical profession. Whilst this relationship has predominantly been portrayed as one in which the medical profession benevolently shielded disabled people and the sick (Porter, 1997), frequently conflating the two, the rise of the Disability Movement has been accompanied by a growing body of disability studies theory that has been highly critical of such a view.

Oliver (1996) and Barnes *et al.* (1999), although drawing on different theoretical frameworks (materialist and broadly Foucauldian respectively), understand disability in contemporary British society to be a product of economic changes associated with industrialisation and the medicalisation of impairment (as one facet of the broad medicalisation of life in the nineteenth and twentieth centuries). The social exclusion and oppression experienced by disabled people is therefore understood as a product of these factors, and the central role of the medical profession within this process is seen as one of oppression not benevolence.

The 'medical model' of disability, which views disability *as* impairment by understanding the social exclusion associated with disability as a product of impairment as opposed to social factors, is itself simultaneously a product of the medicalisation of disability as well as being the discourse that legitimises it (Oliver, 1996). From Oliver's materialist perspective (1996) the medical profession can be compared to the workforce of any other industry, sharing a vested interest in how its product is produced and exerting control over this process. From this perspective then, the 'workers in this industry' can no longer be seen as acting in a benevolent fashion.

In summary then, since the late 1960's, a growing proportion of disabled people in Britain, though to what degree is hard to say - see Barnes *et al.* (1999), have become politicised around the issues related to disability and have come to question the 'medical model' of disability and some of the interventions in their lives by the medical profession (typically those that conceptualise disability as illness and attempt to implement 'normalising' practices of 'cure' or 'rehabilitation').

Having acknowledged that the medical profession may be regarded by some disabled people in a critical light there are a number of more specific reasons why disabled people and chronically ill people may have problematic relationships with medical professionals. Barnes *et al.* (1999) comment that the more knowledgeable a patient is about their own health, the more likely it is that the doctor-patient relationship will feature clashes. Due to the long-term nature of disability and chronic illness, where the individual may accrue great knowledge about relevant health matters, this is particularly likely to occur in relation to such patients. Calnan (1984; cited in Barnes *et al.*, 1999) argues that where doctors lack an effective treatment, they tend to feel insecure and therefore to communicate less, leaving the patient more likely to feel dissatisfied. With the growing politicisation of a proportion of disabled people, they are increasingly likely to question such interventions anyway, if any effective interventions exist at all (with this being subject to how one sees medical interventions around impairment).

It would seem, therefore, that disabled people, chronically ill people and those who may be seen as belonging to both groups, are arguably even more likely to view the authority, effectiveness and the 'nature' of the scientific medical profession in a negative way than non-disabled and non-chronically ill people. Such an outlook must also be seen against the backdrop of a society that is increasingly critical of science, scientific-medicine and the growing dominance of big pharmaceutical corporations, a society that exhibits a growing trend towards 'alternative' therapies and more 'natural' treatments and within which many people increasingly reflect upon the 'risks' that science in its many manifestations entails in their everyday lives (Beck,

1992). However, chronically ill people and those disabled people who require regular use of prescribed medication, (many do not, as disabled is not the same as ill) occupy a distinctly different risk position (Beck, 1992) from many members of society, due to this requirement for regular, and sometimes relatively large amounts, of prescribed medications. With a growing trend for critical reflection on many pharmaceutical products and their corporate producers, members of such social groups may have more reason than most for concern about the effects that such medication might have on them.

Conclusion

It has been argued that scientific-medicine has increasingly been called into question as part of a growing variability of trust in science, technology and 'expertise' (Beck, 1990) that characterises the contemporary period in post-industrial nations. Since 1970, a trend towards 'alternative' therapies, in line with trends towards the right to choose in an increasingly consumer-based economy, have been observed, yet this cannot be taken as evidence, in any simple sense, of the demise of the scientific medicine profession's position of predominance. In fact, it may be most accurate to understand this as the more recent characterisation of a historically ongoing contestation within the field of health. Within this broad context of not simply accepting scientific medicine as the only option with regard to health and an increased scepticism in general, disabled people and chronically ill people have more reason than many to entertain alternatives to scientific-medicine. This has led some disabled and chronically ill people to try a 'natural' substance that they self-prescribe,

albeit illegally, outside of the strictures of the doctor-patient relationship and the concerns about iatrogenic man-made medicines. This medicinal substance is cannabis and its medicinal use, in the context of a contested field of health by people with more reason to participate in such contestation than most, will be discussed in the next chapter.

CHAPTER 8

MEDICINAL CANNABIS USE AS A CHALLENGE TO AUTHORITY

Introduction

This chapter will argue that while most participants in this research were not members of any of the single-issue medicinal cannabis users' groups (although some were, as well as some being members of disabled peoples' groups), medicinal cannabis use can still be seen as a challenge to the authority of medical-science in the way that the discourses of participants involves the assertion that cannabis is medicinally useful. It will also be argued that in this discursive 'clash', the 'no medical value' discourse on cannabis is dominant in the field of health because it draws on historically constructed discursive notions of what is and is not a medicine, with this dominance ultimately resulting from science's status as the dominant 'regime of truth' (Foucault, 1980a) in contemporary society. However, as has been argued in previous chapters, this dominance is subject to a relatively recent shift in the thinking of many members of society, in which science, technology, government, 'expertise' and many other central institutions of modernity are under increased scrutiny, reflection and criticism (Beck, 1992). This being the case, any attempt to assert the medicinal efficacy of a substance, such as cannabis, which is commonly understood as 'natural', might be rhetorically effective as it is a part of a growing body of discourses and practices that are staking a claim as the new 'truth' of late modernity, as the 'natural' is increasingly repositioned from the peripheral to the

central in the everyday thoughts and practices of a growing number of society's members.

Organised groups and the medicinal use of cannabis

One way in which medicinal cannabis use may be regarded as a challenge to authority is through its organised groups and their activities. In the U.K., groups such as the Alliance for Cannabis Therapeutics (A.C.T.) (a group that takes its name from a similar group in the U.S.), and the Medical Marijuana Co-operative Organisation (M.M.C.O.) have been involved in activities aimed at highlighting the issue of medical cannabis use.

The 'new' politics of the post-1960's era have provided a mixture of radical ideology and a repertoire of 'new' types of political action (Byrne, 1997). These resources have been employed by those involved in organised groups related to the issue of medicinal cannabis use. For example, A.C.T. members have written articles for national newspapers and magazines such as *The Spectator*, and in 2000 an M.M.C.O. member gained considerable media coverage by presenting the Queen with a cannabis 'posy' in Manchester (she apparently thought it was simply a bunch of flowers).

However, not all medicinal cannabis users are involved with such groups and whilst it is difficult to know how representative the sample in this research is of medicinal cannabis users in the U.K. overall, only four of the thirty-two participants in this

sample were involved with such organised political groups of medicinal cannabis users (although some other participants were members of disabled peoples' groups). Yet, on an individual level, the self-prescribing of cannabis, because it is a controlled substance under the 1971 Misuse of Drugs Act, is an act of resistance at least in relation to British law.

Medicinal cannabis use and discursive contestation

Whether medicinal cannabis users are publicly and politically active around the issue or simply use it on an individual basis, it can also be argued that both types of *engagement* (a concept that the latter chapters of this thesis will develop) with medicinal cannabis use can involve a challenge to authority at a *discursive level.* From organised activities involving the use of the media to put across their message down to the level of the individual using cannabis because to them it is medicinally useful (as opposed to being of no medical use as the B.M.A. has insisted), the challenge to authority around the medicinal use of cannabis is, from the perspective of the social theorist, primarily a discursive conflict.

Melucci (1992; quoted in Byrne, 1997) has argued that social movements:

> " ... raise a challenge which recasts the language and cultural codes which organise information" (1992: 74-75; quoted in Byrne, 1997).

Such conflicts involve the attempt to impose one 'truth' or reality over other competing 'truths' or realities. In this respect they are conflicts fought at the very level of meaning itself, where meaning is:

> " ... the outcome of symbolic struggles waged on an individual and collective level. ... symbolic systems ... should be located within specific institutional spaces that become arenas for symbolic competitions among individuals and groups. Following this approach, cultural objects gain meaning foremost as objects of practical, contested usage and not as objects of pure contemplation ..." (Lee, 2000: 46).

Cannabis is most definitely an object of contested meaning. The struggle around its medicinal use takes place within arenas such as the media, peoples' day-to-day lives and any other social context where the meaning of the medicinal use of cannabis is articulated by medicinal users or others. This is ultimately a contest in which different groups seek to assert certain sets of meanings over others in a discursive struggle to legitimate their own practice and beliefs in the face of competition from the discourses of the dominant group within the field of health, the scientific-medical profession. In this respect then, the issue of the medicinal use of cannabis involves a 'clash of discourses'.

The clash of discourses

It has been argued above that the issue of medicinal cannabis use involves contestation in which two conflicting 'truths' are struggling to pass themselves as *the* 'truth'. These conflicting 'truths' are:

1. That cannabis, the crude vegetable product, is not a medicinal substance, that it is " ... unsuitable for medical use ..." (BMA, 1997: 77) and that it is rightly classified under schedule one of the Misuse of Drugs Act 1971 as having *no* therapeutic benefit.

2. That cannabis is an extremely useful medicinal substance, which has a long history of medicinal use, and is more effective in a number of ways than conventional medicines, whilst having fewer and less problematic side-effects (if any), which is broadly what medicinal cannabis using participants reported in previous research (Coomber, Oliver and Morris, 2003).

Competing 'truth' number one is what tends to be said about medicinal cannabis use by representative bodies of the medical profession, such as the B.M.A. (1997) and the Royal Society and the Academy of Medical Sciences (Lachman *et al.*, 1998). To put this another way, it is considered to be *the* 'truth' by the professional bodies of the medical profession and by relevant government ministers as is evidenced by their pronouncements on the subject which have been referred to elsewhere. Due to the dominant position of the scientific-medical profession within the field of health, the first 'truth' is the dominant one (even though the profession's authority can be seen as being contested and subject to increasing scepticism, particularly from certain social groups – see previous discussion). In this thesis, this position will be referred to as the 'no medical value' discourse.

In a discussion of critical discourse analysis, Fairclough argues that:

> "I view social institutions as containing diverse 'ideological-discursive formations' (IDFs) associated with different groups within the institution. There is usually one IDF which is clearly dominant ... . A characteristic of a dominant IDF is the capacity to 'naturalise' ideologies, i.e. to win acceptance for them as non-ideological 'common-sense' ..." (Fairclough, 1995: 27).

If we apply Fairclough's argument to our two competing discourses then the 'no medical value' discourse clearly appears to be the dominant one, being that which is held to be 'true' by bodies like the B.M.A., and it is also the one that is enshrined in law. So how does it win acceptance?

The 'no medical value' discourse

Foucault described truth and its relationship with power when he argued that:

> " ... truth isn't outside power, or lacking in power ... Truth is a thing of this world ... Each society has its regime of truth, its 'general politics' of truth: that is the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true" (1980a: 131).

Further to this, Foucault (1980a) also argues that there are five important traits of the 'political economy' of truth, in contemporary society. The three that are of immediate concern here are:

> That truth is based around scientific discourse and its institutions, that the dominant 'regime of truth' is science. Science is the basis of the

> prevalent world-view [at least in much of the Western, late-modern world]. It is 'the truth'.
>
> 'Truth' is produced by a few apparatuses / institutions.
>
> It is an area in which struggle and confrontation occurs in society (1980a: 131-132).

In terms of Foucault's argument above, it is not hard to see why the 'no medical value' discourse is the dominant one. Whilst subject to intense challenge and anxiety (Beck, 1992), science is still the dominant 'regime of truth' in contemporary late-modern societies and scientific-medicine is a part of this. Science's institutions are involved in the production of what passes in contemporary society as 'the truth' and are the accredited sites for such production. That is to say that scientists and doctors are seen as the 'experts' (though this expertise is under challenge in this issue as in others).

It has been argued in Chapter Two that cannabis tincture fell out of popularity in medical practice primarily because it did not 'fit' the criteria of 'what a medicine is', that had developed since the birth of scientific pharmacology during the early years of the nineteenth-century. This discourse on 'what a medicine should be like' concurs even less well with seeing crude vegetable cannabis as a medicinal substance than it would have done with a tincture.

The quote from Foucault also mentions that each society has:

> " ... techniques and procedures accorded value in the acquisition of truth ..." (1980a: 131).

Science privileges knowledge that has been produced using the methods that it endorses, and regards types of knowledge produced in other ways as less valid even if useful (e.g. acupuncture). Those who have articulated the 'no medical value' discourse on cannabis have frequently made the distinction between what they describe as the *anecdotal* testimonies of medicinal cannabis users as to medicinal efficacy of cannabis and *scientific proof* (this can also be seen in some of the work discussed in the literature review). Quotes employed elsewhere have demonstrated the articulation of this very distinction where government ministers have argued that without *scientific proof* of the safety and effectiveness of cannabis as a medicinal substance, it would be foolish to even consider making it available. Contemporary society privileges above all types of knowledge those that have been produced by way of scientific methods. In this case, medical trials are the means by which the most highly valued evidence is produced.

In a society in which science has become the dominant 'regime of truth', the way of producing what is prevalently understood as 'valid' knowledge is the scientific way. Lyotard (1987) argued that scientists question the validity of what they understand to be narratives (or *anecdotes*) on the basis that they are not subject to validation (proof). Narrative knowledge is hence cast as inferior to scientific knowledge, but this is a function of the different 'language games' (Wittgenstein, 1976; Lyotard, 1987) of which they are comprised. The science 'language game' requires validation; the narrative 'language game' does not. Scientific discourse is therefore able to undercut

non-scientific discourse with the rhetorical assertion that the latter is 'unscientific' because it lacks proof. In this case, the non-scientific discourse is the *anecdotal* evidence of medicinal cannabis users that is undercut by those who articulate the scientific demand for 'proof'. The very notion of a statement or articulation as being less valid because it is 'unscientific' is evidence and reassertion of the strong position of science and its discourse within the field of knowledge in late-modern society.

In terms of the dominant 'regime of truth' then, cannabis does not 'fit' the dominant notion of what a medicine should be and there is 'no' evidence of an acceptable form as to its' efficacy, although actually, there is and has been for some time now – see Hepler and Frank (1971, cited in Zimmer and Morgan, 1995: 4) or Iversen (2000). Further to this, production of such acceptable evidence is difficult due to the legal status of cannabis in the U.K. and the U.S. In terms of the dominant 'regime of truth', the *anecdotal* evidence in the form of medicinal cannabis users' testimonies is of an unacceptable form, and is produced by non-experts. As it is this discourse that informs the understanding of the B.M.A. and the government, it is not hard to understand why cannabis is not legally available for medicinal uses.

'Medicinal cannabis users' discourse

This thesis has so far argued that contemporary medicinal cannabis use is a contested activity, that cannabis is seen as a substance with 'no medical value' in many pronouncements by representative bodies of the medical profession, and the

government, and how this is contested by individuals and groups who have a positive view of cannabis' medicinal efficacy. It has been argued that some medicinal cannabis users *engage* with the issue of medicinal cannabis use in an organised political type way, whereas others simply use it for symptomatic relief and assert its efficacy in conversation, if they speak about the issue at all. It has also been argued that medicinal cannabis use is primarily a discursively contested issue and that what is at stake is the potential to assert one 'truth' (Foucault, 1980a) over another.

However, the contemporary period is also characterised by great variation in the faith in science, technology and 'expertise' (Beck, 1992), and science's institutional position as the dominant 'regime of truth' (Foucault, 1980a) is increasingly subject to contestation. In discussing medicinal cannabis use, many participants in previous research (Coomber, Oliver and Morris, 2003) placed importance on cannabis being a 'natural' substance and frequently emphasised a preference for using it instead of prescribed substances. This was true for many for whom prescribed substances did have some efficacious outcome (although typically also side-effects), not just those who argued that cannabis was the only substance that helped them. This positions the medicinal use of cannabis as the use of a 'natural' substance as opposed to a 'man-made' / 'chemical' substance and draws on ideas of natural products as being efficacious, safe (Coward, 1989; cited in Lypton, 1995) and in tune with the body. It places the medicinal use of cannabis within the context of a critical reflection upon pharmacologically produced medicines as part of a critique of science, technology and medical 'expertise'.

Whilst science is still the dominant 'regime of truth' (Foucault, 1980a), at least in late-modern Western societies (and to a lesser extent elsewhere), this dominance is beset by a multiplicity of debates, anxieties, critiques, and in many respects a loss of faith. The shift in public discourses about the nature – society relationship that Beck (1992) discusses, the increasing inclusion of nature within politics and the characteristic reflection upon these issues that contemporary society is starting to see more of, may mean that at some point the efficacy of more natural lifestyles, products and ways of living really do begin to challenge the dominance of science, at least as we might tend to understand it as a set of discourses and practices familiar to us at this point in human history.

This thesis will now examine the content of the discourses articulated in a set of interviews with thirty-two medicinal cannabis users with a view to seeing what the participants talk about, what discursive resources and rhetorical strategies they use, whether there is similarity or dissimilarity between accounts, why talking about 'nature' and 'the natural' is so prevalent and frequent within the discourse of most of the participants and what the discourses of these participants tells us about the potential for discursive contestation with the 'no medical value' discourse.

PART 4 – 'MAPPING' THE DISCOURSE OF THE PARTICIPANTS

The task of the chapters in this part of the thesis is to 'map out', or outline, the main elements of the discourses articulated by participants in their interviews. As one might expect, participants in reasonably lengthy interviews (90 – 180 minutes) spoke about rather a lot. Although the interviews were semi-structured (so featured the same questions in the same order) the responses obviously differ on the basis of many factors such as individual experience of cannabis use as well as different understandings and other issues that the participants wanted to talk about. Whilst such depth of data is traditionally prized by those favouring qualitative methods, it obviously requires considerable effort when thinking about how to approach structuring the analysis of it.

The approach used in this work sought to categorise what participants spoke about, in terms of a number of themes, in order to outline the main features of the discourses articulated in the interviews. Various ways of presenting the 'mapping' part of the thesis were considered but the approach that was eventually settled on hopefully presents what was articulated in an intelligible way.

Clarification of the 'mapping' of discourse

The methodological strategy of 'mapping out' discourses, as is found in the work of Wetherell and Potter (1992) for example, warrants clarification at this point. First in a

series of considerations about 'mapping' the discourses of the participants in this research is, what is it exactly that is being 'mapped'? The discourses reported in this research are taken to be the products of social agents (with differing discursive resources and dispositions) actively producing an account and doing so by way of articulating existing linguistic resources.

Further to this, much of what the participants draw on inter-textually when making articulations in their interviews can usefully be understood by using Gee's concept of Conversation (1999). This concept is especially useful when trying to conceptualise the relationship between everything that has been said on a given topic, in this case medicinal cannabis use, and individuals who speak about the topic (whether this be in the interviews used in this research or in everyday conversations). A Conversation in terms of Gee's (1999) use of the concept (and the capital 'C' is deliberate) can be understood as everything that has been said (in this case) on the topic of cannabis and its medicinal use and is available in newspapers, magazines, on the internet, on television, in academic material and so on, as a huge repository of meanings (which because of the internet is increasingly accessible).

Having clarified some issues pertinent to the 'mapping' approach to participants' discourses, there are a number of advantages to this approach. It can provide a detailed sense of the discourses produced by the participants and can be used to provide a good sense of differences, as well as commonalities, between different participant's accounts (see Chapter Two). Differences within the accounts of the same participant, when talking about similar issues but in different parts of the interviews,

can also be attended to using the 'mapping' approach, hence satisfying discourse analysis's interest in attending to variation within and between accounts.

The 'mapping' of the discourse of the participants will now be presented over a number of chapters. The next chapter, Chapter Nine, looks at various discursive constructions of cannabis as articulated by the participants, discursive constructions of the use of cannabis and discursive constructions of what a 'drug' is, a topic discussed in the literature review in relation to the work of Omel'Chenko (2006). Chapter Ten examines the rhetorical strategy of articulating discursive oppositions, or *contrasts* as Hellum (2005) refers to them. Chapter Eleven considers the discursive articulation of 'nature' and 'the natural' in the participants' interviews. In Chapter Twelve, discussion by the participants about medicine, medical power, medical knowledge and other issues pertaining to issues of power is considered. Chapter Thirteen looks at the significance of vocationally derived discourse in relation to the discourses of certain participants. In Chapter Fourteen some concluding remarks are made in relation to the task of 'mapping' the participants' discourses, also with a view to taking certain findings forward into latter chapters as more specific research aims.

CHAPTER 9

DISCURSIVE CONSTRUCTIONS OF CANNABIS, OF THE USE OF CANNABIS AND OF A 'DRUG'

Constructions of cannabis

In talking about their use of cannabis in relation to a series of areas of interest (which structure the interview) the participants discursively constructed cannabis in various ways. This section (comprised of a number of subsections) is an attempt to 'map' these out and briefly discuss them. Constructions of cannabis in relation to ideas about nature and 'the natural' occupy a separate subsection as they are highly prevalent and, as later chapters will show, central to the discourse of medicinal cannabis users and the discursive contestation around the medicinal use of cannabis.

Cannabis as the only effective substance. Whilst many more participants argued that prescribed medicines were ineffective or problematic in various ways, something that other research has also found (Ware *et al.*, 2005; Reiman, 2007), six participants explicitly constructed cannabis as the *only* effective substance in terms of addressing their symptomatic needs.

However, it is also clearly rhetorically beneficial to make such an argument, as it has a justificatory function (i.e. 'I use this because I have to – it is the only thing that works). Whilst cannabis is an illicit substance and its medicinal efficacy is a contested issue, if disabled and / or chronically ill users are able to argue that only

cannabis helps them with their symptoms, this will be a rhetorical 'move' of some considerable effectiveness providing that the discourse's audience are sympathetic to issues of pain, for example. However, whilst discourse analysis is methodologically interested in how people use language and in analysing accounts in terms of effective rhetorical strategy, it should be made clear that in no way is the researcher sceptical about such claims and suggesting that they are made *solely* for rhetorical purposes. In fact, this issue is typically grounded in a discussion of the user's experience, which reduces such concerns, for example:

> "Yeah ... there isn't anything else that the doctors can give you ... I know if there was anything else he'd [her GP] give it to me ..." (participant five: 15).

This not only reinforces the claim, rhetorically, but clearly suggests, analytically, that this understanding of cannabis is experientially derived. Another participant's discussion of this issue draws on the discursive authority of the medical profession itself, whilst again being grounded experientially:

> " ... the medical professionals are saying to me ... they can't help me. What I'm doing [using cannabis] is the best thing I can do." (participant forty-six: 19).

Arguing that cannabis is the only substance that they find to be efficacious *is* a rhetorically effective 'move' but as other research reports similar findings (Ware *et al.*, 2005; Reiman, 2007) and comments, such as the quotes above, clearly ground this in experience external to the interviews, a middle-ground methodological position that acknowledges the occasioned aspect of these constructions but that also acknowledges evidence (other corroborating research and the experiential grounding

of what the accounts suggest) means that the analyst should seriously consider accepting that cannabis probably *is* the only substance that they find effective. It was also found in Coomber, Oliver and Morris (2003) that many participants would rather not use cannabis for numerous reasons if an effective alternative were available and one of these reasons was the basic financial reality of life on disability benefits, that of cost. Cannabis is relatively expensive for many of the participants and this also suggests that if there were effective alternatives, many more participants would quite probably use them instead.

However, it is also surely correct that anyone with a sympathetic view of physical discomfort, mental anguish (in relation to the likelihood of premature death that some chronic illnesses entail) and social exclusion, is less likely to question the authenticity of such assertions anyway. The bureaucratic structuring of the government and medical profession's (outside perhaps of G.P.'s themselves) engagement with the issue (bureaucratic, distanced, formal, impassionate) would seem, however, to inure them from such considerations and this might explain why the public in the U.K. have been shown in surveys (BBC Online, 1998a: 1) to be sympathetic to medicinal cannabis use, but the government and B.M.A. (1997) retain different criteria in their engagement with the issue (typically the criteria of formal scientific medicine and the 'no medical value' discourse).

Cannabis as safe / benign. Closely related to the notion that cannabis is the only substance that works for many chronically ill and / or disabled users are assertions in the interviews that it is a safe / benign substance. Five participants explicitly

constructed cannabis in this way. Again, such claims can be seen as rhetorically useful in attempting to assert that cannabis is of medicinal value, but again such claims are also grounded in experience in the ways in which they are articulated. However, all five participants who made this point had used cannabis when younger, on a recreational basis, and then later resumed its use for medicinal reasons. Their accounts suggest that they were not worried about trying cannabis to address their symptomatic needs as they already knew it to be safe / benign.

> "So … I thought … if it's not going to harm me … umm … since I've taken it before from the recreational point of view, and to my mind it hadn't harmed me yet … the … why not try it from the medicinal point of view? You know?" (participant thirteen: 13).

> "… so frankly it was like … 'cause if it doesn't work … it's not gonna do me any harm … you know …" (participant forty-eight: 14).

Previous use experience for both these participants, they argue, reassured them when considering whether to use cannabis again. Rhetorically, this also functions to reduce any notions of cannabis and harm in their accounts. The next participant asserts the safety of cannabis through an admission of the use of other illicit drugs that he says he regrets. In doing so, the participant's position, if we take Gee's (1999) advice to always consider discourse in terms of 'who's doing what' (what speaker-position is adopted as well as what can the discourse be seen as attempting to do), becomes one of a mature individual able to reflect upon past mistakes openly and honestly. This seems rhetorically to retain the validity of his assertion that cannabis is a safe substance. It is also worth considering Goffman's (1959) concept of 'manner' in relation to this excerpt. The speaker, participant eighteen, was a well-educated and

rhetorically gifted individual (things that transcripts cannot capture, but nonetheless are significant in spoken discourse):

> "Well, I used a...I smoked...a lot of hash...late sixties, early seventies...I also took...a lot of pills...I took...a couple of hundred LSD trips...and...there was a time in my life when I had a...a bit of problem with amphetamines as well...and...I'd long...since...I regretted the amphetamine...I had too much of the acid...but there's never been a time *since I was eighteen* ...or so...that I...thought...marijuana was in any was detrimental to one's health...or to the health of society...I've always thought it was a very *positive...useful...benign*...substance... and...*And in...I...I...I guess...ten or fifteen years of not smoking*...I...I was always...aghast...at the *stupidity*...of politicians and chief constables...and the judiciary...people who really ought to know better...and the *nonsense* that they pump out about cannabis..." (participant eighteen: 9).

In a discursively fascinating excerpt, the participant employs a number of strategies. In admitting that he regrets the use of some other substances, he reduces any stake (Potter, 1997) that the audience (interviewer) may feel he has in arguing for a simple 'pro-drug' view, and he does this through the classic strategy of 'opposition', or 'contrasts' as some analysts prefer to conceptualise them (e.g. Hellum, 2005). In the excerpt, cannabis is opposed to other drugs that the participant admits concerns around and in doing so cannabis is portrayed as relatively less problematic. One could argue that this draws, implicitly, on the prevalent 'soft drug' / 'hard drug' dichotomy that underpins many prevalent (mis)understandings about drugs and risk, with this dichotomy being inherently problematic itself (Coomber, 2000). He then includes the phrase *" ... since I was eighteen ... "* (see above in italics) which is initially unremarkable, but can be read as asserting the same as saying 'since I was an adult'. Rhetorically, one might argue that this effectively consigns these earlier events to being 'youthful indiscretions', which can be written off as such, and thereby

ought to be discounted from detracting from the validity of his later assertions. The next italicised phrase *"... positive... useful... benign ... "* follows the strategy, often observed by conversation analysts, of emphasising a point by rhythmically employing what is known as three-partedness in a list type construction (Jefferson, 1991, cited in Wooffitt, 1993). Finally, participant eighteen attacks the views of the criminal justice system on cannabis as being "*stupidity*" and "*nonsense*", but artfully inures his account against the possible perception of self-interest by saying that he felt this way during his "*...ten or fifteen years of not smoking...*".

In just 112 words, the above participant articulated a sophisticated range of rhetorical 'moves' to assert the benign and useful nature of cannabis. Whilst the type of analysis employed in relation to this participant is of a 'finer grain' than most of what will be employed in this research (closer to conversation analysis in some ways than a broader brush discourse analysis), it has been used here to open consideration of an issue that will be explored increasingly in this work – the differences between different types of medicinal cannabis users' discourses. The rhetorical sophistication of participant eighteen's account, as demonstrated above, is not typical of all participants' accounts. It may be unsurprising to know that this participant studied literature at university. In keeping with a Bourdieusian conceptual framework, outlined in Chapter Three, this is an example of one participant's account being the outcome of his socially constituted capacity to use language in certain ways, the tendency of his linguistic habitus (Bourdieu, 1992) being to engage, when deemed *relevant* (van Dijk, 2003), with highly developed discursive abilities and a disposition to use words such as 'detrimental', 'benign' and 'aghast' that would not necessarily feature in the vocabulary of all members of English-speaking society. The argument

that will be developed is that, to a degree, participants' accounts will be an outcome of their differentially constituted abilities and dispositions to use language (Bourdieu, 1992).

Emphasising the safe / benign character of cannabis is also important in relation to Beck's (1992) ideas about risk and the tendency to reflect more on it in reflexive modernity. In Coomber, Oliver and Morris (2003) we reported that many of the participants preferred to use cannabis as opposed to prescribed medicines due to concerns about side effects. Discursively constructing cannabis as safe / benign needs to be understood as constructing it in relation to prescribed medicines, as later discussion will show. It will become increasingly clear over the remainder of this part of the thesis that these ideas about cannabis as a safe / benign alternative to prescribed medicines are also rooted in ideas about 'nature' and more 'natural' products being relatively safer than 'man made' products and the growing prevalence of such ideas in everyday life, ideas also discussed in Chapter Six.

Stepping Stone Theory. It was surprising to find that the 'stepping stone theory' (the idea that users who start using cannabis will progress to 'harder' drugs) was only mentioned, or even alluded to, by one participant (because it frequently features in public discourse on illicit drugs). Whilst the participants in this research were all given to viewing cannabis as, in various ways, a useful substance to them, many of them had not used it prior to medicinal use and would happily have not used it had an efficacious prescribed substance been available. Such participants were often critical

of recreational cannabis use, seeing medicinal use as necessary and therefore legitimate.

Participant seventeen is, however, one of a small number of users who exhibit a discourse that is more significant for issues of 'impression management' (Goffman, 1959) than being discursively interesting in other ways (and this can be read as a rhetorical priority in the discourse of such participants). Other participants who tended to exhibit a similar aspect in their discourses were also middle-aged, had not used cannabis prior to medicinal use and often emphasised a stereotypically home counties 'middle-class respectability' within their accounts. The following excerpt can be read as a habitualised display of the self, with a concern to enforce a sense of social distance between herself and those she understood as recreational users:

> "I've always thought of it [recreational cannabis use] as not a good idea and that it would be the thin end of the wedge. But...I'm told by the woman that first suggested it to me that all her son's generation smoke *these things* because it's cheaper than going and having lots of alcohol. *I don't know if that's true.* ...I just would worry that it's the thin end of the wedge and then you go on into harder drugs. ... but I think if you take cannabis on a regular basis and then it becomes of no thrill or interest or gives you no high any longer and you need to move onto a...*ummm*...I don't know how it works if it really works like that. To me it seems that maybe that's what they do, that you have to move on and upwards to harder and harder drugs." (participant seventeen: 21-22).

The use of the phrases *"thin end of the wedge"* and *"these things"* to describe a cannabis cigarette or joint, the assertion that she does not know if it is true that younger people use cannabis as an alternative to alcohol and most interestingly the very telling *"ummm"* pause and change of discursive direction, that can be read as an

intervention right at the point when she actually *does* sound like she knows a fair bit about the issue, can be read as instances of impression management (Goffman, 1959).

Some of the literature discussed in Chapter Two considers similar issues. Plumridge and Chetwynd (1998) show how substance users' accounts are influenced by the needs of the individual to attempt to maintain a positive self-presentation, Hellum (2005) discusses how contrasts are often rhetorically employed by speakers to distinguish themselves from others, and Rødner (2005) shows how such contrasts often work through a process of 'polarisation' in which an individual's account will over-emphasise differences between themselves and 'others' in the situated construction of their own identity. However, the chapter that discusses this issue in more depth, Chapter Sixteen, will also explore how the concern with self-presentation within accounts also reflects differences between different participants, or certain types of habitus (Bourdieu, 1979).

Cannabis as revelatory. Eight participants used 'extreme case formulations' (language that maximises or minimises, states very strongly or understates, what it describes) (Pomerantz, 1986, cited in Wooffitt, 1993) in describing how they felt about cannabis, often when describing first trying it for medicinal purposes. Many participants reported that prescribed medicine had nothing effective to offer them and with many of the participants experiencing significant levels of pain and other symptoms, the revelatory narratives they presented in the interviews, when reflecting on the moment at which they discovered that cannabis was effective for them, are perhaps unsurprising. The language they use can be seen as rhetorically advantageous

within the account in relation to the 'aim' of asserting cannabis as medicinally useful, but also one can well imagine that living with high levels of pain and finding an effective remedy would invoke strong feelings, which the accounts reflect.

> "... And this sort of like...complete feeling of like...*jubilation* that...I could actually do something: I can't....I can't describe...I can still remember that sort of...as I walking down and thinking...*My God, I can do it.*" (participant four: 28).

The most common theme in these revelatory narratives is that of miracle / the miraculous, which is exhibited by four participants. Interestingly, all four also exhibit another shared view of cannabis, the idea that nature is a system of remedies for human illnesses. Three of the four participants also take a spiritual view of this, that God has constructed this system of cures. As the concept of miracles is obviously religious in origin, this association is unsurprising.

> "...hashish is not a drug...it's a medical *miracle*..." (participant thirty: 31).

> "...once one would finish I would light up another one until I felt the pain had relieved to a level where I could bear it...and so, in fact...you know, for flare ups it's...it's just *miraculous* really...You know?" (participant five: 5).

> "That's a big cigarette...I said 'Yeah, it's just a *miracle* one'...that's what I used to tell her [the participant's young daughter]." (participant thirty-nine: 54).

The notion of miracle is used in different ways here, but whilst it is rhetorically beneficial to assert the effectiveness of cannabis as a medicinal substance to such a degree, the esteem within which these participants hold it is also shared by many

other commentators on its medicinal value, including the media – see *The Observer's* article *Cannabis a Medical Miracle* (4.11.2001) for example.

One participant, in a similar vein to those above, describes cannabis as a wonder drug and as amazing:

> "...It [cannabis] helps me sleep...it helps my waterworks...it regulates my bowel...it's a *wonder drug*...it's just *amazing*. I just find it *amazing*. I'd give up everything else for that." (participant three: 15).

The language used to describe cannabis by a small but significant number of participants can be seen to be revelatory and to use 'extreme case formulations' (Pomerantz, 1986, cited in Wooffitt, 1993) to emphasise this in their accounts.

Cannabis as enabling. Two participants specifically used the term 'enables' in their interviews, when talking about cannabis. One participant used it only once:

> "...I know...myself that it enables you to do all sorts of things." (participant twenty-nine: 30).

However, the other participant used it on numerous occasions in her interview and it may be argued that it is a central organising concept within her discourse (at least as it is articulated in these interviews by her). Enablement is often discussed along with independence, control and choice in her interview and it is interesting to note that she has a vocational background in counselling, social work and other socially oriented work. An area that will be explored later is to what degree vocationally derived discourse or ways of thinking and talking about issues is significant in explaining the

differences between different participants' accounts. For now though, this quote also exhibits connotations of the notion of empowerment, when she argues that cannabis for her is about:

> "Choice, control and you know...enabling the ability to be able to do things you know?" (participant six: 21).

One may ask whether someone without this vocational training and background would be as likely to use such language? As will be seen later, such language is most commonly also exhibited by other participants who work in disability-related roles.

Hemp as a plant of many uses. This discursive construction of cannabis comes from outside the direct focus of the interviews or personal knowledge (van Dijk, 2003) and is drawn from the large body of literature on cannabis that can be found in books, magazines and on the internet, which is conceptualised in this research as being part of what Gee (1999) calls a Conversation (everything that has been said about a given topic). It is an argument often articulated by those in favour of a broad legalisation of cannabis, not just for medicinal purposes, and asserts that the oil and fibre of the hemp plant can be used in the manufacture of a multitude of goods and that these products are more 'natural' and less environmentally harmful – Herer (1995) is a good example of such an account. Such articulations can be understood in relation to Beck's (1992) ideas about reflection upon environmental degradation caused by numerous industrial activities. Cannabis is being positioned in these accounts in opposition to such processes and as part of a solution to various environmental problems and therefore as a very positive substance.

However, not all participants articulated these types of concern and of the three participants to articulate this construction of cannabis, one was from the occupationally lower-working class fraction and two were from the occupationally intermediate middle-middle class fraction. However, the occupationally working-class participant (participant thirty-five) requires clarification as his educational trajectory is that of grammar school and art-college and in the interview he points out that he found the art world to be pretentious and that he chose and appreciated the working-class camaraderie of manual labour. This emphasises the complex nature of social class in the late modern period and such observations are important in relation to questions about how different individuals engage with talking about medicinal cannabis use, associated issues and reflection on risk-related issues (Beck, 1992) more broadly.

"I think it's also worth remembering...you know there are other elements of the cannabis plant which do other things...so from a therapeutic point of view it's not just the cannabis plant...there's other things to it as well." (participant one: 14).

"Three thousand years...since time began, I've traced back since time began...the hemp plant as it was called then...has always been known about...it has been part of our society...ships, you know, large ships ...that first sailed the seven seas have brought traders from...place to place...even today hemp is the best quality of rope you can buy...it will produce paper...of the finest quality...in mass without any chemical...unlike...wood processing...you could have totally environmentally friendly paper...of the finest quality...makes a wonderful paper..." (participant thirty: 31).

"...the hemp plant...can be used...for many purposes...it certainly wouldn't do any harm to grow...a lot...lot more plants...in terms of...absorbing carbon dioxide and...putting out oxygen... It can be used as a fibre...it could be also paper...you cut down a number of trees, it's more suitable than trees for making paper...you can make a

> lot of fabrics out of it...but again...a lot of the dyes and bleaches and...chemicals that are used in the manufacture of paper...and other things are produced by people like Dupont...who certainly don't want it...it'd also give an income to third world countries if they could grow vast tracts of it to produce fibre..." (participant thirty-five: 46).

Whilst much of what participants talk about in the interviews can be seen as experientially grounded, there are issues that some participants articulate in the interviews that are outside of this. The 'hemp plant has many uses' discourse is prevalent in much of the societal Conversation (Gee, 1999) on the medicinal use of cannabis, but an argument that will be developed in this thesis is that the discourses of some participants tends to articulate issues of personal knowledge, but for others, inter-textuality is frequently found in their articulation. This is to say that ideas from outside of their direct experience are articulated or 'imported' into talking about cannabis. It will be argued in later chapters that this tendency to articulate meanings from outside of personal experience is not typical of all participants and is of some significance in terms of understanding different discursive 'types'.

Medical grade cannabis. Whilst only only one participant articulates this construction of cannabis, it is interesting in a number of ways. The participant was a member of a group called the Alliance of Cannabis Therapeutics, which drew its name and ethos from an American organisation of the same name, to which it was loosely linked (see previous chapters). The A.C.T. engaged with the issues of medicinal cannabis use by speaking to the media (TV, newspapers, magazines) and also by supplying cannabis for the use of its members.

The notion of medical grade cannabis needs, therefore, to be understood in relation to the activities of this group – as something they produce and supply, or at least as a way of understanding this, as articulated by this participant.

> "You've got to get the right sort of cannabis...and...there's a stuff called skunk on the market...which is very powerful and is...as much use to me as a chocolate tea pot quite frankly, that is no good...but to get something that's pure and unadulterated...cannabis...the sort of thing that hippies shall we say giggled about in the late sixties, early seventies...within reason that's perfect. It's not a cure...I know that...but it helps me...and I think since the advent of, particularly in California, these groups...for medical benefit...and...and distribution therefore...an organisation grew up in this country...to provide medical benefit cannabis. I personally have found the best thing is...home grown cannabis...not adulterated by criminals...by...cross breeding, by anything like that...and...it is...that is the best, something that is pure..." (participant twenty-eight: 5-6).

The notion of medical grade cannabis is an interesting one. The participant's excerpt above can be read as discursively opposing 'home grown' with 'criminality' and 'pure' with 'cross-bred' and 'adulterated' to discursively produce cannabis that could be considered pure or as akin to medical grade. But the notion of medical grade cannabis is not out of place if contextualised in the broader Conversation (Gee, 1999) on cannabis and illicit drugs. In the U.S., a small number of patients do still receive cannabis cigarettes from the U.S. Federal Government, which are administrated by the U.S. Food and Drug Administration. This being the case, such a thing as medical grade cannabis does exist (or the discursive notion of it does). The first patient to obtain this government supplied cannabis, Robert Randall, also founded the U.S. Alliance for Cannabis Therapeutics. Being a member of the U.K. group of the same name, participant twenty-eight would likely know this. However, cannabis was also used by scientific medicine in the past and other illicit drugs, such as cocaine and heroin (or diamorphine) retain legitimate medical use today. So the concept of so-

called illicit drugs as having a medical grade is not as peculiar as it may sound and this participant is ideally located to deploy such a notion. Medical grade cannabis has also been available via prescription from pharmacists in Holland since 2003 (Hazekamp, 2006). Discursively, it has a rhetorical advantage, of course, of legitimation.

Notions of adulteration, crossbreeding, criminality and purity are also reflections upon risk (Beck, 1992), the risks inherent in using the 'wrong' kind of cannabis. They are reflections upon technological 'interference' with nature (particularly in relation to issues of cross-breeding and purity) that construct 'skunk' cannabis as the 'other' to a pure, "home grown" cannabis, with the inherent notions of purity bringing safety.

Cannabis as political. Many participants discussed cannabis in clearly politicised ways (and this will be one way in which different types of discourse on medicinal cannabis use will be differentiated). However, two participants explicitly constructed cannabis use as a political "cause".

> "...people think it's disgusting that disabled people are going through prison... so I think that...it does the cause good anyway." (participant five: 31).

> "...it's all part of fighting the good cause." (participant twenty-six: 39).

Both participants had a highly politicised discourse on cannabis use and were also active in campaigning around many issues on disability rights, as well as being employed in this area too. Whilst this means that the participants could be referring to

"the cause" as the disability movement not medicinal cannabis use, what is interesting is that working in as well as being personally involved in the area of disability rights, the participants are more likely to draw on a politicised discourse and to describe it as a "cause". Later analysis will argue that this type of political *engagement* tends to correspond with a politicised type of discourse.

Cannabis as a political problem not a drug problem. One participant made this argument at the end of a narrative which asserted the benefits that cannabis had for disabled people with whom he is involved. This participant is interesting because his discourse was more critical and questioning with regard to issues of power and cannabis use than most participants from similar social backgrounds (occupationally working-class, unskilled manual work, compulsory education only).

The excerpt that follows is a narrative about the broader benefits of cannabis to one individual of the participant's acquaintance. The asterisks are inserted to disguise the name of an organisation to which they belong, for purposes of anonymity.

> "Through...through the ******* I've met some people from all different...in inverted commas 'walks' of life...I guess most of them can't...but...I mean, I've met one chap who's a *******...and he...when he got his trike built...it was the first time in his...I saw him on his first one. The first thing he ever did, the first test drive was taking it to one of the...******* rallies...'cause it was built on a grant...and...they...he said it was the first time in his life he'd been anywhere without someone helping him...he'd never ever...He said he stopped in the lay-by for over an hour...'cause he gave quite a long time for the journey...and...I was talking to him after this and he said "Well, I did spend an hour, at least an hour in fact sat in the lay-by just...savouring being on my own"...He said he actually left when someone pulled in...someone drove into the lay-by and he sort of just started it up and drove off 'cause he wanted to be on his own. 'Cause he'd never in his life been on his own before...I don't think

> people in that kind of situation that it's wrong for them to be able to...get a high in life...I really don't see the whole problem with people being happy...It certainly doesn't make you want to go and beat people up or...run around sort of with a machine gun or anything...and...a lot of disabled people kind of...get those kinds of feelings anyway...it's not...I...I really just do not understand the problem with it. To me it's just a political problem it's not a...drug problem...with cannabis..." (participant forty-one: 21).

The narrative asserts the importance of cannabis for enabling independence (that cannabis and the trike allowed the acquaintance his first ever experience of being on his own) and opposes cannabis to associations with violence (frequently associated with alcohol, which he also discusses elsewhere in his interview). The notion that the problem with cannabis is a political problem, not a problem with cannabis *per se*, is then introduced by way of this narrative that has emphasised the benefits of cannabis, but it is interesting as later this participant outlines what sociologists would recognise as a materialist view of disability and power relations. He argues that "the system" as he sees it, problematises disabled people due to what he describes as economic non-productiveness. Whilst this construction generalises the lack of employment to all disabled people, which is incorrect, it draws on the same ideas as a materialist understanding of the increased social exclusion of disabled people after industrialisation that is discussed by Oliver (1990). The notion of "the system" can be seen as a way of articulating a culturally prevalent understanding that problematises the organisation of power, sometimes the state sometimes more than this, which will also be seen later in the accounts of other participants. This loss of faith, or at least scepticism, in one or more of modernity's key institutions can be taken as part of the increasing variability of trust in government that Beck (1992) discusses, but it must also be seen as particular, in its experience and construction, to the position of the speaker, a participant whose impairment was the outcome of an agricultural accident.

Use of Cannabis

Whilst the previous section of this chapter discussed discursive constructions of cannabis as exhibited in the interviews of participants, this section will provide analysis of how participants spoke about the *use* of cannabis.

Concerns over amount of cannabis to use, predictability and control. Due to the self-administration of cannabis as a substance that does not come in a form commonly understood as medicine (tablets and liquids, with clear guidelines for administration), it is understandable that participants may have been uncertain about how much to use and have connected concerns about predictability of effect and concerns about control.

However, whilst most participants describe finding out how much cannabis to use through a process of trial and error, two participants discuss concerns about how much to use in more depth. What is interesting about these two accounts is how they differ. Participant eighteen is ultimately unconcerned by the amount issue, whereas for participant thirteen, concerns over how much to use and around unpredictability led him to feel disconcerted about using cannabis (although he was having few symptomatic problems at that time anyway, so did not need to use cannabis at that point).

> "So...dosages...it's tricky, isn't it?...With anything...that the G.P. dosage on...on anything that's prescribed...it will work...they say for instance...you know, five milligrams...valium will have a tranquillising effect...it's not true for fifty per cent of the population...the other fifty per cent is a variation of factor sixteen, isn't it? Somebody might have four times as much somebody might have a quarter of that...so...dosages...it's hard..." (participant eighteen: 7).

In the excerpt above, participant eighteen negotiates the concerns about the amount of cannabis to consume by problematising the notion that prescribed medicines are necessarily immune from this problem themselves. Doing so can be seen as a rhetorical attempt to maintain the idea of cannabis' efficacy in the face of potential critique, but this is also a valid point.

However, for participant thirteen concerns about amount and unpredictability were constant themes in his account, cropping up on five different occasions in an interview that was not particularly long in comparison to many others.

> "I would prefer cannabis...the unfortunate thing is I can't take...a measured...pure, purified...quantity...if I could then I would...that's for sure..." (participant thirteen: 21).

What is interesting is that both participants were of similar age, both male, both occupationally middle-class (of middle-middle and upper-middle fractions) and both graduates. However, participant thirteen, with his concerns about measure, purity and quantity has two significant aspects to his biographical trajectory, as they will have been incorporated through the restructuring of his habitus (Bourdieu, 1979). At university he studied chemistry and his profession afterwards, until illness forced him to stop working, was accountancy. These two areas of training and practice both emphasise a concern for quantity and an enhanced habituated set of linguistic ways of

reflecting upon such issues. Whilst cannabis for the overall sample of participants consistently appears to be primarily about efficacy (their experience that it helps them), an individual participant's reflection upon and discussion of cannabis will depend upon their discursive dispositions and linguistic capital (among other factors). This is reflected above, where the participant says that he would prefer cannabis, but the issues of amount and predictability were a concern. This thesis has made a point of noting that much discourse analysis work on drugs tends to homogenise the discursive work of participants rather than explore the differences between what individuals say and what discursive resources and rhetorical strategies they use in doing so. Later chapters will discuss how vocationally and educationally derived linguistic resources are significant in terms of differentiating between different types of discourse on the medicinal use of cannabis.

Cannabis use as pain management. Four participants spoke about cannabis as part of a pain management approach. In terms of the developing argument that, in a number of ways, participants speak about cannabis in vocational or educationally derived ways (with educational and vocational aspects of their trajectories being an important part of accounting for discursive differences between individuals), discursively constructing cannabis as part of a management strategy is significant. It is indicative of reflexivity that employs specific ways of understanding issues that are less likely to have been accrued by individuals that have certain biographical trajectories (more typically working class) than others (more typically middle class) because such understandings tend to be vocationally accrued, but only in certain types of employment. All four participants were from occupationally middle-class

backgrounds and have particularly significant vocational roles that explain the discursive use of the analogy of cannabis use as part of a pain management strategy.

Participant four refers to pain management on numerous occasions and was an M.A. student with a part-time role in disability advice, having also worked in clinical work previously. It will be argued in this thesis that individuals often drew on discursive resources acquired from vocational backgrounds in speaking about cannabis. Pain management, as a strategy for dealing with physical discomfort, would be familiar to someone from this participant's vocational background.

> "but...now...I think because I've got my *pain management*...under a lot more control...I can take it slow." (participant four: 14).

> "I've got my *pain management*...down to a fine art..." (participant four: 15).

Participant thirty-one was a former nurse and also refers to pain management a few times in her interview. Interestingly, this participant recounted in the interview that she had attended a pain management course at the hospital she worked at prior to stopping work due to multiple sclerosis. Considering this, the argument that understanding and speaking about her cannabis use in terms of a pain management strategy should be seen as using specifically vocationally derived ways of understanding and talking about the issue, seems reasonable.

> "I don't take...medication...I've...talked with my doctor...a lot about this and I've been on a pain management course up in **** [name disguised] hospital..." (participant thirty-one: 6).

> "...it's part of the *pain management sort of...strategy...*" (participant thirty-one: 8).

Participant twenty-eight was a former army officer and if one understands the position of officer as involving the management of certain aspects of army life, then the concept of management as applied to strategies for dealing with issues ought not to seem out of place.

> "...if I use cannabis therapeutically...it won't cure me of all the symptoms but it will *manage them...manage them...it's a...it's a management tool...cannabis is...*" (participant twenty-eight: 11).

Participant thirteen spoke about M.S. as something to be managed, in a part of the interview that had not yet got onto discussing the use of cannabis. Before the illness forced him to stop working he had run his own accountancy practice.

> "So...it's no big deal, it's something...it's like with any kind of disease...when you have any sort of...failing in yourself...you have to *manage it*...so...and that's the whole thing, it's like...M.S. can be *managed*...as best as possible and that's what the task is to do" (participant thirteen: 2-3).

All four of these participants have spoken about cannabis use by constructing it as part of a strategy for dealing with the symptoms of their particular conditions. Whilst not all the occupationally middle-class participants in this sample did this, only occupationally middle-class participants did (and more specifically they were only from the occupationally middle-middle and upper middle class fractions, not of the occupationally lower middle-class fraction). However, it is not being argued that simply being occupationally middle-class is likely to mean that a participant will speak about cannabis use in such a way, but that middle-class educational and

probably more so vocational trajectories (or more accurately, those of middle-middle and upper-middle class fractions) are more likely to produce a linguistic habitus (Bourdieu, 1992) that is disposed to speaking about the use of cannabis in such ways. This is because such trajectories more typically involve vocationally situating the individual in careers that require and reward a more reflexive and strategising approach to everyday working tasks.

Homegrown cannabis. Whilst a larger number of participants grew their own cannabis, a few did not speak about it in interviews (on tape). This could be because the legal situations for possession (for personal use) and cultivation of cannabis are potentially very different (with the latter likely to lead to harsher punishment than the former) possibly making some participants reluctant to make revelations about this. However, six participants discussed the issue and the focus of the analysis of this issue is not how many participants grew their own cannabis, but how participants spoke about this issue and the articulation of meaning around accounting for this.

Participant thirty-nine preferred resin cannabis for social use and herbal cannabis for medicinal use and was the only occupationally working-class participant to express a preference for homegrown cannabis. This participant exhibits no reason for this preference other than a practical one (cost) because the herbal form (grass) was home grown (which she later admitted). This participant also only opposes natural and chemical substances once in her entire interview, but interestingly includes 'magic' mushrooms (wild mushrooms with hallucinogenic properties, e.g. *psilocybe*

semilanceata) in the list of 'chemical' substances. The participant laughs below, because her grass is actually free, as she grows it herself.

> "Yeah, but there's not much difference, I don't find them much different but...my grass is a bit cheaper than...(laughs)..." (participant thirty-nine: 11).

Participant fifty was more typical of participants who expressed a preference for homegrown cannabis, because this preference was constructed in relation to some kind of broader meaning. In this excerpt, he contrasts homegrown cannabis with more powerful 'skunk' (typically hydroponically grown and often having a higher T.H.C. content) and his discourse articulates the idea that home grown is more 'natural' and therefore less risky, that will be explored in more depth below. For the moment, the reader may wish to reflect upon how such preferences are also often constructed around organic food as opposed to food produced using pesticides or other non-organic practices. It will later be argued that this discourse on cannabis draws on very similar ideas to those often used when people express a preference for organic food, for example, and Beck's ideas about understandings of 'risk' in contemporary society and behaviours related to this as strategies of the individual in addressing such concerns is important (1992). However, this thesis will suggest that engagements with 'risk' and its associated discourses are mediated by objective structural factors, how they relate to the unequal social distribution of discursive resources and how these play out in talking about 'risk' and in the understandings of differentially located and socially constituted individuals.

> "Probably there's something sitting in the back of my head that's saying...you know, a plant...possibly it might have been grown in a pot baby boiler in which case it might have some very weird chemicals

> in it...but...it's less likely to have...you know, *skunk* scares me 'cause I don't know how they get it to be that strong...I don't know what there is...in there and I'm not interested in finding out even I just don't want it...There's an idea...there's probably some sort of...green hippie idea in the back of my...but this [home grown cannabis] is natural...you know, so...there's probably something going on that's saying it's...it's...a less risky form...to use...there's less chance of someone...dabbling around with it, changing what I'm smoking..." (participant fifty: 17-18).

Participant fifty's account here is reflexive in as much as he can be seen to be speculating upon the source of his own understanding "...there's probably some sort of...green hippie idea in the back of my...", but he is most definitely explicitly constructing home-grown cannabis in opposition to ideas about 'skunk' and 'risk' (he even actually uses the word "risky" himself). It is also interesting in the respect that he has concerns about 'skunk' cannabis based on unknowns:

> "*skunk* scares me 'cause I don't know how they get it to be that strong...I don't know what there is...in there..." (participant fifty: 17-18).

Beck (1992) discusses the invisible character of many manufactured risks (his main example being radiation) as well as emphasising that much of the anxiety around such risk is due to unknowns. This excerpt seems to be a good example of precisely this.

Participant five exhibits a particular significance as to why she only uses homegrown cannabis. However, this participant also attaches what she calls political significance to it, as she later says that she does not believe in putting money into the 'black market' of drug supply.

> "...I never use resin. I only use grass, you see because politically I don't believe in buying it which is why I grow my own..." (participant five: 7).

Other participants who said that they grew their own cannabis expressed similarly ethical reasons as to why they did so, as did one participant who no longer grew his own due to the police raiding his house on a number of occasions (he was able to see the funny side to having to promise to his friend and landlord that he would stop, because it was becoming too expensive to keep replacing the front door).

With the exception of the one occupationally working-class participant mentioned above, all the remaining participants who expressed a preference for homegrown cannabis in the interviews were from the occupationally intermediate middle-middle class fraction. This suggests some degree of social class – lifestyle connection with symbolic consumption (the connotations that participants attached to home-grown cannabis in this section) being particularly important to this group.

Discursive constructions of what is or is not a 'drug'

The rest of this chapter looks at discursive constructions in the interviews that can be seen as occasioned and specific attempts to negotiate what is and is not a 'drug', with all the negative connotations that this tends to carry in public discourse. The reader may recall that such discursive negotiations were also found in research by Omel'chenko (2006), discussed in Chapter Two.

Cannabis as not really a drug / cannabis is a 'soft' drug. The argument that cannabis is not really a drug is an interesting discursive assertion. It has the rhetorical advantage of lessening the perception of cannabis as risky / problematic and reducing the problems that this understanding of cannabis could make for the possibility of it being seen as a medicinal substance, or in challenging the 'no medical value' discourse on cannabis. It draws on the previously discussed ideas that cannabis is safe and benign and opposes this to the ideas of 'drugs' as substances that are risky to consume (notions of 'addiction' and risk of fatality being uppermost among these). The notion that cannabis is a 'soft' drug draws explicitly on the 'soft' drug / 'hard' drug discursive dichotomy that has great prevalence in the discussion of drugs in everyday life (Coomber, 2000). In this respect it might be argued that such articulations draw on culturally prevalent ways of talking about and understanding drugs (Glassner and Loughlin n.d., cited in Silverman, 1994), which can be taken as reflecting and articulating the 'normalisation' among *some* in society of certain drugs, particularly cannabis, in recent years (Parker *et al.*, 1998), which in the practical understandings of many has unmoored cannabis from connotations of 'risk' and 'abnormality'.

These articulations of cannabis 'not being a drug' are clearly also not limited to the U.K. either, as can be seen in Omel'chenko's (2006) discourse analysis of Russian drug users sometimes constructing cannabis as *ne narkotik* (not drugs). However, Omel'chenko's (2006) work also raises the point that such constructions are specific to the contextual requirements that an individual's discourse must serve in a particular situation and as such, these constructions can also be shifting.

The argument that cannabis is not really a drug was explicitly made by three participants. All three had used cannabis recreationally prior to medicinal use. All three were from different occupational social class positions and educational and vocational backgrounds. However, this is not a particularly discursively sophisticated argument and it does draw on the 'soft' drug / 'hard' drug discursive dichotomy that is prevalent in the public Conversation (Gee, 1999) on 'drugs', so is unlikely to be the exclusive discursive resource of any particular social group.

The argument that cannabis is not really a drug typically employs an opposition being articulated between cannabis and other illicit substances (typically the so-called 'hard' drugs of 'crack' cocaine and heroin), often drawing on the discursive distinction between the 'natural' and the 'chemical' or 'man made.' These issues will be discussed in the following chapter, however this dichotomy is incredibly prevalent in the accounts of participants in relation to all kinds of issues. As will become increasingly clear over the remaining chapters, the discursive category of 'the natural' is taken by most participants to be intrinsically preferable in many ways but particularly in terms of safety. 'Chemical' or 'man-made' substances are typically constructed as problematic, unsafe and dangerous.

> "People just don't know anything about it, do they? They don't...they don't see that...cannabis is not really a drug, is it? It's something totally different. It's away from all the *chemicals* like...heroin and...cocaine...the 'crack'..." (participant twenty-two: 41).

> "So any...*chemical* drugs...I'm...opposed to probably...Nearly all of them...and...It's...it's a different...category...I...in my mind I don't perceive cannabis as a drug...per se. I see it as...a remedy or a relaxant or...whatever...and...I would never...touch things like heroin...'crack'..." (participant thirty-eight: 8).

In a similar way to the excerpt above, participant thirty constructed such an opposition between "narcotic drugs" and cannabis. The term 'narcotic' emanating from American drug discourse and usually taken to mean opiate drugs, e.g. heroin.

One participant (participant five) explicitly constructed cannabis as a 'soft' drug in her interview. Her discourse in general was among the more complex of the participants, although it has been argued that access to this discursive resource (the 'soft' / 'hard' drug dichotomy) is not particularly specific to any social group due to its prevalence in the general discourse on drugs and in turn the commonness of this as a topic, or societal Conversation (Gee, 1999) that British society engages with.

> I considered it [cannabis] a *soft drug*. I would never take...hard drugs...and...I've also got complete phobia about needles ..." (participant five: 12).

Other discursive constructions around the term 'drug'. One participant problematised the broad term 'drugs' and argued that the term tends to homogenise the different substances that it encompasses. He used the examples of cannabis and heroin and also argued that alcohol and cigarettes are "far worse" than cannabis and that if cannabis is to be included in this all encompassing term 'drugs' then so should they.

> "I think one of the problems as well is that they...they...because...it's unfortunate but, because drugs is such a broad term, you know? People say drugs, yeah? and they include cannabis in the same word that seems like heroin. They're just not the same...you know? If you're going to do that then you might as well mention alcohol and cigarettes, you know, things that are far worse." (participant forty-six: 14).

Interestingly, the latter point that the participant made in the excerpt above is very similar to that which was more recently made in a report by the Royal Society for the encouragement of Arts, Manufactures and Commerce (R.S.A, 2007) (about producing a categorising system that places alcohol and tobacco products, along with illicit drugs, in order of the risks that they pose to individuals and society). Another participant can be seen as questioning the language used in terms of what is seen as a drug and what is not, around alcohol.

> "I kept it [smoking cannabis] a secret for a while because they've made it plain that they were anti-drugs...anti-drug use completely...apart from the fact that they used to drink wine quite regularly...which to me is drug use...but anyway they wouldn't agree with that..." (participant forty-one: 41).

Earlier in this section a number of participants were shown arguing that cannabis is not a 'drug', whereas in this subsection, two participants are arguing that other substances, not usually spoken about as being 'drugs', *are* drugs. This is significant when one of the main tenets of discourse analysis is considered, i.e. that discursive constructions shift subject to what individuals are using language to accomplish. Bearing this in mind, participants often either argued that cannabis is not a 'drug' or that other substances are 'drugs', with the effect usually being to downplay the problematisation of cannabis or to problematise other substances (and in practice, with oppositions being formed, both rhetorical strategies are often used together).

One participant exhibited an understanding of the literature around drug-effects. This participant, the founder of the A.C.T. in Britain, had formerly worked as a media researcher, and later producer, for television, specialising in working on television programmes that addressed medical issues. Whilst it would not necessarily be

expected that this participant would articulate a well-informed understanding of many issues relating to cannabis because of this vocational background, see Coomber *et al.* (2000) (on media workers and drug-related 'knowledge'), this participant appeared to be relatively well-informed.

> Interviewer: "I think a lot of people...just...just tend to think there's this rather deterministic relationship between the use of...a substance and the effect it has on the person and they don't take into account...the kind of..."
>
> Participant: "set and setting ..." (participant thirty-two: 16).

'Set' and 'setting' are terms from the work of Zinberg (1984) and refer to his model for understanding drug effects, which argues for considering the substance(s) administered, individual factors (set) and the social context (setting). One would not necessarily expect most participants to be familiar with this work. However, this participant recounted how, on initially hearing that cannabis might be useful for people with multiple sclerosis, she went to London and researched the issue at the Institute for the Study of Drug Dependence (now Drugscope). This raises some significant questions about the relationship between vocational and educational experience and how people engage with an issue, which in turn raises interesting questions about how this engagement then leads to participants who are differentially capacitated regarding the use of language and have differing tendencies in terms of what they can say and are likely to say in interviews such as those looked at in this thesis.

This chapter has 'mapped' and examined discursive constructions of cannabis, of the use of cannabis and discursive constructions as negotiation around what things are or

are not 'drugs'. The reader should now have a sense that articulations around cannabis, its use and discursive negotiation around what is and is not a 'drug', can be seen as serving certain rhetorical ends (most obviously the assertion that cannabis is safe and efficacious) but that such assertions are not only being articulated for arguments sake, they also relate to the experience and beliefs of the participants. In turn, these experiences and beliefs are grounded in the increasing variability of faith in scientific medicine, as a particular manifestation of a broader variability of faith in science, technology and government (Beck, 1992) that is increasingly characteristic in contemporary society (see Chapter Six). Talking about, for example, cannabis as safe / benign, the many uses of the hemp plant, 'medical grade' cannabis and homegrown cannabis, are all articulations of ideas about 'risk' (Beck, 1992) and 'nature'.

The reader may now also have a sense of the degree of differences between the discourses of some of the participants. Many of the different constructions of cannabis that were 'mapped' earlier in this chapter were actually articulated by only certain participants. The great variability in terms of what is spoken about, using different discursive resources and rhetorical strategies will continue to be seen throughout the rest of this part of the thesis and accounting for this is one of the main aims of the thesis. The next chapter will 'map' and discuss the rhetorical articulation of discursive oppositions in the participants' interviews.

CHAPTER 10

DISCURSIVE OPPOSITIONS

This chapter will examine the articulation of discursive oppositions, or *contrasts* as Hellum (2005) refers to them, within the participants' interviews. As rhetorical strategies, discursive oppositions are common in everyday discourse, which often involves speakers attempting to make assertions (McKinlay *et al.*, 1993; Wooffitt, 1993; Potter, 1997). The creative use of discursively opposing one idea with another is a common rhetorical strategy in relation to this.

In terms of literature considered in the literature review (Chapter Two), Hellum (2005) found that participants who were Swedish backpackers and had used cannabis whilst travelling would contrast cannabis with other substances, for example alcohol, where notions of alcohol being a damaging substance were emphasised, and ecstasy, where the 'risks' of ecstasy use were emphasised in contrast to cannabis being constructed as relatively safe. The latter contrast articulated by these participants revolved around the notion that as ecstasy is a pharmacologically manufactured ('man-made') substance and cannabis is 'natural' that the latter must be safer to use than the former. This assumption that the 'man-made' is innately less safe than the 'natural' has great prevalence in the contemporary period in relation to all manner of products and is also exhibited by the participants in this thesis.

Rødner (2005) has also discussed similar issues, but points out that in contrasting their use of one substance with that of another and in emphasising the problems of the latter to present the problems with the use of the former in a minimising way, they are

not just attempting to construct the use of one substance in a positive light, *but are also trying to do the same with regards to themselves.* Self-presentational issues are again one aspect of such oppositions (this thesis will devote a chapter to this, see Chapter Sixteen).

More broadly, Derrida (1977) has argued that Western culture has a tendency to feature discourses that deploy such oppositions, but in which one aspect of the opposition is hierarchised above the other. So oppositions are common in people's creative use of language, but also in the linguistic resources that they might draw on to speak about issues, i.e. oppositions – frequently hierarchically organised – are pre-existent within language, although the hierarchies are often subject to contestation and struggle.

However, these discursive contrasts are not simply part of a discursive 'game', the aim of which being to portray cannabis and themselves in as positive light as possible. Whilst participants' discourses can be read as attending to such concerns, they must also be seen as articulating (albeit in particular and occasioned ways) their understandings of cannabis, by also talking about alcohol, tobacco, other illicit drugs, prescription medicines and all manner of "chemical" / "man-made" substances.

Oppositions of cannabis and alcohol

Discursive oppositions between cannabis and alcohol were one of the most common oppositions found within the interviews in this research, with eighteen participants

doing so, in various ways (which is over half of the entire sample). This is probably due to the prevalence of alcohol consumption in the U.K. and the common perception of alcohol as being related to various 'social problems'. There were no social class patterns to the eighteen participants who articulated this discursive opposition in their interviews.

The main discursive thrust of what was said on this matter was that cannabis was preferable to alcohol in relation to a range of issues. Whilst being able to argue that cannabis is preferable to a legal substance has the rhetorical benefit of implicitly or explicitly questioning why cannabis is illegal, if it is more useful and less socially problematic than a legal substance, the various ways in which participants discursively opposed cannabis to alcohol tended to involve culturally prevalent ideas about alcohol, often grounded in the participants' own experiences of alcohol and its consumption.

The most common discursive opposition made between cannabis and alcohol was, perhaps predictably, made in relation to alcohol being strongly associated with violence. Seven participants spoke about alcohol in such a way, in comparing it to cannabis. The understanding of alcohol as being strongly linked to violent behaviour (as well as various other risky behaviours) is, however, strongly shared by many members of society.

> " ... like ... people take vast amounts of alcohol and everything ... and get violent ... I have never, ever, known anyone to get violent out of cannabis ... 'cause its too mellow <laughs>." (participant thirty-nine: 20)

As has been seen in certain previous extracts, extreme case formulations (Pomerantz, 1986, cited in Wooffitt, 1993) are rhetorically used here, with "...never, ever..." used to emphasise the point and the participant's laugh after describing cannabis as "too mellow" reinforces the taken-for-granted understanding that cannabis is not associated with violence. Historically, however, cannabis *has* had such associations (see films such as *Reefer Madness* for example) but since the 1960's cannabis has predominantly been associated with non-aggression in the minds of many members of society, with the use of the term "mellow" by this participant being taken to be a humorous play on this.

Five participants discursively opposed cannabis with alcohol on the broader basis of 'social problems'. Whilst, in effect, many of these social problems may be related to the commonly perceived link between alcohol and violence, there are other social problems that alcohol is commonly associated with in the minds of the public (such as anti-social behaviour, unprotected sexual relations and domestic abuse). The five participants tended, however, to oppose cannabis to alcohol on the fairly non-specific basis of "social problems" and not to expand on this. Perhaps the prevalence of such ideas about alcohol means that as a rhetorical strategy they do not need to say any more than this for it to be effective.

> "I thought it [cannabis] was a lot less trouble and less social trouble than alcohol actually." (participant twenty-three: 4-5).

The idea that cannabis was less problematic than alcohol was also discussed in relation to personal experience by some participants. One such participant drew on her personal experience of working as a nurse.

> "...over the years I've done a lot of work with...recovering alcoholics...the effects of alcohol on people's bodies and brains it's horrendous...and...and also their social situation...and so I feel very strongly about that and I do believe that the...socially and recreationally...cannabis should, should also be legalised..." (participant thirty-one: 13).

This excerpt shows that participants may speak about cannabis by sometimes using discursive resources drawn from particular vocational discourses as well as articulating vocationally derived experiences (as one part of the practical or personal experience that informs peoples' understandings of an issue, in this case cannabis).

Two participants spoke about cannabis within discursive oppositions to alcohol in relation to having previously had a problematic relationship with alcohol consumption themselves.

> "I was trying to...live a legal life...just...I wanted to be legal...so I drank...alcohol...for recreation...and I...it just got worse and worse and worse, did my consumption of alcohol...until I was, I was very ill with it...I'd have a smoke...at crucial points in my life...I've gone looking for some cannabis and smoked it...I used it...at, just to sit and think about my situation...and it's...helped me...to clarify things...over the years...but because I was trying to stay within the law...I stuck to alcohol...which nearly killed me" (participant thirty-five: 17).

In an excerpt from one of the most interesting interviews of the sample, this participant opposes alcohol to cannabis by arguing that alcohol nearly killed him, whereas cannabis allowed him moments to reflect upon his life and gain insight into his problems (one of which being his relationship with, and consumption of, alcohol). He draws attention to the fact that he used alcohol because he was trying to be law-abiding, although it was cannabis that actually helped him, out of the two substances.

As in a previous excerpt from a different interview, we can also see the use of three-partedness (Jefferson, 1991, cited in Wooffitt, 1993) "...it just got worse and worse and worse..." to emphasise the point that he saw alcohol as such a source of trouble in his life. Whilst we can see that his account is organised to rhetorical effect, it is also drawing on personal experience of a very difficult period in a persons life, so the emphasis is not just to assert cannabis' usefulness by way of opposition, it is also the outcome of deeply held conviction, being the outcome of personal experience.

The last two types of opposition between cannabis and alcohol that will be discussed were only articulated by one individual each. Whereas many participants constructed alcohol as a problem in relation to violence or a broader sense of social problems, the last two are interesting for their uniqueness and as examples of how the discourse of certain participants is different in the respect that it tends to assert the value of cannabis by discursively attacking key aspects of the orthodox discourse (Bourdieu, 1979) on cannabis as being of 'no medical value' or attacking key discursive aspects of the medical and scientific discourse that supports the 'no medical value' discourse. Such articulations are not common and tend to be limited to the discourse of a small number of participants.

> "...but obviously I support the fact that they're doing, you know, more medical research into it...because obviously they wanna find out if there's anything in cannabis that is gonna affect people badly over time...you know...but...you know, what medical studies do you reckon they did to find out the long term effects of alcohol...or cigarettes? Did they do any of it?" (participant forty-six: 33).

In this excerpt, the participant is in favour of medical trials of cannabis, but also argues that alcohol and cigarettes had not been subject to such trials for safety. Whilst

alcohol and tobacco both have histories of use that clearly pre-date the practice of clinical testing of products to be internally consumed by people, it is an interesting point to raise. In effect it argues that the assertion that cannabis could not be legally available without such testing is contradictory in relation to the legal position of alcohol and tobacco, which are comparable substances to cannabis (at least he poses them as being so within the excerpt) and within the construction of others too, also cross-culturally, see Omel'chenko (2006). This participant's discourse does attack the argument inherent in the 'no medical value' discourse, that cannabis could not possibly be considered for legalisation without clinical safety tests.

> "...people call it a drug of choice, I mean, I don't like that phrase particularly...that's what it is because it's illegal...when it becomes legal...because they will do...it will not be so much of a drug...in that alcohol is not so much of a drug and yet I believe that to be more of a drug...and certainly nicotine...it's terrible...terrible..." (participant twenty-eight: 19).

In this excerpt, the participant engages with the various meanings, or possibilities of articulating, the term 'drug' (something that other participants also did and was addressed in the previous chapter), this time also engaging with a discursive opposition between alcohol and cannabis. He asserts that whilst cannabis can be called a drug, because it is currently illegal, when it is legalised (which he is certain will happen) it will be seen as less of a drug than alcohol and tobacco, because of what he believes to be the more problematic issues that alcohol and nicotine have, compared to cannabis. The term 'drug' carries connotations of risk and danger and the participant can be seen as asserting that legalisation will help to reduce such connotations. In doing so, he is arguing that cannabis is only seen in this way at the moment because of the connotations carried by calling it a 'drug.' These connotations

can be seen as one key way in which cannabis is discursively disqualified or undermined, from being credibly understood as a medicinal substance, as the application of the label 'drug' has very significant outcomes for the substance to which it is applied.

Oppositions of cannabis and tobacco

Six participants discussed cannabis in terms of discursively opposing it to tobacco. All six were occupationally middle-class (which perhaps reflects broad social class patterns around smoking) with only one of them being from the occupationally lower-middle class fraction. Five of these participants simply spoke about tobacco as being more dangerous than cannabis in terms of health risks, with the implicit or explicit argument being that cigarettes are legal but cannabis is not, despite cigarettes being more dangerous, in their opinion, than cannabis.

As with alcohol, whilst such arguments have a rhetorical aspect to them, in terms of attempting to assert the relative safety of cannabis, these arguments draw on commonly shared understandings of tobacco – that smoking is dangerous. Having said this, most of them smoked cannabis and mixed it with tobacco. This may well account for why the risks of tobacco use were articulated in terms of either broad and unexpanded notions of risk, constructions that deploy the term 'drug' (and its various connotations of risk) or addiction, as opposed to specifically talking about smoking related carcinogenic risks.

> "I think...it's [cannabis]...is...a...I think that...is not as damaging...as...certain other drugs that are around...you know, like cigarettes" (participant twenty-six: 30).

This participant constructs cigarettes as a drug, thereby emphasising the risk element to smoking, by bringing into play the 'risk' connotations that the term 'drug' entails.

One participant also spoke about tobacco in opposition to cannabis as problematic, but in relation to his personal experience of smoking and ideas about 'addiction' or dependence. Again, it is now cigarettes that are the 'drug.'

> "I loath the fact that I have to smoke cigarettes...I really do but I can't get them out...it's a drug I'm hooked on...it's the only thing in my life that controls me...the tobacco..."

> "... over the last what, six years?...I've been doing this [using cannabis]...and...there have been times where I've gone as long as nine months...without it...this...I'm satisfied myself that there's absolutely no habit attached to it" (participant thirty: 6).

Over these two extracts, from the same page of transcription, the participant exhibits the belief that he is "hooked" on smoking cigarettes, but he asserts the view that his use of cannabis is not habitual. It is also rhetorically interesting that he describes cigarettes as "a drug" but not cannabis. In this excerpt, the connotation seems to be that a drug is something that induces a pattern of habitual use, this being the case for cigarettes but not cannabis. Again though, this is rhetorically significant in portraying cannabis as the relatively less problematic of the two substances.

Oppositions of cannabis and other illicit drugs

Eight participants spoke about cannabis by way of discursively opposing it to other illicit drugs. Of these, six were from the occupationally middle-middle class fraction. As above, with alcohol and tobacco, cannabis is discursively opposed to other illicit drugs in ways that rhetorically construct a relatively lower level of risk when using cannabis, as opposed to other illicit drugs. This is done in a number of ways.

Three participants spoke about cannabis and other illicit drugs by simply asserting that other illicit drugs were more dangerous. Of these, one particularly emphasised the dangers of 'addiction' in relation to other illicit drugs, and alcohol, but not cannabis.

> "I don't know many people who smoke [cannabis] regularly who are constantly saying 'I wish I could get this off, I wish I could stop'...and I've seen plenty of alcoholics doing that. And hard drug users...doing that sort of thing...'Oh, I wish I could stop doing this'." (participant forty-one: 27).

This excerpt also features the term "hard drug users", with the 'hard' drug / 'soft' drug dichotomy already having been addressed in this research. Cannabis is positioned implicitly as a 'soft' drug due to it being opposed to the explicit use of the phrase 'hard' drug. As has also already been discussed, the 'hard' drug / 'soft' drug dichotomy is a highly prevalent part of society's general discourse on drugs (Coomber, 2000) and constructs so-called 'soft' drugs as relatively less risky in a range of ways, in relation to so-called 'hard' drugs.

Two other participants draw on the 'hard' drug / 'soft' drug dichotomy.

> "I mean, you knew in yourself...I knew...that obviously it [cannabis] wasn't as bad as hard drugs like heroin or...whatever...and I mean, I never...ever...would have wanted to have tried anything like crack or LSD..." (participant forty-eight: 11).

This excerpt is interesting in the way that the 'hard' drug / 'soft' drug dichotomy can be read as exerting a taken-for-grantedness around the comment "obviously it [cannabis] wasn't as bad as hard drugs". Rhetorically, if it is accepted that the use of so-called 'hard' drugs is inevitably more problematic than the use of so-called 'soft' drugs, then this assertion is harder to challenge. Extreme case formulation (Pomerantz, 1986, cited in Wooffitt, 1993) is again used to further emphasise the relative dangers of 'hard' drugs, "...I *never...ever*...would have wanted to have tried anything like crack or LSD..."

Two participants drew on the tendency within public discourses on a whole range of issues to hierarchise substances that are constructed as being somehow 'natural' over those that are constructed as being somehow more 'chemical' or 'man-made' (and this discursive issue will be discussed in greater length later in this chapter). In doing so, they construct cannabis as relatively less problematic than other illicit drugs.

> "[I am] Really anti-drugs...any drugs...I'm still...I'm...Things...I wouldn't have chemicals...which is why I prefer to...smoke [cannabis] than take my...pain killers or my sleeping tablets...Chemicals...don't live in our body...It's a weird thing but I'm just not...So any...chemical drugs...I'm...opposed to probably...Nearly all of them... And ...It's...it's a different...category...I...in my mind I don't perceive cannabis as a drug...per se. I see it as...a remedy or a relaxant or...whatever...and...I would never...touch things like heroin...crack..." (participant thirty-eight: 8).

The assertion seems to be that as cannabis is not chemical, in the 'man-made' sense, that it is intrinsically preferable to 'chemical' substances. This excerpt is also interesting because it starts by using the term 'drug' but actually talks about prescribed substances, thus equating all pharmacological substances, prescription or illicit, as problematic. There is clearly an articulation of 'manufactured risk' (Giddens, 1999) here.

In another participant's account, cannabis is emphasised as being natural, hence preferable to illicit drugs that are not, in this case explicitly using the term "pharmaceutical".

> "I regarded it [cannabis] more as a natural product...rather than things like Valium and alcohol and umm...the other types of drugs that were about. Umm...I've never really looked upon it as being in the same context as things like Valium...right...which help to relax you. I've always regarded Valium as a *pharmaceutical* type drug which umm...I don't have any time for." (participant six: 7).

Cannabis opposed to chemical / man-made substances

Five participants spoke about cannabis by opposing it to ideas about 'chemical' or 'man-made' substances in various ways. Of these five, one was occupationally working-class (from the upper-working class fraction), two were occupationally lower-middle class and two were occupationally middle-middle class. As has been remarked elsewhere in this thesis, talking about cannabis in relation to ideas about its 'naturalness' is common to the majority of participants, so this cross-class spread is unsurprising.

One participant, the occupationally working-class participant, gave an interesting account that hints at where such ideas came from. Two excerpts from the participant's interview suggest formative influences on her thinking about cannabis and how they have been employed in her thinking about pharmaceutical products.

> "I have very good friends that looked after me and they educated me with it...they...they've forbidden me to take any amphetamines like...what they used to be called then...speed, acid...mushrooms ...coke, heroin...they forbidded it...they forbidded any chemicals..." (participant thirty-nine: 19).

> "...all the tablets that doctors give you, why the hell can't they do it to the cannabis, because...the chemicals the doctors in the pharmacy give you do more damage, done more damage to my body than cannabis has ever done..." (participant thirty-nine: 42).

The "very good friends" to whom she referred are a group of bikers that she was still associated with at the time of the interviews. The possible contradiction between "chemicals" and "mushrooms" is only an issue if one reads the list of drugs as examples of chemical, instead of illicit, drugs that she was 'forbidden' from taken.

The second excerpt suggests an interpretation made by her, or at least constructed within this account, of the iatrogenic effects (Illich, 1995) of her encounters with the medical profession being due to the "chemical" constituency of prescribed medicines that she had been given. It is interesting to speculate, though nothing firmer than this is methodologically justifiable, as to how the strict 'forbidding' of certain illicit drugs earlier in her life may have informed her later likelihood of understanding prescribed medicines as problematic. Interestingly though, any assumptions about cannabis being safe because, unlike the listed illicit drugs (except mushrooms) and the

prescribed medicines, cannabis is often seen as 'natural', go unsaid. Yet it is in relation to a 'natural' / 'chemical' or 'man-made' dichotomy that such oppositions are informed.

> "I will take...sleeping tablets...and...as opposed to not taking them...and...and my pain killers...which I'd...I'd...I'd take them...and...when I can't take cannabis...I would prefer...I'm just...putting chemicals in there. I just don't...you know, and I'm quite...what the doctors what they're gonna do with the cannabis, I'm a bit...hesitant about it because I think if you're gonna start doctoring about with it...then you are gonna lose some of its properties...I don't know how chemistry works but...you can't...you know, they're talking about a sort of aerosol like a puffer, an asthma puffer and stuff like that and I thinking wow...you know...you're just mucking about with it. You're changing it...it's not gonna have the same properties...Is it still going to be a natural remedy?...If you're gonna start, you know....playing about with its'...structure...it's not the same stuff at all..." (participant thirty-eight: 59).

This participant had been asked about strategies for coping with shortages of cannabis in terms of supply. She said that under such conditions, she reverted to using prescribed substances, although she regarded this as putting chemicals "in there" (into her body). Interestingly, she then moved into a discussion in which she voiced fears about the research to produce cannabis-based medicines, in which she constructed this as "mucking about with it" and questioned whether it will still be a "natural remedy". Again, the 'chemical' / 'natural' dichotomy is displayed here.

Another participant constructs cannabis in opposition to the 'chemical' in a more direct and explicit excerpt.

> "Yes I have Diazepam for spasm... for me in an ideal world I would go for physiotherapy...no drugs like that...they've all got side-effects...and some cannabis...which I think is more natural somehow a more natural substance...I may be totally wrong...I know it's natural

> because it grows as opposed to some sort of chemical thing..."
> (participant seventeen: 17).

In this excerpt, prescribed substances, like Diazepam, were constructed as having side-effects and cannabis was constructed as not having side-effects, or at least less likely to, because it is 'natural.' The absolute certainty of her ontological category of 'natural' is questioned for a brief moment but then reaffirmed by the common-sense assertion that it must be natural "because it grows." In common with the previous participant's excerpt, reflection upon the risks of pharmacological products seems to articulate the broader social variability of faith in science (Beck, 1992) or more specifically pharmacology.

This participant and the previous one certainly discuss this opposition in relation to strategies of healthcare, whereas the first participant did not. The social class difference opens up the possibility of considering the idea that occupationally middle-class individuals are more likely to discuss cannabis use in relation to strategies that are the outcome of reflecting upon iatrogenic risk, than occupationally working-class participants are. Arguments about the late-modern reflexive self as argued for by Beck (1992) and Giddens (1990; 1991) (albeit a not entirely identical argument), being more typical of middle-class individuals than those from the working-class, are perhaps relevant here (Savage, 2000; Atkinson, 2007).

> "I've had these very strong pain-killers...eight a day for something like nine years...and they are very strong...they are addictive but I think they are addictive for people who don't need them...You know if you take something because you need it, it's not an addiction...but your body gets used to it...you know and I suppose I'm trying, 'cos I am on so much medication...umm...I get my medication delivered in cardboard boxes every three months, right, ...its like umm...I think one of the boxes behind you...you know...it gets full, large amounts,

> and I am trying at all times to sort of look at ways of reducing the amounts of chemicals....or what I regard as man-made...more man-made chemicals than I suppose in a sense I regard cannabis as more of a healthy option...although it sounds weird to say that...but I regard it as a healthier option that has more benefit than the less healthy option ..." (participant six: 3).

This excerpt also constructs cannabis in opposition to 'chemical' or 'man-made' substances and, as with the previous two excerpts, does so within an account that also features aspects of strategising and risk reflection. Medicinal cannabis use is clearly constructed here as part of a strategy, which is interesting in relation to Beck's (1992) ideas about individualisation in reflexive modernisation, in which individuals are extracted from traditional social relations and re-inserted as reflexive individuals in a different modernity. However, such reflection on cannabis use as part of a strategy is, in this research, found to be typical only of those who have occupied certain vocational roles (see the end of this chapter) and thus it is argued in this thesis that reflexivity is in reality greatly structured by the possession of discursive resources and a habitus that is disposed to reflexivity (Bourdieu, 1979; 1992).

Interestingly, this participant also discusses the medicalised notion of 'addiction' and this concept seems to be a key part of her reflection on the risks of prescribed medicines. As medicalised discourse is the discourse of the dominant institutions within the field of medicine, we ought not to be surprised that it features here. Her discussion of addiction is interesting, because she can be seen to be negotiating the moral stigma of addiction, by arguing that addiction only applies to people who do not "need them" (have a medically legitimised requirement). This is of course another example of participants attending to issues of self-presentation within their accounts. She then constructs cannabis in opposition to such risks, by calling it a "healthy

option." This term draws on a lifestyle type discourse, the type of meanings that circulate within ways of talking about, for example, dieting and food (e.g. breakfast cereals high in fibre might often be called or marketed as 'healthy options'). It is also worth noting that as someone with a background in health-related counselling, her account is unsurprising for exhibiting an awareness of, and negotiation around the construction of, addiction. Again, reflexivity is structured by vocationally accrued capacities and dispositions (Bourdieu, 1979).

The last participant to be discussed in this subsection also exhibits a set of understandings informed, in part, by medicalised discourse. This participant, however, was also one (among a few others) whose interview was most remarkable for exhibiting a strong rhetorical tendency towards 'impression management'. In the excerpt below, she talks about being surprised that cannabis could help with the symptoms of multiple sclerosis, when she first tried it. Her assertion can be read, in the broader context of how she often presented herself throughout the interview, in light of what might be described as a discourse of 'middle-class respectability'.

> "Oh yes...I was totally astonished because I had no idea that anything that wasn't...sort of drug-bound...i.e. man-made could have such a benefit without a side-effect...because it really doesn't seem to have a side-effect." (participant three: 11).

This participant's excerpt suggests an ignorance of alternatives to orthodox medicine, or a more total acceptance of orthodox medical discourse and its' claims to monopolisation of effective healthcare, but it can also be read as an assertion that the participant is keen to present herself as not the 'kind of person who would know about such things.' This reading is supported by her assertion just before the above

excerpt that recreational use (as opposed to medicinal use) of cannabis would be "so alien to our nature ..." (participant three: 11) which one might argue is quite a robust rebuttal!

Cannabis opposed to prescription medicines

Whilst much of the discussion around 'chemical' substances was actually about prescribed medicines, some participants spoke about the two discursive categories distinctly. In fact, twenty participants constructed an opposition between cannabis and prescribed medicines in their interviews. This number, however, is not surprising as the interviews asked specifically about prescribed medicines and it is also seemingly the case that the majority of participants came to use cannabis medicinally out of a dissatisfaction with prescribed medicines (Coomber, Oliver and Morris, 2003).

Talking about 'chemical' / 'man-made' substances in the interviews often involved talking about prescribed medicines, but can also be seen as a way of talking about scientific medicine's professionals and practice. Doing so brings into play two areas as discussed by Beck (1992), a critique of the medical / pharmaceutical industries (and reasons why disabled and / or chronically ill people may have a particularly fraught relationship with, as well as be sceptical about, the interests of these professions have already been addressed, see Chapter Seven) and a broader concern about anything seen as being non-naturally produced. The twenty participants discussed in this subsection are of a broad range across the occupational social classes.

It is also the case that the construction of this opposition by the twenty participants is the outcome of mainly practical reasons, such as various undesirable side-effects they had encountered from prescribed substances, the ineffectiveness of prescribed substances, or the relatively slower time to take effect (typically of tablets) compared to cannabis (smoking as a route of administration tends to produce effects quicker than taking tablets due to absorption into the blood stream being quicker through lungs than the stomach). Some participants also constructed cannabis as preferable to prescribed medicines with reference to the previously discussed ideas about 'nature' / 'chemical' and 'man-made' although these ideas have been touched on already and will also be discussed later.

Whilst later chapters will move towards the construction of a set of 'types' of medicinal cannabis users' discourses, that will describe different types of discursive engagement with the issue, talking specifically about prescribed medicines and cannabis as an alternative was limited to practical preferences or more elaborated practical preferences (practical preference plus some ideas about 'chemical' / 'natural').

This chapter has argued that discursive oppositions are common to everyday discourse and has demonstrated that they were commonly found in the interviews. Participants in this research often combined discursive oppositions with other rhetorical strategies, such as three-partedness (Jefferson, 1991, cited in Wooffitt, 1993) and extreme case formulations (Pomerantz, 1986, cited in Wooffitt, 1993). The

discursive oppositions that were articulated by certain participants between cannabis and alcohol, cigarettes, other illicit drugs, 'man-made' substances and prescribed medicines, articulated discursive resources specific to certain vocations or otherwise less prevalently distributed discursive resources. However, most articulated 'common-sense' ideas, i.e. prevalent ways of talking about an issue that are relatively uncontested, for example the association between alcohol and 'social problems' or the idea that 'natural is better'. In doing so, assertions are often likely to be accepted by those the speaker addresses, with the articulations drawing on the rhetorical force of the relatively uncontested nature of such 'truths'. Articulations about cannabis and 'nature' / 'the natural' were the most common and are the subject of the next chapter.

CHAPTER 11

DISCURSIVE CONSTRUCTIONS OF 'NATURE' / 'THE NATURAL'

Whilst the previous chapter highlighted how constructions of cannabis within discursive oppositions are often underpinned by meanings that seem to coalesce around a discursive opposition between the 'natural' and the 'chemical' / 'man-made', these themes were recurrent in the talk of most participants. This happens not just in relation to talking about cannabis directly, but also in relation to more abstract ideas (e.g. cannabis being part of a whole system of natural cures that are deliberately on Earth for humans to use), as well as within a series of oppositions between 'natural' and 'chemical' / 'artificial' / 'man-made' substances.

Of the 32 participants in this research, the discourse of 19 participants featured constructions of the 'natural' in various ways and these 19 participants were from different occupational social classes. It is argued in this thesis that oppositions between the 'natural' and the 'man-made' are now such a common way of talking and thinking about so many issues in late-modern society, with the 'natural' having multiple positive connotations (Coward, 1989; cited in Lypton, 1995), that it is unsurprising that so many participants from different social backgrounds, different educational experiences and different vocational backgrounds all have access to this discursive resource. However, whilst Beck (1992) also suggests this, by arguing that reflexivity around science, technology, 'expertise' and the society – nature relationship will increasingly characterise the 'risk society', the empirical work in this thesis suggests that such reflexivity is more common and more concerted among

occupationally middle-class participants (specifically the occupationally middle-middle class and above), and that this is because of their possession of educationally and vocationally derived discursive resources and dispositions, as well as particular aspects of engagement with the medicinal use of cannabis (such as a politicised engagement and having engaged in personal research into it).

Drawing on Bourdieu (1979) it will be argued that, in terms of regarding the accounts of some participants as being involved in a process of discursive struggle 'against' what can be conceptualised as the 'no medical value' discourse on cannabis, that understanding cannabis as 'natural' is both discursively significant and a hugely effective rhetorical 'move', due to the increasing acceptance by more and more members of society around the increasingly fraught relationship between nature and society (Nerlich *et al.*, 1999; Sutton, 1999) that, to put it somewhat crudely, 'natural is best'. The fact that other research (Hellum, 2005) has also shown that cannabis users (recreational) tend to construct cannabis discursively in relation to ideas about the 'natural' tends to reinforce the belief that cannabis is commonly positioned in relation to such oppositions and society – nature debates.

This chapter will outline how participants articulate ideas about 'nature' and the 'natural' (that Chapter Seventeen and subsequent chapters will build on).

Constructions of cannabis as 'natural'

Whilst many participants spoke about cannabis as natural, within a number of oppositions (as discussed previously), or as part of a more abstract set of ideas, many participants simply spoke about cannabis as being 'natural'. However, some participants' accounts were more complex than others and drew on a wider range of discursive resources (as will be shown in the example of the fourth participant discussed in this subsection).

> "I still think it's healthier...I really do...more natural, you know?"
> (participant forty-seven: 23).

The connotations of natural substances as being "healthier" are clearly exhibited here. It will be argued in a later chapter (Chapter Seventeen) that constructing cannabis as natural draws on a whole discursive set of assumptions that are clearly exhibited in public discourses around a broad range of issues, such as organic food, ecological issues and naturopathic medicine. It will also be argued that through these various Conversations (Gee, 1999) lifestyles, products, policies and a whole plethora of social behaviours that are understood as being more 'natural' are increasingly coming to be seen as preferable by many people and that this must be understood in relation to arguments that individuals in contemporary society exhibit an increased tendency to reflect upon (as well as deploy strategies as a response to) various understandings of risk in everyday life (Beck, 1992). However, as has also been argued (in Chapter Six) the problematisation of key aspects of modernisation (Brand, 1990) is an historically recurrent theme and is in fact a central aspect to reflexive modernity (Beck, 1992) and many critiques of modernity itself, from within the arts, social movements and the social sciences, for example, Lyotard, (1987).

> "I do regard it [cannabis]...to me it seems more natural...you know it's like using nature to help you rather than the laboratory." (participant six: 3).

In recent decades, science, technology and 'expertise' have become subject to an increasing variability in trust (Beck, 1992), and one manifestation of this is in the field of health where, as Illich (1995) argues, medical science is increasingly being recast from hero or heroine to possible purveyor of some kind of 'Frankenstein' technology (such arguments also echo those made by Lyotard about the loss of faith in the grand narrative of modernity as progress (1987)). Pharmacological products, as articulated using the phrase "the laboratory" in the excerpt above, are one part of this broad reflection upon manufactured risk (Giddens, 1999) that individuals increasingly engage in. It is also important for the reader to reflect upon how such scepticism towards the medical profession may well be common among many disabled and / or chronically ill people anyway, due to scientific medicine's lack of success with chronic illnesses and the way that some disabled people problematise the role of medicine in relation to disability.

> "Yeah...I don't think it's [cannabis] as harmful to the body because when you think about it...it is actually from a leaf...so it's a natural...remedy... Maybe I am just making an excuse for...you know...but I don't think so...and...it is a natural method and...when you think before the National Health Service and I think of...my mother...they used to do a lot of...their own creams and their own medication...'cause they had to pay for the medication then...so this is just a...maybe that's why I accept it because I had already seen it..." (participant fifteen: 12).

This excerpt is more in-depth and captures rhetorical construction and the reflexive use of language very well. The participant is aware that what she argues could be taken as simply being a justification when she says "maybe I am just making an

excuse", but she then discounts this by drawing on her recollection of older relatives making medicinal substances from plants that grew wild near where she grew up in Scotland. At the end of the excerpt, she wonders whether this is why she was willing to accept the idea that cannabis could be a medicine, because "I had already seen it ..." i.e. people using plants as medicines.

> "...and I also think that...because I...I use something that's entirely natural...that can't be too bad...I...I don't see that there's a problem in that...in that there is...I don't know, shall we...shall we say...that it was going to be beneficial for you as a human being...to have two glasses of mineral water a day...chances are that you'd have two glasses of mineral water a day...and...and I believe...I don't see what's wrong with it...I mean, as an entirely natural substance..."

> "...I didn't know but I've been told that if you've got a...a head ache and you're a naturalised...natural born...Jamaican...you go to your granny and 'Oh, I've got a head ache granny'...there will be a small plant in the back garden...soaks it in hot water and gives it you...and...it...in this society that we live in it's in majority a Western society...and don't want to accept it as a medicine...and...you know, it's...I think about it we're sort of...we should be a little bit more aware of it..." (participant twenty-eight: 13-14).

In these two excerpts, that are both part of the same narrative, the participant starts out by twice asserting that cannabis is natural and uses the 'common-sense' notion of drinking mineral water to draw the similarity of water being natural too, as well as healthy. In the second excerpt, he draws on the example of Jamaican folk-medicine using cannabis as a remedy for headaches and asserts that a Western society such as our own ought to be more aware of the medicinal value of cannabis. This articulation can be seen to be engaging in a questioning of modernity, science, technology and 'expertise' (in medicine) as it questions 'Western' ways and suggests recourse to more traditional forms of medicine. This is further evidence of the tendency to reflect critically upon whether scientific-medicine is, or is always, 'best.'

The excerpt is also important for demonstrating that some participants, importantly not all, drew on a broader range of discursive resources when making assertions about cannabis. Interestingly, this participant was a member of the Alliance for Cannabis Therapeutics and the interviewer (myself) got the sense that many of the arguments and ideas articulated in his interview were well practised. Indeed he had spoken on radio and television about the issue of medicinal cannabis use and saw himself as part of a movement to advance the issue politically.

'Natural' opposed to 'chemical'

Nine participants articulated oppositions between the 'natural' and the 'chemical', mostly in fairly abstract ways. All of these participants were occupationally middle-class (eight from the middle-middle and one from the upper-middle class fractions). Some articulated this opposition when they spoke about cannabis itself.

> "[cannabis] is more natural...and...than the chemicals that could be shoved into my body if...I allowed...the doctors to have their way...and it's...a natural substance...and for me that's really, really important..." (participant twenty-six: 24).

This excerpt is interesting, because the preference is not simply about the participant saying that they preferred cannabis because they found it worked better than prescribed medicines. The participant is constructing a preference because they understood it to be natural.

Most of the participants who discursively opposed 'natural' to 'chemical' did so without actually talking about cannabis at all, so their use of this opposition was more abstract or "universalistic, less local and more context independent" (Bernstein, 1990: 96; quoted in Chouliaraki and Fairclough, 2005) from the interviews direction, which was to discuss the medicinal use of cannabis. It is highly significant that all the participants who spoke about 'natural' and 'chemical' phenomena by way of what Bernstein (1990; cited in Chouliaraki and Fairclough, 2005) understands as an elaborated orientation to meaning were occupationally middle-class. It will later be argued that this is because these participants possess discursive capital that enables them to be able to draw on a more elaborated set of meanings and to articulate them by talking more abstractedly about an issue (i.e. asked about cannabis, they are more likely to step outside of the immediate context of discussion). This is not to say that occupationally working-class participants could not do so, just that, as the data suggests (because only one of them did and his educational trajectory was not 'typically' working-class) they may be less well discursively capacitated and disposed to do so, or able to do so.

> "You know I don't like pesticides and...G.M. foods and stuff...I'm more aware of them...and...you look at the sort of...our cancer rates for example...and...there's got to be a logical reason...why we've got...you know, the sort of highest rates of cancer in the world considering with...you know, tiny little island...there's obviously something...you know?...Yeah putting pollutants and things...in my body is not...is not something that I'm keen on..." (participant thirty-eight: 19).

This participant discussed her preference for cannabis in contrast to a broad range of what she understood as "pollutants." Pesticides and genetically modified foods were used as examples and tied in to ideas about cancer rates, in what is very much the

kind of critical reflection on modernisation that Beck discusses (1992). Rhetorically, there is an attempt (not entirely convincingly) to emphasise the effects of such "pollutants" by constructing Britain as a "tiny little island" with a claim that it has the highest cancer rates in the world (although of course "rates" would be per capita, so the size of the country would be irrelevant). What is clear though is that this participant is able and disposed to draw on meanings and discourses outside of the immediate context of the conversation and to deploy a discourse that reflects upon a range of manufactured risks (Beck, 1992) in advancing her argument.

'Nature' opposed to 'artificial drugs'

One participant articulated this discursive opposition, which is very similar to the oppositions discussed directly above. As above, this participant was also occupationally middle-class (although of the lower-middle-class fraction). It is significance that this participant stated that she had a very 'homeopathic outlook' and was also a Buddhist. Knowing that a person is a Buddhist with a very homeopathic outlook aids interpretation, because it can be argued that this participant is drawing discursively on ideas about nature as being a system of cures for humans to use and that these would be better for us than manufactured medicines that are 'out of sync' with 'nature' and therefore our bodies. It is also significant because it suggests the importance for certain articulations from certain participants of lifestyle or, as will later be argued, engagement (i.e. the view that talking about medicinal cannabis use is a part of how the participant *does* medicinal cannabis use as a form of social practice – what it is about for them).

> "Well, I've always been a nature person...anything that comes out of the soil...has its potential...so I never really saw it [cannabis] as something bad or evil...because if it was bad it wouldn't be there in the first place...everything must have its remedies...each plant must have its remedies..."

> "...I was a child of the sixties and then...the seventies came and I just saw...too much destruction...lot of disrespect for the nature...in general...and that I believe in you know put too much emphasis on...on artificial drugs...and rather going to the roots...and...I mean we would know, I already used to know there were...valuable plants in Africa that people who smoke remedies from them to heal themselves..." (participant forty-four: 10-11).

In these two excerpts, from the same narrative, 'nature' is constructed as being a system of remedies, deliberately here for humanities use and is contrasted with 'artificial drugs' that are placed within this narrative of the participant witnessing destruction and "disrespect for nature", so it has an ecological / risk (Beck, 1992) tone to it as well.

Cannabis as part of a system of 'natural' cures

Six participants constructed cannabis as part of a 'natural' set of cures, on Earth for humanity's use. Rhetorically, the idea that nature, and in some participants' articulations, God, has provided a system of natural remedies could be quite a powerful argument, subject to the beliefs of those receiving such ideas. It is obviously also the case that these ideas are discursively fascinating, as well as being fairly abstract. However, of the six participants who spoke about this, two were occupationally working-class and four were occupationally middle-class (two from

the middle-middle and two from the lower-middle class fractions). This is interesting, although it is important to bear in mind that the argument being advanced in this thesis about social class, the capacity and the disposition to use language in certain ways (Bourdieu, 1979, 1992), and restricted or elaborated orientations to meaning (Bernstein, 1990; cited in Chouliaraki and Fairclough, 2005), is that occupationally middle-class participants are more likely to draw on more abstract ideas and knowledge not obtained from personal experience, inter-textually and to employ them in their discourse than occupationally working-class participants, as opposed to saying that occupationally working-class participants do not do so at all.

However, one of the occupationally working-class participants who did talk about cannabis as part of a system of natural cures deliberately on Earth, does so fairly briefly.

> "God put all plants on Earth to be used" (participant thirty-nine: 63).

The excerpts of occupationally middle-class participants and the other occupationally working-class participant were more complex.

> "I believe...everything is on this Earth for us...everything...I've always believed that...there's cures for everything...but...we've just gotta find them...and I believe it's in the plants...I really do...you know?" (participant forty-seven: 23).

The excerpt below features an example to elaborate on the issue (the example of Yew extracts used in medical research).

> "I do have a belief that...all the...you know, things like pain and all those things that there are...natural remedies out there like cannabis is a natural remedy, you know, like they're using Yew...extract of Yew to treat certain cancer conditions...you know, I believe that there are...you know, that's what the world is about, you know, it's an interaction thing. I believe that there's...things to do with all those issues, you know, in the natural world and we should take advantage of them..." (participant five: 32-33).

The next participant, whose occupational working-class position was the outcome of employment choices after leaving art school, also deploys the idea of cannabis being part of a deliberate natural system of cures, but in a more characteristically middle-class discursive way. It is part of a longer and more elaborate narrative, this time opposing this natural system to the vested interests of pharmaceutical companies and exhibiting the critical reflection on science, technology and 'expertise' that Beck discusses (1992).

> "...it is as if...God gave me it [cannabis]...in...it's part of creation...but as in many things you'll find that...for many conditions...there are natural cures...that exist...in nature...you know, even animals you'll find will eat certain plants...to...to make themselves better...and it's as though, it...we've got it all there...in creation to...to heal ourselves...but it seems that...because of vested interest, man...has...has...purified certain chemicals and taken bits out and...and use those...instead of using the whole of it...and the ones...and there seems to be a vested interest in...in keeping people using...patented medicines...instead of using natural cures, I think that's a reflection on the whole of society is...I think...and I think there is a vested interest by the pharmaceutical companies and anyone else that makes money out of it...they keep...things as they are..." (participant thirty-five: 27 - 28).

So whilst not only occupationally middle-class participants spoke about the idea of cannabis as part of a system of natural remedies on Earth, most participants who did were occupationally middle-class and the excerpt of one of the occupationally working-class participants was somewhat less elaborated (Bernstein, 1990; cited in

Chouliaraki and Fairclough, 2005), whilst the other occupationally working-class participant discussed above has a more typically middle-class educational trajectory (Bourdieu, 1979) anyway. This issue will be revisited in a later chapter (Chapter Nineteen), when an argument about different 'types' of medicinal cannabis users' discourses will be advanced.

This chapter has addressed the common tendency to articulate cannabis in relation to ideas about 'nature' and 'the natural' within participants' interviews. Whilst such articulations were found in the accounts of the majority of participants, more abstract articulations, e.g. 'nature' discursively opposed to artificial drugs or cannabis as part of a system of natural cures, tended to be produced by participants of the middle-middle occupational class or above. Arguments about why this is the case will be further developed in later chapters. The next chapter will address participants talking about the medical profession, medical knowledge and other issues of power within their interviews.

CHAPTER 12

'THE MODERNISATION CRITIQUE' – TALKING ABOUT MEDICINE, GOVERNMENT AND OTHER ISSUES OF POWER

It was argued in Chapters Six, Seven and Eight that, over the last few decades, scientific-medicine has increasingly been subject to various forms of critique and challenge and that whilst it has seen such contestation before (and that rarely, if ever, has it not been subject to this), it now faces challenges to its authority on a number of 'fronts.' Not only is scientific-medicine subject to society's increasingly variable faith in key social institutions of modernity such as science, technology, government and 'expertise' (Beck, 1992), but in relation to medicinal cannabis users it was also argued that chronically ill and / or disabled people have a number of more particular reasons as to why they may be more likely to question the effectiveness and motives of the medical profession and of medical practice. Whilst not *all* disabled people think about the medical profession in terms of questions about power and oppression, a number of participants in this research did. Many of these were also actively involved in disability issues in a political sense, so it ought not to be surprising that they might discuss the medical profession and the practice of medicine in ways that consider issues of power.

This chapter will examine the discussion of topics by the participants that articulate various criticisms of medical, pharmaceutical and governmental institutions and related issues. However, this thesis raised a question in Chapter Six in relation to the ideas of Brand (1990) and also Beck (1992) about to what degree people from different social backgrounds might be capacitated to be able to engage critically with

the key social institutions of modernity, such as scientific-medicine. The chapters in this part of the thesis that have sought to 'map' the discourse of medicinal cannabis users have already indicated that some participants appear to be discursively better capacitated and more disposed (Bourdieu, 1979; 1992) to critically engage with dominant discourses and associated social institutions than are other participants. Exploration of this question is one of the main aims of this thesis (accounting for differences between the discourses of participants), and this chapter will show that participants from certain occupational social class backgrounds, due to educational trajectories and vocationally-oriented discursive resources, tend to engage in the discussion of a broader range of topics with a higher potential for critique than other participants.

Understandably, talking about medicine and the medical profession was one of the main themes of the interviews. The interview schedule asked questions about the involvement that participants had with medical professionals, whether they had told them about their use of cannabis and whether they used prescribed medicines. Previous research, using the same data that this thesis draws on (Coomber, Oliver and Morris, 2003), argued that one of the main reasons that medicinal cannabis users give for using the substance is dissatisfaction with prescribed medicine. This chapter will start with participants' talking about issues related to the medical profession.

Medical power

Three participants spoke about doctors and medical power in very critical ways. In terms of arguments to explain the different types of medicinal cannabis users' discourses that will be developed over the course of this thesis, it is notable that two were from the occupationally middle-middle class fraction and the one occupationally working-class participant discussed here had an educational trajectory involving grammar school and art-college, and could be understood as markedly different to the other working-class participants in terms of cultural capital.

> "Doctors are...are a notorious closed shop, aren't they? I think that very few of them will even...entertain the idea of working alongside...or using the skills of...alternative...what we call alternative practitioners ...although most people...either know themselves or have somebody in their family or circle of friends...who has benefited from say reflexology or...acupuncture...or hypnotherapies. And these things do work...some have worked for centuries some of them pre-date the idea of doctors. When doctors were also barbers...people were...were using...bark and herbs and all sort of stuff...that...has been efficacious for centuries. Doctors in the main I think don't welcome that...they're jealous...of their status...and their power...will be your pain...and... I've already said that...is my pain...it's not theirs...it's mine...and I'll deal with it. And if they...prescribed something for me...that does all the things that cannabis does...that would be tremendous...but they don't. And they won't entertain...that there can be a body of knowledge ...outside...their relatively narrow...medical school training...and their practice...that might be beneficial..." (participant eighteen: 42-43).

Whilst this excerpt touches on so much that is interesting, arguably what is most interesting is how the participant situates doctors in relation to knowledge, power and professional interest. The historical aspect to this account is also fascinating and the rhetorical swipe at the medical profession, the assertion that alternative therapies have worked for centuries and pre-date the very notion of doctors "when doctors were also

barbers", is not only witty but also points out that medical science (as discussed in previous chapters) has only held its privileged position in the field of health for the last one hundred years or so. His phrase "their power...will be your pain" struck the researcher as such a powerful utterance that it immediately resolved the dilemma of what the final title of this thesis should be.

In a similar vein, the following participant talks about medical power, although his most insightful material will be discussed further below.

> "I'd feel that somebody was...overstepping their place...by stopping me from using the medicine [cannabis] that helps me. I'd feel that it was highly intrusive...of any government to try and tell me what's good for me. At the age of...nearly sixty years...I don't...see...anyone within that cabinet who has more experience than I have...and if they've been doing their research they'll have come to the same conclusion...truly doing their research...they will found the things I've found out...but it...what tends to happen is that the...government's scientist...will simply say whatever they...they're told to say..." (participant thirty-five: 49).

In this excerpt, the participant uses the term "medicine" to describe cannabis (thereby asserting that it is a medicine), questions the authority of the government to tell him what it good for him (in a libertarian-type argument) and also attempts to undercut the authority of the government by asserting that no one in the cabinet has more experience than him "at the age of...nearly sixty years...". This participant also makes an argument about knowledge and power, rather more directly than the previous participant, by asserting that government scientists will simply say whatever they are told. Whilst this might initially appear to be a rather simplistic assessment of the relationship between government and research, it does demonstrate a *critical* awareness of how knowledge and power might be related at certain times.

The 'medical model' of disability

One participant mentioned the "medical model" of disability in his interview. He had worked in services by and for disabled people and professed to being actively involved in disability issues on a local and national level. As was discussed in Chapter Seven, the medical model of disability is the dominant discursive model in society's (mis)understanding of disability, the simple notion that disability and impairment are one and the same and that the social exclusion that disabled people face is an outcome of individual impairment, as opposed to being an outcome of a disabling society - see Oliver (1983), with the 'solution' being that of 'cure'.

The participant only mentions the medical model briefly.

> "I suppose really I became aware of it [cannabis] for therapeutic purposes... when I was looking for alternatives... looking for alternatives to the medical model and the medical approach..." (participant one: 4).

This participant had, elsewhere in the interview, outlined a biographical history of growing up in an oppressive home for disabled children in Eire, which included descriptions of various unhappy experiences with medical professionals. It is, therefore, perhaps unsurprising that he would want to explore "alternatives to the medical model and the medical approach...". However, the understanding of disability issues in relation to the social model of disability (which engages critically with the medical model) is significant in the respect that it involves a *critical*

engagement with the practice of medicine vis-à-vis disabled people which is 'fertile ground' for then questioning dominant ideologies about what might or might not be seen as a medicine.

It is also important to consider that when the participant constructs his first use of cannabis for medicinal purposes as part of a search for alternatives to the medical model, this can be seen as retrospective and involving ways of understanding that had been acquired since the time in question and that this way of thinking about it is derived from being involved in disability issues (and in fact, disability awareness training – which was his job). The argument being raised here is that, for some participants, vocationally derived linguistic resources are articulated at certain times in the construction of their particular discourse.

Anecdotal / clinical evidence

As has been discussed in earlier chapters, scientific-medicine as a set of discourses and practices involves a preference for knowledge that has been produced by way of clinical experimentation. Whilst some evidence of this type for the efficacy of cannabis does exist – see Hepler and Frank (1971, cited in Zimmer and Morgan, 1995: 4), the majority of evidence is what tends to be described as being 'anecdotal', i.e. derived from the experience of medicinal cannabis users themselves.

There is clearly a hierarchy of types of knowledge that is imposed in the societal Conversation (Gee, 1999) about medicinal cannabis use, with clinical 'experimental'

knowledge privileged in relation to that which is discursively constructed as being merely 'anecdotal' evidence. Examples of those who espouse such a hierarchy between these two types of knowledge are groups representative of the medical profession, such as the Royal Society and the Academy of Medical Sciences (Lachman *et al.*, 1998), the British Medical Association (B.M.A., 1997) and the British government, for example Paul Boateng as Minister for Home Affairs in 1998 (cited in Nando.net, 1998).

Significantly, only two participants explicitly address the issue of 'anecdotal' / 'clinical' forms of knowledge. Doing so in a critical way could be seen as one crucial part in the construction of what Bourdieu called a heterodoxical discourse (1979, 1992), a critical discourse that can challenge the dominance of scientific-medicine and its' orthodox discourse on what things can validly be seen as medicines and the idea that cannabis is not a medicine (ideas that are discussed in depth in later chapters).

One of the two participants who addressed this issue did so only in passing.

> "I suppose if anyone had said there was this problem with people smoking it...people with M.S. smoking it...I would say why? Why shouldn't they, sort of thing? I've always felt that there was so much anecdotal evidence that no one takes any notice of." (participant twenty-three: 5-6).

Interestingly, this participant had worked as a nurse prior to retirement (as well as having done other things, such as a history of art degree), and cited her medical training books as one source of her awareness that cannabis had a history of medicinal use (the often cited use of cannabis tincture by Queen Victoria, for

example). The participant's comment that no one takes any notice of 'anecdotal' evidence could be read in relation to her understanding of medicine and the 'clinical' / 'anecdotal' hierarchy of knowledge. As has been the case with other participants' accounts, vocational experience can be seen as significant when talking about medicinal cannabis use in these interviews. However, in this instance, it is hardly what one might call a critical engagement with the issue.

The second participant, however, went into the 'clinical' / 'anecdotal' issue in far more depth and over a number of excerpts. He is a participant who has been discussed a few times already and who exhibits quite a complex discourse with a tendency to draw on all manner of ideas (such as nature being a part of system of cures). He was also connected to the Alliance for Cannabis Therapeutics and had spoken publicly on the issue in the past.

"I respect [people]...who...whose...whose opinions are based on experience rather than something they've read in a book...they're the people who really know...that it [cannabis] helps pain and the people who've got pain...who use it...and get relief...and...we are the only people who actually know that...but somehow our...statements or testimony are...are referred to as anecdotal...which I find is...is kind of odd..." (participant thirty-five: 8).

"I think really people in charge have another agenda...it simply suits them...to say 'Well, we have no scientific proof'...I'm the living proof...but I can't prove it...and...nor can other people that I know who gained relief...but it...because it's not...I'm not a scientist and I have no...back up of scientific fact...it's ignored...and...people simply say 'Well, you must like it [cannabis]', and then...'that's why you're going on about it'...and somehow that takes the truth out of the statement, it...people...people perceive it as though we're trying something on...instead of it just being...reporting of what happens...this helps me. I get 'Oh, you would say that'...which is awful...'cause it's like being dismissed..." (participant thirty-five: 9).

The first excerpt features a rhetorical attack on the discounting of his experience as 'anecdotal'. The second excerpt features a sense of the denial of experience as 'anecdotal' as involving power or an "agenda" and that the alleged lack of "scientific proof" for cannabis as a medicine is used as a matter of convenience. Interestingly, the participant discussed the issue in a narrative way, deploying the kind of arguments he had faced and in doing so he demonstrated an understanding that talking about medicinal cannabis use is about opposing discourses, opposing interests and rhetoric. He described how opponents of his view attempted to undermine his discourse, by saying that he had no scientific evidence and that he "must like it [cannabis]" with the implication that medicinal cannabis use is a ruse for people to use cannabis for pleasurable purposes. He also showed an understanding of this in the phrase "somehow that takes the truth out of the statement". The arguments he described facing asserted that he must have wanted to use cannabis for pleasure, because with a lack of scientific evidence for its medical efficacy, surely that can be the only other explanation. In this respect, scientific evidence *is* evidence – the only recognised evidence – and this is articulated as having a common sense quality to it, as the most dominant discourses do (Bourdieu, 1979), because they are able to pass as being self-evident.

However, for all the discursive dominance of science, medicine and their 'truth' claims as part of the dominant regime of 'truth' (Foucault, 1980a), discourse of the type exhibited above, for all its local and limited scope for resistance (Foucault, 1980a), can be seen as rhetorically effective because it too draws on common-sense assumptions in its construction. The assertions that he respects people whose understandings are based on experience because "they're the people who really

know..." and his assertion "I'm the living proof' are useful discursive strategies in an age of increasingly variable levels of faith in science, technology and 'expertise' (Beck, 1992). His account certainly engages with core aspects of the 'no medical value' discourse on cannabis and discourses and practices that it draws on for its claims of 'truth.' Whilst individuals like him are making such statements, especially to the media, these discursive resources and strategies are put into circulation, being made available as discursive resources that others might also deploy. Importantly though, as science, technology and 'expertise' come under more and more critical consideration, this kind of critical reflection will not only be more common but will also be accepted by more people and critical analysis of the issue may grow.

The British Medical Association

One participant (a member of the Alliance for Cannabis Therapeutics) talked about the B.M.A., attacking its authority by making reference to a seemingly problematic statement in its book on the medicinal cannabis issue (B.M.A., 1997). In this book, in a section that considers cannabis and cannabinoid-based drugs, the B.M.A. states that as cannabis is composed of various compounds, including over sixty cannabinoids, even if cannabis does have medicinal benefits, it would not be possible to know which particular agents were involved:

> "and medical knowledge would not be advanced nor treatment improved" (B.M.A., 1997: 69).

This statement can be read as suggesting that because the B.M.A. does not understand how it is that cannabis might be effective in relation to the symptomatic effects of various chronic illnesses and can be useful in certain ways to people with certain impairments, that medical knowledge would not be advanced by its use as a medicine *and therefore it should not be available for such use.* Certainly from the perspective of medicinal cannabis users, what matters is that cannabis is efficacious and not understanding how should not impede its availability.

This is made even more curious by discussion, elsewhere in the book, of substances in common medical usage that have a "relatively undefined mechanism of action" (Levitt, 1986; cited in B.M.A., 1997), such as chemotherapy, which is used in the medical treatment of cancer. In the following excerpt, the participant seizes upon this issue.

> "...most recently the B.M.A. came out...and said...that... 'Oh, we don't know...we don't know what it is that's working.' They don't know, it won't advance science...if we allow it to be prescribed...and...and I've said 'Well, he's just being a witch doctor...he's...he's really...angry...because they don't know'...you know...and that I say to that... 'Well, there [are] thousands of people out there who are handling their problems themselves...and they're more expert...about that particular problem than you are...for all the letters after your name, for all your...pink stripes and your...offices and all the rest of it and...and titles and...they know...they're the experts...you...you just admit it..." (participant twenty-nine: 31).

This excerpt is interesting because the participant attempts to undermine the B.M.A.'s claim to authority due to this lack of understanding how cannabis might be medicinally efficacious and attempts to assert the expert status of those who use cannabis medicinally, saying "...they're more expert..." He also describes the B.M.A. representative as a "witch doctor", perhaps as part of the attempt to

undermine his (and their) claim to authority over this issue. This is then a case of what Porter (1997) has discussed as the increasing contestation of the right to speak in relation to health, as the participant's excerpt clearly poses medicinal cannabis users as "more expert" than the B.M.A. on this issue. This must also be seen against a background of a growing variability of faith and trust in 'expertise' *per se* (Beck, 1992).

As has been seen in other parts of this section, some participants, at certain times in their interviews, will critically engage with key aspects of science, medicine and the 'no medical value' discourse that draws on them as the dominant 'regime of truth' (Foucault, 1980a) and that these engagements can be read as attempts to undermine the authority of these medical discourses or of medical professionals themselves and to assert the authority of the idea that cannabis *is* a medicinally useful substance. As should be becoming clear, most participants do not tend to engage in this critical type way. One of the main tasks of this thesis will be to explain why this is.

Cannabis-based medicines

Six participants discussed the issue of cannabis-based medicines. To briefly put this in context, cannabis-based medicines are medicines that consist of synthesised or extracted cannabinoids, as opposed to simply using cannabis itself as a medicinal substance. The B.M.A., the government and other representative groups of the medical profession had expressed support for the development of cannabis-based medicines (as opposed to the medicinal use of cannabis itself) and at the time of the

interviews, G.W. Pharmaceuticals were in the earlier stages of attempting to develop a cannabis-based sub-lingual spray (something that some of the participants in this research were aware of). Significantly, of the six participants who discussed this issue, five were occupationally middle-class, with three being from the middle-middle and two from the lower-middle class fractions. The occupationally working-class participant is yet again participant thirty-five, whose educational trajectory and cultural capital was significantly different to that of the other occupationally working-class participants.

Of the six participants who spoke about cannabis-based medicines, four did not problematise them. This is interesting, because so many participants had emphasised the importance of the natural qualities of cannabis in various parts of their interviews and two of these four participants had themselves done this. However, it is strongly borne out by the interview data that the participants use cannabis primarily because it works. This being the case, one might argue that medicinal cannabis use is above all things a pragmatic issue for medicinal users (although also clearly one that is imbued with all sorts of meanings by different participants too). The high level of dissatisfaction with prescribed medicines and the prevalence of this within participants' accounts of why they turned to cannabis (Coomber, Oliver and Morris, 2003) support this interpretation. This being so, seeing cannabis as 'natural' and articulating this as a positive thing in the interviews does not mean many medicinal cannabis users would not at least try a cannabis-based medicine. The apparent contradiction between many participants liking cannabis for its perceived natural qualities and being open to using a cannabis-based medicine is therefore understandable.

> "...I think when they take the element out that's going to work for us hopefully they're going to put it in some sort of inhalant or tablet, I don't know, inhalant I would expect or something" (participant three: 38).

Elsewhere in her interview, this participant had positively emphasised the natural aspects of cannabis, but it did not stop her from intimating that she would try a cannabis-based medicine and she also told the interviewer that she had volunteered to be involved in trials with G.W. Pharmaceuticals (in relation to the development of the cannabis-based sub-lingual spray).

Two of the participants who spoke about cannabis-based medicines, however, took a very different view, constructing the issue as problematic. As has been discussed earlier, many medicinal cannabis users greatly emphasised the perceived natural aspect of cannabis and articulated many positive connotations of this in their interviews. They also opposed this to the 'chemical' or the 'synthetic' in scientific-medicine and other aspects of contemporary life. Interestingly, both of these participants also discussed a preference for organic food and one might speculate (and on the basis of two participants, it would be hard to do more than speculate) that for participants such as these, the use of cannabis is not just a practical issue. That is not to argue that they would use it medicinally if it did not provide them with symptomatic relief, but their rejection of a cannabis-based alternative to cannabis itself suggests a deeper commitment to a 'natural' lifestyle (consistent with an expressed preference of organic foods, for example) than might be the case with the other participants discussed above.

> "...if you're gonna start doctoring about with it [cannabis]...then you are gonna lose some of its properties...I don't know how chemistry works but...you can't...you know, they're talking about a sort of aerosol like a puffer, an asthma puffer and stuff like that and I thinking 'wow'...you know...you're just mucking about with it. You're changing it...it's not gonna have the same properties...Is it still going to be a natural remedy?" (participant thirty-eight: 60).

It is interesting that the participant asked "is it still going to be a natural remedy?" If her orientation to the issue were simply, or largely, a pragmatic one then the pertinent question might have been *is it still going to work?* Perhaps the concern that it may no longer be an effective remedy is obvious and as such unspoken, but this excerpt hints at the importance of the 'natural' as a set of meanings that is of great importance to some medicinal cannabis users.

The other participant who problematised cannabis-based medicines expresses a real fear around the issue.

> "...since cannabis...is a naturally occurring substance so it can't be patented...the pharmaceutical companies...wouldn't be able to make out of it in the same way...unless they can genetically modify it...the molecule...the molecule and just put...in it a thing that scientist...and then they can take that...and I'm horribly afraid that something like that will happen..." (participant thirty-five: 44).

Elsewhere in the interview, this participant had expressed fears around cloning, genetically modified foods and was one of the participants who saw nature as a system of cures providentially available to humans. These last two participants can definitely be seen as articulating a discourse that problematises the pharmacological interest in cannabis and that more broadly seems to relate to their wider lifestyle-related views on the 'natural' and a strong preference for products that could be understood in that way. The fact that both participants talk about pharmacological

involvement in producing a cannabis-based medicine in ways that are extremely vague about how this might work, scientifically, whilst still being certain that it would be a bad thing, can be seen as testimony to the extent to which such ideas are assumed by them to simply be 'common sense'. Social anxiety about manufactured risk (Beck, 1992; Giddens, 1999) is relatively common in contemporary society and is becoming an increasingly prevalent way of discussing a range of issues, such as this.

Talking about government and other issues of power

As has been discussed in earlier parts of this thesis, medicinal cannabis use relates to issues of power in various ways. This section addresses participants talking about issues of power and powerful institutions such as the government, the police, global capitalism, pharmaceutical companies and other connected issues. As has also been argued elsewhere, many members of society increasingly exhibit variable levels of trust in numerous key institutions of modernity, including those discussed in this section, however, chronically ill and / or disabled people may also be critical of certain institutions due to reasons more particular to them. Finally, as has been seen in previous chapters in this part of the thesis, many participants discuss similar issues, but there are significant differences around what participants talk about and how they talk about them. Further evidence of this will be provided in this section.

Government

Of the eleven participants who spoke about the government in the interviews, the most apparent thing about them is their social class. All of them were occupationally middle-class except for two. As has often been the case in relation to other issues, most of the occupationally middle-class participants who talk about this were from the middle-middle class fraction (six of them) the remaining three occupationally middle-class participants being from the lower-middle class fraction. It is also notable that five participants worked in or had worked in disability-related employment and two were members of the Alliance for Cannabis Therapeutics. This suggests that those who regularly engaged with the issue of medicinal cannabis use in a politicised way were also most likely to talk about the government in relation to cannabis use.

Three participants spoke about the potential legalisation of cannabis for medicinal use as unlikely to happen due to how it might affect the political interests of the government.

> "...there's certainly no reason I think for cannabis to be illegal...that it's just a political decision, the government will not be seen as being soft on drugs..." (participant forty-eight: 26).

This participant uses the term 'soft on drugs' and it is certainly the case that drugs are not just a highly sensitive moral issue (Szasz, 1975), but also a highly sensitive political one. It is also an issue that considerable political capital can be made from, with politicians often attempting to appear to be 'tough on drugs' (a useful position to adopt for the populist career politician due to society's tendency to see drugs as underlying so many social problems). This might also be why the media seems to

greatly enjoy exposing the drug use of politicians, at whatever previous stage in their lives it may have taken place (e.g. Bill Clinton and more recently David Cameron).

Two other participants portrayed the government as reluctant to spend the money to legalise cannabis (participant seventeen) and as a government that simply likes oppressing people (participant forty-four). Other participants discussed the government as willing to support legalisation for medicinal uses if the medical establishment supported it (participant thirty) and the previously mentioned view that government scientists will say what they are told to say by the government (participant thirty-five).

One participant's discussion of this issue is far more in-depth. He cites the reaction to the House of Lords' report, which was favourable to the medicinal use of cannabis.

> "...straight away the Home Office...the Department of Health and the B.M.A...who represents all these doctors who know their patients are using it...and it's doing, working better for them than their prescribed drugs, they all band together... and immediately...that conclusion is publicised [the House of Lords' Select Committee on medicinal cannabis use]...they all shout together in harmony... 'No...no way!'...and you think ah, ah, you know?...it's like...they're all in the same lodge...and you think...they...they've...I mean...it's too...it's too immediate and they're too together...it's got to be worked out, it's got to be planned...it's got to be 'no...say no...say no, say no, say no...no...no...''cause otherwise this is gonna go boom! in their faces and so and so is gonna be out of a job and so and so is gonna lose billions, you know?" (participant twenty-nine: 67-68).

Whereas other participants loosely identify 'political interests', this participant cites specific government departments and suggests concerted action between them and the B.M.A. This participant was a member of the Alliance for Cannabis Therapeutics and had written to and debated, on television and radio, with government ministers on the

issue. One might suggest that the more particular character of this excerpt is therefore an outcome of his political engagement, that talking about cannabis has to some degree to be seen within the context of a participant's degree and type of engagement with its use (for example, a politicised discourse tends to be articulated by people who engage with medicinal cannabis use in politicised ways). This idea will be expanded on in later chapters that seek to describe 'types' of medicinal cannabis users' discourse.

Economic interests, global capitalism and pharmaceutical companies

Criticism and suspicion as to the actions and interests of global capitalism and pharmaceutical companies in particular has become a prevalent theme of public discourse in recent years, as well as within popular cultural representations, such as the film *The Constant Gardener.* Of the nine participants who discussed 'economic interests', global capitalism and pharmaceutical companies (the three themes are taken together due to the degree of overlap in participants' discussion of them making it hard to separate them out), most did so in relation to questions toward the end of the interviews that asked them why they thought cannabis was prohibited for medicinal use.

Of the nine participants who discussed these themes, eight were occupationally middle-class (three from the lower-middle, four from the middle-middle and one from the upper-middle occupational class fractions). This suggests the significance of cultural capital (Bourdieu, 1979) in discussion of these issues. Of the nine, six

participants mentioned the economic interests of pharmaceutical companies as being somehow involved in the continued prohibition of cannabis for medicinal purposes.

> "The pharmaceutical companies...medicine...again...it's the mighty dollars, you know that...money can be effected...some are just gonna lose out..." (participant fifteen: 41).

> "...you can't patent a plant" (participant twenty-eight: 28).

These participants share the view that the legal availability of cannabis as a medicinal substance would impact negatively on the profits of pharmaceutical companies and, as the participant above says, a plant is not something that can be patented, so how would pharmaceutical companies make money out of it? Interestingly though, particular strains of genetically modified cannabis (hemp) plants have been registered by the Dutch company HortaPharm B.V. although this European registration is not the same as a patent.

Disabled people and economic productivity

One participant spoke about disability, economic productivity and government. His comments could have been included in the section above, about government, but what he says has been separated because his comments also address more than this. The participant in question in this section was one of three disabled / chronically ill bikers who were kind enough to be interviewed. Yet this particular individual exhibits a type of discourse that is markedly different to that of the other two from this sub-group of participants. His interview offers some of the best evidence against an over-extension

of a simple social class – language model within the analysis part of this thesis. For all the developing focus on educational and vocational trajectories as explanatory as to how different participants come to be differentially constituted in terms of dispositions and capacities to use language (Bourdieu, 1979), this excerpt shows the danger in over-extending this conceptualisation into something more reductive and simplistic, such as a model of social class and language as being about individuals who *will* speak in certain ways, not individuals who *tend* to speak in certain ways. Such an overly simplistic model could never account for an individual with compulsory education, no qualifications, a background in unskilled manual labour and an excerpt that essentially outlines a materialist perspective on disability, power and the economy, as is found in the work of disability theorists such as Oliver (1983; 1990).

> "We're [disabled people] inconvenient, we're slow, we're not productive...we tend to not produce much 'tax-wise', we tend to not spend much because we have a low income in the first place, so [they] don't make much out of us...We're...I just feel like its surplus to requirements..." (participant forty-one: 51).

In this excerpt, the participant is discussing how many chronically ill and disabled people argue that cannabis is medicinally beneficial to them but the government and medical establishment does not seem to listen. Elsewhere in his interview, he had argued that another reason as to why cannabis was not legally available for medicinal use was that disabled people are economically unproductive (not true in many cases of course) so why should they be allowed to "feel nice" (participant forty-one: 48)? This idea that people are not supposed to 'enjoy their medicine' is, of course, also to be found in Parsons' discussion of the 'sick role' (Parsons, 1951).

It is not just the case that no other occupationally working-class participants made such points, it is the case that no other participants of *any* social class made them. So social class and observable tendencies to articulate certain types of discourse can only ever be tendencies (Bourdieu, 1992).

American geo-political interests

One participant discussed cannabis in relation to American foreign policy on drugs and the broader ends that such policies may be seen as serving. A member of the A.C.T., this participant (thirty-five) is perhaps by now familiar to the reader and his discourse will later be categorised as being not just politicised but also involving a critical engagement with the dominant discourses of medicine and science around what types of substances can be seen as a medicine and the criteria for making such judgements (e.g. the hierarchy of clinical and anecdotal knowledge). In this excerpt, he is talking about the 'DuPont conspiracy' (the idea that the American industrial company DuPont conspired to have the cultivation of cannabis and the hemp plant prohibited and prohibitively taxed to protect its own synthetic products, such as plastics) (Herer, 1995). He then moves on to discussing American geo-political policy:

> "...I started reading...and I started looking around...and just thinking it...really it's kind of logical that there are certain people...who will not want cannabis to be legalised...for...their own reasons...not because it's...nothing to do with our health or well being...but...because of...financial matters...financial reasons...and power basically...and they...particularly D.E.A. [the U.S. Drug Enforcement Agency] with this excuse to go in...and...to other countries...and interfere with the policies, putting in charge the

> government that they [the U.S. government] want...and...and it seems to me what they're doing in South America...and all the globe...investing huge amount of money...and saying it's to eradicate...cocaine but it seems more of a...to...eradicate...the left-wing people who are...who were in there..." (participant thirty-five: 47).

What is interesting about this excerpt is that it is evidence that participants tend to speak about the issue in ways that reflect their involvement in it. As a member of the A.C.T. this participant was involved with the issue of medicinal cannabis use on an active political level and his discourse can be seen, in various excerpts, as being politicised. Unlike his account, most participants tended not to speak about the issue in ways that drew on such a broad range of ideas.

In terms of analytical questions about the different discursive resources that some participants might draw on in their interviews, this excerpt is also important. His comment that "...I started reading...and I started looking around...and just thinking", suggests that at least some of the knowledge he used to speak about medicinal cannabis use came from personal research. Later chapters will discuss how many participants who articulated more political and / or critical discourses also discussed undertaking personal research / reading around the issue.

Miscellaneous other issues and themes

This section discusses a range of themes and issues that *some* participants talked about during their interviews but which do not fit into any of the previous sections. They are good examples of inter-textuality and articulation, with participants drawing

on a wide range of discursive resources and using them when speaking about medicinal cannabis use, but are also significant in terms of a continued analysis of which participants exhibited certain increasingly identifiable types of discourse on medicinal cannabis use.

Processed foods, pesticides and G.M. crops – Risk and cannabis, the natural alternative

Earlier discussion has shown how the meanings articulated in these interviews by many participants often appeared to coalesce around the significance of ideas about 'nature' and natural products as being intrinsically preferential to 'man made' or 'chemical' products, and that cannabis is frequently spoken about within discursive oppositions to such substances (often these are prescribed medicines). It has also been argued that this can be seen as part of a broader tendency within late modernity for more 'natural' products and lifestyles and that the interventions of science and technology have increasingly been understood in terms of risk (Beck, 1992) by many in society.

This section looks at excerpts from participants who talked about processed foods, pesticides, G.M. crops and cloning, and this thesis sees talking about cannabis as related to, and often drawing on, a broader set of meanings that revolve around the increasingly problematised view of science in relation to medicine, food and other areas. To a degree, this kind of discourse is related to lifestyle choice, however, the data again suggests that factors related to social class (not simply social class itself)

are significant, with four of the five participants who did talk about these issues being occupationally middle-class (these four, again, being from the middle-middle class fraction).

One participant spoke about processed foods, but right before this excerpt he had just said that he deliberately had no contact with the medical profession at all and that, at the time of the interview, this had been the case for quite some time. Elsewhere in the interview he recounted how his young son had developed autism as, what he believed was, a result of having received the M.M.R. vaccination. He then gave an account of how he and his family had changed their dietary habits.

> "And I drink purified water with...never eat white bread, it's always whole meal flour, it's all...soya flour...We've really cleaned things up, we really have...and...we certainly make sure we eat more fruit...and...things like that...And...Yeah, we're fussy, we've become really fussy. I mean, white sugar, none of us touch white sugar anymore...We're working on a principle of if it comes from the cow it's foul sort of things, you see, leave it alone...And...But there's another thing, you know? I mean...that's just typical of this system, ain't it? They take the cow... a nice sort of like...grass eater, a herbivore ain't it? And they feed him sheep offal, didn't they?...Yeah...there's got to be an outcome, hasn't there? There's got to be a result..." (participant twenty-two: 40).

Whilst the reference to B.S.E. (cows being fed sheep offal) is fairly obvious, making a reading with regard to what the participant means by "the system" is somewhat trickier to interpret. However, one reading might be to see it as being used to mean some loose amalgamation of governmental, scientific and 'expert' power and practice. Beck's (1992) argument about the contemporary period being characterised by scepticism on the part of some members of society towards science, technology, government and 'expertise' would seem to support this. Irrespective of this

speculation, the participant links discussion of these issues to why he does not trust the medical profession and why he chooses to use cannabis instead. What appears to be a relatively safe reading is that somehow he is constructing cannabis, as many participants did, in opposition to various risk factors (Beck, 1992) and one might speculate that the meaning of cannabis for this individual has arisen over time from its use and a set of lifestyle choices that involve its construction in opposition to a set of risks that he perceives as emanating from the "system."

Another participant spoke about pesticides in her interview and, as in the case above, this occurred in relation to the broader context of risk-type ideas about contemporary society and the 'natural' v 'chemical' / 'man made' discursive opposition that lies at the heart of talking about medicinal cannabis use, for most of the participants in this research.

> "You know, I don't like pesticides and...G.M. foods and stuff. I'm more aware of them...and...you look at the sort of...our cancer rates for example...and...there has got to be a logical reason...why we've got...you know, the sort of highest rates of cancer in the world considering with...you know, tiny little island...There's obviously something...You know?..." (participant thirty-eight: 19).

This excerpt was preceded by the participant talking about her preference for cannabis because she saw it as natural, compared to her prescribed painkillers, which she only took if she ran out of cannabis. As with the excerpt previously discussed, this participant links the preference for cannabis to broader examples of risk-type reflection, in this case two, pesticides and G.M. foods, and cites them as connected to high rates of cancer in the U.K. As with the previous participant, this participant articulates meanings around cannabis that relate to broader risk and lifestyle issues.

As has also been seen elsewhere in this thesis, the common-sense nature of risk-type discourses is observable in the respect that although she cannot articulate evidence of a relationship between pesticides, G.M. foods and cancer rates, it seems to be common sense to her.

One other participant also spoke about G.M. foods. Interestingly, this participant was a member of the A.C.T. The interview data has suggested, in relation to a number of earlier excerpts, that individuals who engaged with the issue of medicinal cannabis use in a politicised way tended to draw on a wide range of discursive resources in their interviews. As they often spoke to the media about the issue, it is perhaps not surprising that they would have quite a bit to say on the subject when given an opportunity to speak about it at length. This participant discusses G.M. food within a narrative that starts by talking about the U.S. moral panic around cannabis in the 1930's, then discusses a range of other issues, including G.M. foods. Only a small number of participants exhibited accounts that strung together as many issues as this. As mentioned previously, this type of discourse tends only to be found among those who engaged with medicinal cannabis use as a political issue.

> "...they [the U.S.] condemned it [cannabis] in the Thirties, you know, and they made... films...silly films like Reefer Madness and things like that...and...and...they built up hysteria amongst the population...about something which was...comparatively harmless, you know...compared to the things that...to the alcohol, the cigarettes...all the synthetic drugs because...half of them...they don't know what they're doing, they don't know anymore than...one cent of the truth about G.M. crops...they say 'Oh, that's fine' and Jack Cunningham stands up in the House of Commons and says 'It's fine...believe me, it's fine'...he...how does he know?" (participant twenty-nine: 67).

As was also seen previously in this part of the thesis, cannabis in this excerpt is discursively opposed to alcohol and cigarettes, as well as "synthetic" drugs (as contrasted with 'natural' cannabis). G.M. crops are also raised here and the reading being adopted on the significance of this is that cannabis is portrayed as "comparatively harmless" whereas G.M. crops (like alcohol, cigarettes and synthetic drugs) are portrayed by this participant as the real risk, with those in authority (Jack Cunningham – Agriculture Minister at the time of the interview) being portrayed as ignorant of what the real risks actually are. This excerpt suggests that whilst many participants' accounts featured the 'nature' v 'chemical' / 'man-made' / risk-type discursive oppositions, some participants, perhaps because of their degree of involvement with the issue, elaborate a lot more by drawing on a wider range of inter-textual meanings and articulating them in-depth within particular and occasioned narratives, such as the one above.

The environment / developing global economies

Two participants spoke about the environment and developing global economies in the interviews. In line with arguments made above, both were A.C.T. members and as has also been argued above, this is another example of how these participants tended to exhibit the broadest range of issues being addressed in the interviews. Positioning the hemp plant in relation to articulations about the environment as well as the economies of developing countries can be seen as 'opening another front' in the discursive critique on modernisation.

> "...the hemp plant...can be used...for many purposes...it certainly wouldn't do any harm to grow...a lot...lot more plants...in terms of...absorbing carbon dioxide and...putting out oxygen. Hemp can be used as a fibre...it could be also paper...you cut down a number of trees, it's more suitable than trees for making paper...you can make a lot of fabrics out of it...but again...a lot of the dyes and bleaches and...chemicals that are used in the manufacture of paper...and other things are produced by people like DuPont...who certainly don't want it...it'd also give an income to third world countries if they could grow vast tracts of it to produce fibre...and...it seems to me that...nobody's helping...the countries who have a load of debt..." (participant thirty-five: 46-47).

This participant pulls together issues of environmental concern, "third world" economies and, as has been seen in the interviews of many other participants, he articulates a discursive opposition between the 'natural' (hemp) and the 'chemical' - "dyes bleaches and chemicals that are used in the manufacture of paper". Distrust of science, technology (Beck, 1992) and powerful commercial interests are articulated here around the DuPont multinational company who feature in certain conspiracy-type narratives about the prohibition of cannabis in the U.S., see Herer (1995) in an eco-ethical-type discourse.

> "... the thing is that these countries where they can most easily grow the stuff...are the people that really do need the boost to their economy...you know, they could be growing a material that has got so many uses...I mean you're talking thousands of uses industrial, building...you know...and...there's got to be something stopping it, I mean...these women in...I think it's in Switzerland... who actually market...stuff...mainly from the hemp plant...including, as I said, disposable nappies, you know...and it can be used...and of course it's renewable...it's not like cutting down...five hundred year old trees...you can grow, with modern technology...you can grow two or three crops a year, or two crops a year, really...a continuous...it's a continuously...renewable product...you know?...so...it's gotta be good to the environment, it's gotta be good for the atmosphere, it's gotta be good...for developing countries' economies... it's such a natural thing, it's been there for so long..." (participant twenty-nine: 69-70).

This participant also articulates concerns about the environment and developing world economies. However, this participant does so with a variation, in which modern technology can be used to aid the growing of hemp crops, so the 'natural' and technology (as an aspect of scientific intervention) are not opposed in a simple sense in this excerpt. However, what could initially appear as a contradiction can be understood in terms of critiques of modernisation often seeking to reform, as opposed to halt, the process (Beck, 1992). Reflexive modernity may reposition nature in relation to society but this does not necessarily mean an all out rejection of science and technology, just a continued reflection on their effects.

The discourses of individuals must also be comprehended in relation to what they may be understood as trying to achieve within the immediate context, as well as the broader contexts of contemporary society and reflexivity around nature. In arguing that the hemp plant is a renewable source that can produce more crop yield with modern industrial farming techniques the participant is asserting the potential effectiveness of the hemp plant even more. What might appear to be rhetorically contradictory can be seen as serving a discursive purpose. The rhetorical device three-partedness (Jefferson, 1991, cited in Wooffitt, 1993) is also noticeable at the end of the excerpt, with the use of three "its gotta be good" articulations to underline his point at the end. Participant twenty-nine was an A.C.T. member, with a lot of experience of talking to the media about the issue, so the presence of this rhetorical device, also popular with politicians, is not surprising.

This chapter has examined the discourses of participants in relation to a range of issues that all relate to the increasing variation of faith in the key social institutions of science, technology, government and 'expertise' (Beck, 1992). Much of this related to the medical profession, medical knowledge and medical institutions (i.e. the B.M.A.), but other related issues such as global capitalism, pharmaceutical companies, environmental issues and developing global economies were also discussed by *some* participants.

In the introduction to this chapter, reference was made to a question posed earlier in the thesis, in relation to the work of Brand (1990) and Beck (1992), about the degree to which people from different social backgrounds might be capacitated and disposed to critically engage with powerful discourses and institutions. Previous chapters in the 'mapping' part of this thesis have already shown that not all participants seem to engage in talking about such a wide set of issues and that this seems to relate to social structuration in terms of differential access to education and vocation. This chapter has further demonstrated these patterns within the data where it has been seen that many of the issues discussed in this chapter tended to be articulated largely by members of the middle-middle occupational class or above. This has interesting implications for Beck's (1992) arguments about reflexive modernity, because the capacity and disposition to be reflexive is surely not distributed equally across society and neither, suggests this thesis so far, is the possibility of effective participation in critical challenges to powerful discourses, such as the 'no medical value' discourse on cannabis. The next chapter will explore the accounts of certain participants in relation to the presence of vocationally derived discursive resources.

CHAPTER 13

VOCATIONAL DISCOURSES

The 'mapping' of the discourses of participants in this research has at times already drawn attention to the ways in which some participants, when talking about certain issues, appear to draw on vocational discourses. This section will explore this more thoroughly.

In all, twelve participants exhibited aspects of vocational discourses in their interviews. With regard to the emerging significance of social class related factors in relation to apparent differences between participants' discourses, all twelve were occupationally middle-class. The type of vocations whose discourses were drawn on by these participants were nursing, disability workers, health workers, a media researcher, a sociology student (she is now studying for an EdD so the researcher takes this to be her vocation), an electronics scientist and a managing accountant (who had managed and owned an accountancy practice). Initially, some of these vocations may seem more obviously relevant to talking about medicinal cannabis use than others, however, discourse associated with these vocations was drawn on by participants who previously occupied them, or still occupied them, at the time of the interviews. The arguments made in this chapter will be taken further in later chapters (Chapter Nineteen in particular) in terms of understanding the differences between the discourses of participants in terms of different *types* of medicinal cannabis users' discourses. For now, a brief discussion of how vocational discourses were drawn on, by some participants in their interviews, is required.

Ex-nurses drawing on medical discourse

Of the twelve participants discussed in this chapter, three were ex-nurses. As users of cannabis in medicinal ways it is perhaps unsurprising that, at times, they brought medical knowledge and ways of talking about medical issues to bear in discussing their own use of cannabis. However, there is something very interesting about these participants. Trained to understand medical issues within a medicalised set of discourses and practices, all three were also acutely aware of the limitations of scientific-medicine for chronic illness (two had M.S. and one had M.E. and back problems). This brief consideration of the specifics of these three participants is enlightening, as it allows us to account for how they sometimes deploy medical discourse and at other times recognise the limits of scientific-medicine, with these two initially contradictory tendencies actually co-existing due to their past socialisation into understanding issues of health and medicine as nurses (medicalised discourse and practice) and understanding the limits of this for them as people with chronic illnesses.

When asked to describe their use of cannabis in practical terms (how much they used, how often they used it and when they used it), they all spoke about cannabis using medically informed language. Participant thirty-one spoke about attending a 'pain management' course, before leaving nursing but after being diagnosed (her attendance was for her own benefit, not professional development). Later in the interview she said the following:

> "...it's [cannabis] part of the pain management sort of...strategy..." (participant thirty-one: 8).

Interestingly, this tendency to speak about cannabis in medicalised ways could also be seen as having a justificatory rhetorical function, that cannabis use is validated by articulations that employ medical language to talk about it.

> "Well, with regards to...removing the pains in my legs...it...[cannabis] has a wonderful effect whereas at the moment what I'm taking is a drug called Tegretol...which has been shown to be...helpful in cases of trigeminal neuralgia...and that's for other neuralgias as well...and...it's...dampened down...these unpleasant feelings...but it hasn't got rid of them...so, from that point of view, I think that the cannabis is more effective...than the...Tegretol..." (participant sixteen: 23).

In the excerpt above, another participant is clearly using medical discourse, e.g. "trigeminal neuraligia", but more than the obvious issue of her discourse drawing on this type of language, it also functions in a justificatory way (as was seen with the previous participant). She argues that the drug Tegretol has been "shown to be helpful ..." (i.e. in medical studies), but that cannabis, for her, is more effective. The authoritativeness of her articulation is drawn from the authority of scientific-medicine. In both excerpts, medical discourse seems to have been drawn on and articulated in ways that opposed the 'no medical value' discourse on cannabis. As Foucault argued:

> "... discourse can be both an instrument and an effect of power, *but also a hindrance, a stumbling-block, a point of resistance* ..." (my italicisation) (Foucault, 1979: 100-101; quoted in Young, 1981).

This use of medical discourse and knowledge to oppose the 'no medical value' discourse on cannabis is apparent in the nurses' interviews in other places too. The final quote below again articulates medical discourse but also articulates the limitations of scientific-medicine. Initially, it can be read as almost acquiescent, but the final remark about doctors can also be read as a comment upon their discursively imposed limitations.

> "I mean, you know...we're not idiots...we're not going to take it [cannabis] if it doesn't do us any good...I mean...you know, there's no point...but...you know, I...I can understand where the medical establishment is coming from...they're saying... 'Oh...you know, there hasn't been the research...to show that...this particular preparation...is advantageous...to...you know, people suffering from X, Y, Z... .' Doctors live in a research-based world..."

In summary, the ex-nurses drew on medical discourse at certain points during their interviews and tended to use it to justify the use of cannabis, to portray cannabis in ways that drew on the legitimacy of articulating it in relation to medical discourse and to be critical of medicine and its role in excluding cannabis from being seen as a medicinal substance.

Disability workers

Three participants from the overall sample worked in disability-related roles. Two worked for disabled peoples' groups (run by and for disabled people) and one was a freelance disability equality trainer. All three exhibited aspects of a particular position and discourse on disability, the 'social model' of disability (Oliver, 1983). Whilst

there is nothing inevitable about disabled people understanding disability in terms of this critical perspective (in fact, the pervasiveness of medicalisation makes it more likely that they will not employ such an outlook), groups run by disabled people and for disabled people have arisen in recent decades, in part as a result of the dissatisfaction that some disabled people have had with provision being made for them by medical professionals and / or charitable organisations and the assumptions that such provision has involved (Oliver, 1990). The growth of groups run by and for disabled people and the critical perspective on the medicalisation of disability, the 'social model' of disability, may therefore be seen as tending to have a reciprocal existence (Oliver, 1990). Indeed the 'social model' of disability may be seen as the central ideological element of the disability movement.

These three participants drew on this type of discourse at times during their interviews, some of them on numerous occasions. One participant simply mentions 'the medical' model of disability in passing:

> "I suppose really I became aware of it [cannabis] for therapeutic purposes when I was looking for alternatives...looking for alternatives to the medical model and the medical approach..." (participant one: 4).

Another participant discussed issues of power and the rise of the disability movement, in relation to medicinal cannabis use, in quite a long part of the interview.

> "Well...It's only really happening the last sort of...twenty years that disabled people start to have...started to have a voice...but in order to get that voice they have to become 'stroppy' disabled people...you know they have to stop the buses or...demonstrate or...you know...and...make...become complete pains and embarrass people to do things...and...I think it's...would be...it is a lot more difficult for

> disabled people to say... 'We want cannabis... Cannabis is good for us'... and... and... you know... people aren't necessarily gonna take that... seriously... I think that... when it comes to... things that are good for disabled people... in... you know, when it comes to medical staff... it has... it always seems to fall on... non-disabled... and... professionals... to actually... sort of move that... and have the influence... so... and I... you know, and I... think that... because the people who do make the decisions and because the people who are... powerful... are not disabled..." (participant twenty-six: 43).

In trying to account for why many people offered so-called 'anecdotal' evidence for cannabis' medical efficacy, yet it was still not legally available for such uses, this participant produces a narrative about the rise of the disability movement and positions cannabis within this set of events. For the participants who worked in disability roles and for disabled peoples' organisations, the medicinal use of cannabis tended to be positioned in this way, as an intrinsic part of the broader struggle for disabled peoples' rights. Having this discourse available to draw on, a discourse that produces the position of disabled people and, in this case, their use of cannabis as intrinsically political, and occupying vocational roles in organisations that are involved in social struggle does increase the habitualised tendency to articulate a discourse that is intrinsically politicised. This argument will be taken forward in later chapters that attempt to account for the different types of discourse exhibited by different participants.

Social / Health workers

There were two participants who could be described under the broad term social / health workers, their actual vocational positions had been in social work / counselling

for one and social work / health clinic worker for the other. Both drew on discourses that are associated with these types of vocations during their interviews. Participant four, the social worker and health clinic worker, described her approach to using cannabis as "pain management" (in the same way that one of the nurses did who was discussed above).

> "Fortunately it's [pain] not been that bad for a long time...
> but...now...I think because I've got my pain management...
> under a lot more control..." (participant four: 14).

The concept of 'pain management' suggests an informed strategy or practice for dealing with pain that is derived from the discourse of the health profession (thus exhibited also by a participant who was a nurse and seemed to derive it from attending a specific course). Whilst not hugely insightful, in and of itself, this excerpt does seem to give some evidence of different types of professionals within the health field sometimes articulating similar discourse when talking about medicinal cannabis use and this discourse being medical in origin.

Participant six, the social worker / counsellor, was given to reflecting upon her use of cannabis in terms of ideas about 'enablement'.

> "...it enables me to live my life more...because I'm able to cope
> better with everyday things. It enables me to sleep better than I
> would...which will give me energy, it enables me to relax and
> therefore not be so tense...and this is what I'm getting back from the
> other people who use it as well..." (participant six: 10).

'Enablement' can be read as part of a strategy of improving one's overall conditions and a way of talking about this that might have its origins in counselling (which was

the vocational background of this participant). It is also significant that "enables" could be seen as the opposite of "disables", as the participant is basically arguing that cannabis plays an empowering role within her life and importantly she also says "this is what I'm getting back from the other people who use it as well…". Her excerpt can be read as an attempt to assert the empowering / enabling aspect of cannabis as common experience of medicinal cannabis users.

Media researcher

The vocational role of media researcher seems less apparently likely to contain the possibility of accessing discursively useful resources for talking about cannabis in critical and challenging ways. However, this participant was a researcher for television shows with medical aspects to them and was the founder of the Alliance for Cannabis Therapeutics in the U.K. Having said this, her interview was most interesting in terms of what she said about the process by way of which she came to use cannabis and the work of the A.C.T. Her mention of 'set and setting' that originates from the work of Zinberg (1984) has been mentioned previously and is of course significant in terms of a participants vocation providing particular discursive resources for talking about medicinal cannabis use.

Sociology student

Another participant who exhibited a degree of vocationally derived discourse in her interview was a sociology student.

> "...I think it was a newspaper article on...I think it might have been on M.S. actually...and said that the benefits of it...and I sat and I tried to work out if there was any correlation between me smoking and me feeling better..." (participant thirty-eight: 8).

> "I find...that if I'm stressed I'm more aware of the pain...whether it's psychological or is it physiological I don't know..." (participant thirty-eight: 15).

In both excerpts, a social science type reflection upon these issues is clearly exhibited. In the first excerpt, she described reading a newspaper article and wondering whether when she had previously used cannabis she had actually felt better (this participant had been a recreational cannabis user anyway) and used the term "correlation". In the bottom excerpt, she considered the relationship between stress and pain and employed the distinction between psychological and physiological. Interestingly, this student had been a psychology undergraduate before transferring to sociology. This is more evidence for certain participants drawing on vocationally derived ways of talking about medicinal cannabis use, as well as evidence as to the affect of higher education.

Scientist (electronics)

This participant had worked in scientific research in the area of electronics and had completed a PhD in this field when he was younger. The vocationally derived aspect of his discourse was often visible in terms of the complexity of how he would speak about issues. In response to being asked whether he felt using cannabis in conjunction with prescribed medicines had ever caused him any problems, he said the following:

> "No, I find it just the opposite...I find that you can harmonise between the two... 'cause obviously the medicines you're taking...are...because of the nature of their design are non-natural and therefore they're acting upon those parts of the body...whereas the cannabis...attaches itself more to the brain...and the other medicines don't, they attach to physical parts of the body independently...and the cannabis attaches itself to the brain...thereby controlling your body from the brain, basically the master switch...whereas other medicines don't control it from the master switch...so therefore intermixing the two...I find there's always harmony between them...there's never a problem..." (participant thirty: 35).

Whilst arguably anyone could know about how medicinal substances work (whether they act upon receivers in the brain or act on organs within the body) and talk about it (although one of the main arguments in this thesis is that access to knowledge and powerful linguistic resources are still unequally distributed in social life) it is perhaps more likely to have been said by someone with a background in science. As before, this stands as more evidence for vocationally informed ways of talking about medicinal cannabis use.

Managing Accountant

The final participant whose interview exhibited a degree of vocationally derived discourse was a managing accountant (an accountant who had owned and managed his own accountancy practice). Admittedly, this vocational background seems the most unlikely of those discussed to provide vocationally derived ways of talking about medicinal cannabis use.

> "...it's something...it's like with any kind of disease...when you have any sort of...failing in yourself...you have to manage it...so...and that's the whole thing, it's like...M.S. can be managed...as best as possible and that's what the task is to do..." (participant thirteen: 2-3).

As he would discuss later, cannabis was part of how he "managed" multiple sclerosis in his day-to-day life, but it is interesting to speculate upon how successful professional people might come to understand the way to deal with chronic illness as being about managing it, in the same way they might "manage" their business lives. Whilst this excerpt is not hugely significant in and of itself, again, it is more evidence for how certain participants bring vocationally derived discursive resources to bear in talking about their medicinal use of cannabis.

This chapter has shown how various participants, at times, draw on vocationally derived linguistic resources when talking about their medicinal use of cannabis. It would appear that, at least for the participants of this research, those who had certain vocational backgrounds (nursing and disability organisation workers) tended to draw on these resources with the most critical outcomes for engaging with the 'no medical

value' discourse on cannabis. For those working for disabled peoples' groups, one might expect this. Being employed by organisations run by and for disabled people, it has been argued, tends to result in a more critical outlook on the medical profession and their relationship to disabled people and issues of power. However, nurses (or ex-nurses) have actually been part of the medical profession, so one might not necessarily expect them to be as critical as their interviews have shown them, at times, to be. Yet it has also been argued that access to medical discourse brings the possibility of subverting that discourse against its own interests. The next chapter will make some overall summary remarks about the 'mapping' stage of analysis and will indicate how this inclusive process of analysis led to the emergence of the more specific aims of this thesis.

CHAPTER 14

SUMMARY DISCUSSION OF 'MAPPING' THE DISCOURSES OF MEDICINAL CANNABIS USERS

Part Four of this thesis has 'mapped out' the discourses articulated in the interviews of the 32 participants. However, it is clear that there are great differences between what different participants used language to *do* in their interviews. Cannabis and its use were rhetorically articulated in various ways by different participants, for example via articulations that constructed it in opposition to other substances (prescribed medicines, alcohol, tobacco or other prohibited substances, often so-called 'hard' drugs like heroin or 'crack' cocaine), with medicinal cannabis use being constructed in various relatively positive ways. The most commonly articulated set of meanings around cannabis that were exhibited in these interviews relate to constructions of cannabis as 'natural' or around cannabis and 'the natural', often constructed by way of discursive oppositions with 'man made', 'chemical' or 'synthetic' products (often those listed above).

What is most striking about the picture of different participants' discourses that is provided by the 'mapping out' approach is the degree of difference, in terms of the amount of issues discussed and the discursive resources that are used to do so, between different participants' interviews. The data strongly suggests a relationship between social class related factors and discursive differences, with occupationally middle-middle and upper-middle class fraction participants in particular tending to talk about a wider set of issues and to draw inter-textually on a wider set of discursive resources to do so.

Within this pattern of participants from certain middle-class occupational class fractions tending to talk about a broader range of issues and to draw on a wider range of discursive resources to do so, a smaller number of participants can be seen as exhibiting aspects of a more politicised discourse that, in some cases, also seems to take on a more critical engagement with aspects of the dominant discourses in the area of health, those of the medical profession and of scientific-medicine (e.g. clinical evidence being preferred to anecdotal evidence or around what kinds of substances are understood as legitimate 'medicines').

It is also apparent that an overly simplistic conceptualisation of the relationship between social class and language would be unhelpful, as there are clearly instances of working-class participants exhibiting discourse that is broad, inter-textual, critical and resistant in content. However, occupationally working-class participants did tend to exhibit this type of discourse far less often, with most working-class participants not doing so at all. The one working-class participant who did consistently exhibit this type of discursive engagement (participant thirty-five) had an educational trajectory that was far from typical of occupationally working-class participants in this research. Yet the incidences of this type of discourse being exhibited by working-class participants are far from insignificant. Later chapters will argue that occupational social class in itself is not explanatory of the differences between participants' accounts that have been discussed in this part of the thesis. In fact, it is a number of social class related factors that account for such differences.

If there is one aspect that appears to be most common to different participants' accounts, it seems to be the tendency to discursively construct cannabis, in various

ways, in relation to meanings about 'nature' and 'the natural.' It can be seen from discussion in this part of the thesis that this often serves the rhetorical purpose of constructing cannabis as relatively safe, benign, or beneficial and that there is often a 'common-sense' or naturalising discursive function to this. Being seen as 'natural', cannabis seems to be understood by many participants as intrinsically safer, more benign or beneficial and that this is simply 'common sense.' It has also been argued in previous chapters that in late modernity this seems to be true of many other substances, products or lifestyle choices that are also understood as being 'natural', with preferences for organic foods among a growing number of people serving as just one example of this. These articulations have been understood in relation to Beck's (1992) arguments about contemporary society and the growing tendency to reflect critically upon certain key aspects of modernisation such as science, technology, government and 'expertise' and how embracing 'the natural' is increasingly popular with many of society's members, in numerous ways, in everyday life.

The chapters in the next part of this thesis, Part Five, will seek to address the more major findings that have been discussed in this part of this thesis. The significance of understanding cannabis as 'natural' in relation to the discursive struggle around the medicinal use of cannabis, situated within this particular part of the contested field of health, is one of these. The differences between different participants' discourses will also be further examined over a number of chapters, and the thesis will argue that this can be understood in terms of a series of 'types' of medicinal cannabis users' discourses. The significance of all of this for the discursive struggle to have cannabis' medicinal benefits recognised will also be addressed.

PART 5 – ANALYSIS AND DISCUSSION

CHAPTER 15

PROCESSES IN THE ENGAGEMENT WITH DISCURSIVE RESOURCES

Introduction

This chapter attempts to do something different to the rest of the analysis. Rather than talking directly about the discourse of participants, it attempts to produce an understanding of how different participants articulate different discursive resources within their interviews. However, this requires some immediate clarification. This is not an attempt to explain why different participants say different things in their interviews. After all, it would be very odd indeed if different participants were all to say the same thing. This chapter looks at participants' discussions of using cannabis to see whether they offer evidence as to why some of them talk about medicinal cannabis use in ways that draw on a broader range of meanings than others. For example, the 'mapping out' chapters have shown that whilst a majority of participants are given to talking about medicinal cannabis use in relation to ideas about 'nature', only a few talk about a range of miscellaneous issues such as the B.M.A. or Zinberg's (1984) concepts of 'set' and 'setting', for example.

It will be argued that participants who exhibit what will later be described as 'politicised' or 'heretical' type discourses offer evidence within their interviews of

having actively sought out more information about all manner of issues with regard to medicinal cannabis use and that this deeper engagement with the societal Conversation (Gee, 1999) about medicinal cannabis use (everything that has been said and written about medicinal cannabis use) provides a broad range of meanings that can then be, and in some participants' interviews are, articulated when talking about medicinal cannabis use.

Processes in the engagement with discursive resources

The interview schedule that was used in gathering the data for this research asked, among many other things, whether participants had used cannabis prior to using it in relation to their impairment and / or chronic illness, where the idea to try cannabis as a medicinal substance had come from and various questions that probed the early stages of the participant's experience with cannabis. The findings in relation to these questions are very interesting and are discussed in Coomber, Oliver and Morris (2003). In relation to these issues, the participants reported that:

> Nine had not used cannabis at all prior to medicinal use, eighteen had used before, but had not been using for some time prior to medicinal use and five had used cannabis anyway and then came to realise that it was medicinally useful for them.
>
> Seven came across the idea of using cannabis medicinally in the media (most of these from newspaper articles, oddly enough many of which were in the

Daily Mail), ten had the idea suggested by a friend / acquaintance, four had it suggested by a medical profession, two had tried it previously for mental health reasons and two found out by way of personal research.

So the data hints at various topics that taken together can be regarded as insights into how cannabis becomes meaningful for medicinal users and that this involves various issues.

However, some participants also spoke about doing personal research into medicinal cannabis use and the various topics related to it. This is very interesting because although only five participants spoke about this (and it must not be assumed that those who did not speak about it did not necessarily do so as well), these five all articulated what will later be described as more 'elaborated', drawing on Bernstein's use of the term (1975), 'politicised' and in one case 'heretical', drawing on Bourdieu's use of the term (1992), types of discourse. Most significantly, this 'heretical' type of discourse (consisting of features that critically engage with scientific-medicine's 'no medical value' discourse on cannabis), was exhibited by only one participant. It will later be argued that for an individual to exhibit this type of discourse, they must gather a broad base of knowledge to articulate within particular discursive settings (such as an interview). It is also significant that of these five participants, three were members of the Alliance for Cannabis Therapeutics, one was a disability group manager and one an electronics scientist with a PhD (who also ran a disability issues website). This is significant in terms of all five being engaged with issues around medicinal cannabis use, and in some cases disability, in a critical social sense but all five also had the educational benefits typical to the occupationally

intermediate and professional fractions of the middle-classes (the one occupationally working-class participant discussed here went to grammar school and art-college, so his occupational social class is misleading if viewed in isolation from his other biographical information). In summary, they exhibit a critical type of engagement when talking about medicinal cannabis use and more powerful linguistic capital (Bourdieu, 1992) to use in doing so.

A television researcher and producer with a background in making medically related television shows and what she described as "academic parents", participant thirty-two described being told that cannabis could be medicinally useful for her (with multiple sclerosis) by way of being given a medical journal paper in 1991 (it is not insignificant in terms of social class and education issues itself that she would be given such a source of information).

> "...I just said 'Oh I'll try this, I've tried every other bloody thing'...and 'what a joke'...you know, it was sort of like...'can I get hold of some?' ... And then it...it kind of...you know, I just...and...but then...what I started doing...I researched it ...I went to I.S.D.D. They were incredibly helpful...they all...I found out all these bloody articles..." (participant thirty-two: 20-21).

Arguably, for a professional researcher one would be surprised if she had not researched this idea. However, the I.S.D.D. (Institute for the Study of Drug Dependence, today known as DrugScope) was and still is probably not well known to the general public. Her vocationally acquired knowledge of such places, as well as a professionally developed disposition to research things, explains her taking this trip to London (from Yorkshire). A year later, she had written an article published in *The*

Spectator magazine and had founded the Alliance for Cannabis Therapeutics in the U.K, both under an assumed name.

In terms of trying to understand how this participant comes to exhibit what will later be described as an 'elaborated' type of discourse on the medicinal use of cannabis, Bourdieu's (1979) concept of trajectory is very useful. For Bourdieu (1979), trajectory is a way of understanding how the biography of an individual's life involves movement through time and through positions in various 'fields'. This movement, understood as an individual's trajectory, explains how an individual accumulates and deploys certain types and amounts of various forms of capital and how the habitus of the individual is restructured as this journey through life takes place. In relation to participant thirty-two, her trajectory from the cultural capital and social capital (Bourdieu, 1979) of being born to "academic parents", through studying classics at Oxford to a job in television equips her with the knowledge and inclination to engage with medical literature (she specialised in medically themed television programmes) on medicinal cannabis use and to have an 'elaborated' discourse on it.

Participant twenty-eight, a privately educated ex-army officer, described over two excerpts in his interview how he discovered, through research, that cannabis could be medicinally useful for people with M.S. and how he came to know much more about it since trying cannabis, finding that it helped him, continuing to use it and continuing to research the issue.

> "...I had M.S. ...I did what I could to find out about it because I enjoyed researching and finding out about it...that I did...and...what by...let me see...I was diagnosed...by within a year...looked at the internet and library books and...it was, I noticed that it was very

> difficult to read anything about M.S. without reading about cannabis...or marijuana, call it what you want...and it got to a stage where...when I was reading that there was a...there was a fair bit of data about the...the value of cannabis..." (participant twenty-eight: 5).

Perhaps the most important aspects of what he talks about here are his comments that he enjoyed researching and his mention of the internet. His mention of the internet is significant because the interviews were conducted between 1998 and 2000 and at this point in time, internet usage was becoming more and more prevalent among the general public. At that time, as now, a search of the internet on the topic of medicinal cannabis use provided a large amount of information (some sources obviously more useful than others) at the fingertips of anyone who did such a search, or was inclined to such engagements with knowledge. As such a source of knowledge, the internet is a significant part of what is conceptualised in this research as the societal Conversation (Gee, 1999) about medicinal cannabis use, a repository of all manner of information.

However, such a repository does not just contain information, but also ways of talking about an issue or discursive resources. Such resources are hypothetically accessible to anyone with access to the internet, yet this raises some issues for consideration. It is still the case that not everyone in the U.K. has internet access now (so it is safe to assume that this was even more so between 1998 and 2000) but more importantly, not everyone is inclined towards researching issues, or to be more crude, even reading much at all. It would seem safe to argue overall that access to the internet and having the habitual disposition (Bourdieu, 1979) to behave in a particular way (i.e. to research issues) were not equally socially distributed across different social groups and still are not. This being the case, access to this broad repository of

ideas on the medicinal use of cannabis and thus the likelihood of articulating them within interviews such as those looked at in this thesis, was not equally distributed either.

> "...within five minutes the remedy [cannabis] was working...and...my initial knowledge was only what, two percent of what I have now about cannabis...and...its, it was...curiosity..." (participant twenty-eight: 15).

Having found that cannabis helped him, this participant carried on researching the issue to learn what he estimates to be many times more than what he knew when he first consumed cannabis. He describes this as "curiosity", but as is argued above, such 'curiosity', thirst for knowledge or whatever else we may call it, is unequally distributed in society. In the later chapter on 'types of discourse', this issue will be further discussed.

Participant thirty, a man with a spinal chord injury who had a background in electronics, a PhD in electronics and ran a website about disability related issues, expressed a similar interest in reading around the medicinal cannabis issue.

> "... I might say then since ninety ... ninety-five [1995] I've been aware and keenly interested in...anything ...anywhere about it [medicinal cannabis use]... because it's something that affects me ..." (participant thirty: 13).

In terms of previous arguments about trajectories, cultural capital and dispositions (Bourdieu, 1979) towards wanting to know more about medicinal cannabis use (as opposed to just being content with it providing some medicinal benefit), this participant's academic background suggests that he would be endowed with the

capacity and disposition to be able and inclined towards researching medicinal cannabis use from the internet and other sources. Indeed his disposition, which he describes as "keenly interested", towards becoming knowledgeable on the subject is borne out in his interview by later talking in depth about the long history and various uses of the hemp plant.

Participant thirty-one worked for a disabled peoples' organisation, had a spinal injury, was a social psychology graduate with a post-graduate diploma in counselling and had a nursing background. She described coming to use cannabis medicinally out of a preference for more natural medicinal substances and that once she found that cannabis did indeed help:

> "subsequently [to finding out that cannabis was medicinally beneficial] ...I did become aware that there are... issues, debates, campaigns, etc... but at the time...I wasn't plugged into that..." (participant thirty-one: 17).

As with previous participants discussed in this chapter, she has the type of trajectory (Bourdieu, 1979) that can account for acquiring linguistic capital and a disposition to research issues that seems to be associated with possessing a broader and more critical type of discourse on the medicinal cannabis use issue. However, unlike the previous participant she spoke about "campaigns", indicating a more politicised type of engagement with the issue of medicinal cannabis use. It has been discussed previously that disabled medicinal cannabis users, particularly those who work within the field of disability, tend to have a politicised type of discourse on the topic and that this is an outcome of it being located within the broader set of disability issues. Five other participants also exhibited a more politicised type of discourse in the interviews,

with three of them working for disabled peoples' organisations. As has been argued previously, another key differentiator that has emerged within this thesis seems to be that the type of discourse articulated by a participant is related to the type of engagement with the issue of medicinal cannabis use that the participant has. It is also interesting to note that this participant's partner, another participant in the interviews, also worked for a disabled peoples' organisation and she exhibited a similarly politicised discourse as participant thirty-one.

Participant twenty-nine had M.S., a background in engineering and was a member of the A.C.T. He articulated what will later be described as a 'politicised' type of discourse. This participant described reading various newspaper articles and other material on the issue and spoke about a broad range of issues, drawing on a multitude of discursive resources in the articulation of his account.

Newspaper articles on medicinal cannabis use from the 1990's

As was mentioned earlier, seven participants in this research reported first encountering the idea that cannabis could be of medicinal use by way of the media, more specifically newspapers. A search for such articles printed during 1990 –2000, the time during which participants reported reading such articles, using Lexis-Nexis produced details and content of 30 newspaper articles printed in the Times, the Independent, the Daily Mail and the Mirror. These articles are insightful in a number of ways. They tend to simplify and misrepresent the issues, which is a common trend of media reporting around drugs (Coomber, Morris and Dunn, 2000). For example, they frequently failed to distinguish between cannabis and cannabis-based medicines

often implying that cannabis itself could be prescribed in the U.K. until 1971. This misunderstanding was in turn exhibited by at least one participant in the interviews (participant seventeen). Some articles implied that the B.M.A. was in favour of legalising cannabis for medical use, though it was actually in favour of investigating the medical potential of cannabinoids not cannabis *per se* (B.M.A., 1997). This is very interesting though because it means that much of what was said about medicinal cannabis use in the press at the time does not convey the impression that cannabis was of 'no medical value'. On the contrary, it often implied the opposite. Through such misunderstandings, much of this newspaper-based discourse can be seen as being far from hegemonic.

The newspaper articles can also be seen as providing a range of ways of thinking and talking about the medicinal cannabis use issue, some of which the reader will recall were also articulated by participants in the 'mapping out' chapters (see Part Four). Some of the more prevalent themes in the articles were:

> Cannabis helps various conditions; for some patients, cannabis is the only thing that helps; cannabis as efficacious, safe, non-toxic and very effective; the long history of human use of cannabis as a medicinal substance; prescribed medicines often being ineffective and / or having side-effects; anecdotal and clinical evidence; Dutch standardised quality cloned hemp plants; Jack Herer's 'theory' about DuPont Industries; third world / environmental issues and the hemp plant; cannabis as natural (although interestingly this is a theme that featured in only three of the thirty articles, something that will be discussed in later chapters).

Some of the articles talked about clinical and anecdotal evidence and reproduced the hierarchical distinction between them. However, some also challenged it through the narratives of medicinal cannabis users being featured in the articles. Such narratives from users, who had a range of illnesses and impairments, may have played a role in popularising medicinal cannabis use in the U.K. at that time, as readers identified with their stories and decided to try cannabis medicinally for themselves.

Conclusion

This chapter has discussed how a number of participants spoke about doing personal research into medicinal cannabis use and how these users are typically of vocational and occupational social class backgrounds which would fit with the notion of having a life trajectory (Bourdieu, 1979) that would endow an individual with the disposition to want to gather knowledge about the issue of medicinal cannabis use. This argument will be further developed in later chapters.

This chapter also looked at the themes found within some British newspaper articles between 1990 and 2000 on the topic of medicinal cannabis use. It found that due to misunderstandings and misrepresentations in the articles as well as the deliberately included content of the articles, that such articles were often far less hegemonic than might have been expected and that they offered a repository of useful discursive themes and arguments that could be articulated by those who had read them when talking about the issue of medicinal cannabis use elsewhere (such as in the interviews

used for this research). A point that will be taken up in the Chapter Seventeen is how the theme of cannabis being a natural substance, and the typically attributed benefits of this, was found in only three of thirty newspapers articles, yet it is the most common, and arguably central, aspect to the majority of participants' discourses in this research. For the moment, the next chapter will focus upon issues of impression management within the interviews.

CHAPTER 16

IMPRESSION MANAGEMENT WITHIN INTERVIEWS

Introduction

This chapter looks at instances of impression management, by the participants, within the interviews. The 'mapping out' chapters (Part Four of the thesis) briefly noted such tendencies among some participants in the subsection on talking about the 'stepping stone' theory which is discussed in Chapter Nine. To remind the reader, it was argued that there are a number of participants whose interviews were more significant for exhibiting issues of impression management than being discursively interesting in other ways. However, discussion of this aspect of participant discourse first requires a brief discussion of exactly what 'impression management' is.

Impression management – Goffman and Bourdieu

Familiarisation readings and early attempts at analysis of the interviews showed that one of the ways in which participants' accounts differed was the extent to which *some* participants, at certain times, appeared to be greatly concerned with presenting themselves and the history of their use of cannabis in certain ways. It is hardly surprising, on reflection, that in discussing the use of a substance that some argue is medicinally useful but much of society understands to be primarily, or exclusively, an illegal recreational 'drug' (with all the meanings that coalesce around this term), that

some participants would exhibit a concern to manage the way that they present themselves in interviews when talking about their use of such a substance. It is certainly the case that these sections of certain interviews, in which such rhetorical strategies to present the self in 'a certain light' can be seen, are fascinating. In discussing what some participants seemed to regard as the most sensitive topics of the interviews and negotiating a favourable presentation of themselves and their behaviour, their use of discourse and rhetorical strategies can be seen as being at its most artful.

However, some guiding theoretical concepts are required and the work of Goffman (1959) has been helpful here. Goffman's (1959) dramaturgical approach has at its heart the analogy of individuals as actors, giving performances, playing roles and appearing keen to protect the positive moral standing of the self. Goffman (1959) discussed various strategies used by individuals to effectively and convincingly perform their roles and such strategies are significant to this research in relation to the individuals' concerns to manage the perception of themselves.

Goffman's (1959) notion of *impression management* involves the individual attempting to portray themselves in idealised ways. In a discussion of Goffman and impression management, Ritzer (2003) argues that Goffman adopts quite a cynical view of the individual, that is to say that Goffman conceptualises the individual as playing roles that may often consciously involve misleading those that are understood to be the 'audience.' However, this raises a question about to what degree such performances are in a simple sense consciously produced.

In relation to this question, Goffman's (1959) concept of impression management can usefully be employed in conjunction with Bourdieu's concept of habitus (1979). If impression management involves the tendency for people to portray themselves in a favourable light then this can be seen as being done in habitualised ways, not necessarily consciously, with impression management being the product of a socially constructed habitus negotiating its own portrayal. This suggests that the way in which an individual may want to be seen is socially constituted itself and perhaps not particularly conscious in operation (as much habitualised behaviour tends to be at most only semi-conscious).

Impression management in the participants' interviews

This chapter discusses four participants whose discourses most closely match the type later discussed (in Chapter Nineteen) as 'practical'. Whilst there are other participants whose discourses in these interviews most closely matches this discursive type, these four are of interest as their interviews exhibit varying degrees of concern for impression management (Goffman, 1959), and in two of the four cases this might be said to be the defining characteristic of their interviews. This is important to this research in terms of attempting to explain the significant differences between participants' discourses.

The four participants discussed here have some things in common. All four reported not having used cannabis prior to trying it for medicinal use and all four reported using it exclusively for medicinal reasons (and asserted this strongly in their

interviews, which is telling in itself). Three of the participants had also been members of the Multiple Sclerosis Society (the fourth had rheumatoid arthritis so would not have been a member), which had adopted a policy similar to that of the B.M.A. in the respect that it was in favour of research aimed at developing cannabis-based medicines but did not condone the use of cannabis among its members (although many members used it anyway) at the time of the interviews.

It is also significant that the displays of impression management (Goffman, 1959) begin fairly early on in all four interviews, when participants were asked what their thoughts were about cannabis prior to using it and how they came to use it (see Appendix A). With medicinal cannabis use being a contested and sensitive issue one might expect to see aspects of impression management (Goffman, 1959) at this point. The narratives that are produced at this point of the interviews by these four participants can be understood as assertions that they are using cannabis because it is the only substance that helps them, that they are not generally amenable to illicit drug use and that this is not the 'sort of thing' that they generally approve of. In short, and somewhat crudely in sociological terms, one might describe these narratives as displays of 'middle-class respectability'.

> Interviewer: "What were your initial thoughts....about cannabis?...I suppose what I'm getting at really...a lot of people associate it with...sort of recreational use or whatever..."

> Participant: "Yeah...to be quite honest, my first...when they've said to me...you know...and I can still remember the...'I could use cannabis...it's illegal'...and...I had...I can't tell you the position of the first person but she's quite high up in the community now...and...a very....very well spoken, very well...respected person of the community...and does hold a position of quite...significant... influence...and...no...well, she...no, she'd actually...I wouldn't...no,

> I'm not gonna say...on tape that...'cause it would be too easily identifiable...but...it...you know...I said 'I can't believe that you're telling me...to try this'...I...I was just...I was absolutely shocked...that they were actually suggesting that I used it. I wouldn't say I was horrified...but I was shocked... 'what?!...Why are you saying this?'...You know, and...we did have a lot of conversations about it and...as I said it wasn't a decision that...I took lightly..." (participant four: 22-23).

In terms of Gee's (1999) suggestion that discourse be considered in terms of 'who's doing what's?' this excerpt can be read as a performance of habituated 'middle-class respectability'. The participant describes being "absolutely shocked" at the suggestion of using cannabis, even though it came from a "very....very well spoken, very well...respected person of the community..." and the reader may notice the use of three-partedness (Jefferson, 1991, cited in Wooffitt, 1993) to emphasise the well spoken / respectable character of the source of the idea that the participant should try using cannabis. This narrative has the effect (and readings should be seen as trying to identify what problem a narrative might be a solution to) of negotiating the problem of accounting for why the participant came to use cannabis when it is something they were initially very much opposed to and to maintain a sense of still broadly being opposed to the use of 'drugs'. Indeed the fact that all four participants exhibit impression management (Goffman, 1959) around this part of the interview is telling itself, because it hints at strongly habituated inclinations against cannabis and drugs as aspects of lifestyles that they did not approve of.

Most participants' interviews did not feature strong impression management negotiation narratives at this point *because* there is not so much to negotiate (i.e. they did not have strong feelings about cannabis in the first place). In fact, most participants reported having a relatively open-minded attitude to cannabis prior to

using it (if they had not already used it prior to medicinal use anyway). This also explains the three-partedness (Jefferson, 1991, cited in Wooffitt, 1993) of the construction of the "very....very well spoken, very well...respected person of the community..." in this narrative as well as the extreme case formulation (Pomerantz, 1986, cited in Wooffitt, 1993) of the language used (i.e. the word 'very' is a strong term to use, especially in triplicate) and the justificatory role of the person who suggested using cannabis to the participant in the narrative. The reading here is 'I would never have considered using something like cannabis were it not for the status of the person who suggested it.'

The same participant adopts a similar strategy later when asked whether it was necessary to experience a 'high' in order to obtain the benefits that she used cannabis for.

> "I don't want that ... I don't need it ... I don't like it ..." (participant four: 31).

Three-partedness (Jefferson, 1991, cited in Wooffitt, 1993) is again used here as a rhetorical strategy for making emphasis. This suggests strong feelings on the subject matter, which could be seen as part of a habituated stance on such issues and the performance of this. Similar exhibitions were made elsewhere in her interview but it is worth pointing out to the reader that the impression management exhibited by this participant is relatively moderate.

The next participant, participant eleven, exhibits similar discursive tendencies.

> "If it hadn't been for the person...telling me...there would be no way I would have actually...thought of using...cannabis as opposed to morphine because as far as I'm concerned...the two are like totally different. One's a class A restricted drug...and the other one's...but it's actually a class B drug...too...as far as I was concerned cannabis was only ever used as a recreational drug that never had any therapeutic values whatsoever...and...it was there...to make people feel...happy and higher...to improve their sex lives...to...be cheaper than going out and buying a bottle of Scotch...and have more or less the same effect... and...now, the person that told me this...has got medical background ...so, he or she knows...very much more than I do..." (participant eleven: 17).

Again, we can see the exhibition of extreme case formulations (Pomerantz, 1986, cited in Wooffitt, 1993) "*no way* I would have actually...thought of using...cannabis" and "cannabis was *only ever* used as a recreational drug that *never* had *any* therapeutic values *whatsoever*". The presence of a respected individual who justifies his decision to use cannabis (a person with a medical background) in the narrative is similar to the previous participant's narrative.

The next participant, participant seventeen, is one of two participants who most strongly exemplify a tendency towards displays of 'middle-class respectability' when talking about medicinal cannabis use in the interviews. The excerpts that follow are taken from five pages in which the participant spoke about how she came to use cannabis. As the whole interview was only thirty-five pages long, this was quite a short interview with a relatively large part of her discourse featuring displays of 'impression management'. The reader also needs to know that the whole five pages could be seen as one long section that exhibits impression management and that the participant also does it elsewhere in her interview.

> Interviewer: "Umm, if you could think back for me, what did you think of cannabis prior to your first ever use of it?"

Participant: "I think I thought it was really naughty and wrong and awful and not the thing to do. I was actually offered it as a drug by the doctor about five years ago, four years ago? And I said 'oh no no no no no no, I don't need that yet thank you.' That's why I'm flummoxed that it's not available now, and we've got to go into all this rubbish about it needs to be tested and all that stuff, 'cos it was available as a drug ...but it's been withdrawn, unless you're already on it."

Interviewer: "If I can paraphrase, umm your ideas about cannabis were, in some way, that it was something you didn't really want to have anything to do with, before you used it in this way?"

Participant: "I wouldn't touch it as an umm leisure thing. No ... it's only for medicinal purposes that I would want to use it."

Interviewer: "What I'm actually interested in is peoples' ideas about it before ..."

Participant: "That it would be something wrong." (participant seventeen: 5-6)

Interviewer: "Can you describe to me how you first became aware that cannabis could have some therapeutic benefits for yourself?"

Participant: "Umm ... I think I was vaguely aware of it from the media again, but I was actually at a wedding when someone came and asked me, a friend, how was I doing with the M.S. and asked 'have you ever thought about trying cannabis?' I said 'oh no no no no no', and they said 'well you should try it' and I said maybe I would. They said 'I'll get you one.' That's how it started."

Interviewer: "Was she a therapeutic user?"

Participant: "Her son was" (participant seventeen: 7-10).

Finally, she describes a conversation with her doctor after she had smoked cannabis and felt light-headed and likely to fall over.

> "He [her doctor] said, 'please don't do that, it won't look good in the local 'paper'." (participant seventeen:7-10).

In the first excerpt, extreme case formulations (Pomerantz, 1986, cited in Wooffitt, 1993) can be seen in "naughty, wrong and awful" as well as three-partedness (Jefferson, 1991, cited in Wooffitt, 1993), as well as "oh no no no no no no, I don't need that yet thank you" as her reported response to being offered cannabis by her GP. Interestingly, the reported conversation with her G.P. would have been in about 1994, whereas cannabis had not been legally available to prescribe since 1971 and even then it was as a cannabis-based tincture not cannabis *per se*. However, as the previous chapter revealed, newspaper articles about medicinal cannabis use during the 1990's frequently conflated cannabis and cannabis-based medicines and this could be why the participant believed that cannabis had been available on prescription until a few years before the interview. It is also interesting to speculate as to whether this mistaken belief that cannabis had previously been available as a prescribed substance served in some way to justify, to herself, her decision to use it.

The second excerpt above features a friend asking if she had tried cannabis to help with the symptoms of M.S. which in her account she responds to by saying "'oh no no no no no'", but her friend's son is reported as being a medicinal user, which can be read as the justificatory part of the narrative. The final excerpt features her G.P. advising her that falling over from using cannabis would not look good "in the local 'paper". All of this would seem to relate well to Goffman's (1959) sense of

impression management as being about the concern to maintain a positive social standing, with the local newspaper being a particularly obvious aspect of visibility within the local community.

The final participant (participant three) exhibits similar discursive tendencies.

> Interviewer: "Have you got any recollections of...before your first use of it of being particularly anti-cannabis or any thoughts about it? I'm just trying to get at any thoughts that ..."
>
> Participant: "I had to be anti-drug full stop because of my children. I had to listen to them, especially my son, who'd come back from a party in this area and say that ... and some of the classiest houses that they'd been to with one friend or another, where a plat would have been passed round full of ecstasy tablets. I lived with that and prayed that what you had taught your children had rubbed off, but as for myself being part of it or access to it, no."
>
> Interviewer: "Yes it's not necessarily about you being a part of it...it's what you thought of it really."
>
> Participant: "Well I didn't, because it just didn't occur, it just wasn't something I would ever think of having access to."

The part about her son going to parties where ecstasy tablets were available (on silver plats) even at "some of the classiest houses" shows a concern for positive social standing (Goffman, 1959). It is as if she is saying 'surely such things ought not to be going on there.' There is also a hint of charge-rebuttal, understanding a speech act as the rebuttal of a comment perceived as a moral 'charge' (Silverman, 1994) when the participant says "as for myself being part of it or access to it, no."

Finally, the same participant later discussed the local M.S. Society, which she had been a member of. The remark at the end is perhaps most revealing of all and is insightful when trying to account for why these well educated middle-class participants exhibit a discourse that is practical (i.e. tends to speak only about the practicalities of cannabis, sticks to the questions asked and does not inter-textually articulate other relevant issues).

> Interviewer: "As you know some other people with M.S. as well...umm do other people who have M.S. that you know, know that you use cannabis?"
>
> Participant: "We all do. None of us, I mean I wouldn't invite my friend over here and sit and smoke, it's not that ..."
>
> Interviewer: "No, it's not a social thing ..."
>
> Participant: "No, not at all, but she doesn't ask where I get mine from, I don't ask where she gets hers from, but we both know it helps."
>
> Interviewer: "So presumably as you all use it you all agree it's beneficial and that's it?"
>
> Participant: "Yes, but nobody really talks about it, you just, it's just there and it works. You can't stand on a corner and talk about it because it's just not on, is it?" (participant three: 28-29).

It was actually from this excerpt that the researcher first became interested in how certain users seemed to spend much of their interview negotiating the 'respectability' issue, with the image of numerous respectable members of the community all using cannabis and aware of each others' use, but no one talking about it. However, it is the last sentence that is most interesting – "You can't stand on a corner and talk about it because it's just not on, is it?" This utterance suggests a middle-class habitus that is

averse to the notion of entering into public discourse on the matter (which some other participants actively pursued through the media), which in turn suggests a habitually informed type of engagement with medicinal cannabis use, as something to do but not to talk about, because "...it's just not on, is it?"

It is in this respect that these participants and their discourses differ the most from the discourses of other participants. Later chapters will show how *some* participants, especially from particular occupationally middle-class fractions, engage with medicinal cannabis use as a practice in very different ways, actively seeking to speak about it publicly (not just within the realms of academic research with its assurances of anonymity and confidentiality), but in some cases to the media, and describe coming to use the substance as seeking information on the subject and speaking out publicly on the issue.

Conclusion

This chapter has started the task of engaging with participants' discourses on a more explanatory level than the initial 'mapping out' chapters of analysis. It has looked at a discursive tendency towards impression management (Goffman, 1959) exhibited, in varying degrees, by four participants. It has been argued that these participants tend towards this type of discursive engagement because of the contradiction between their use of cannabis and their deeply habituated stance on drugs and the inappropriateness of them, with significant parts of the interviews being understood

as arenas within which this contradiction must be negotiated to maintain a positive moral standing (Goffman, 1959).

It is this tendency within the habitus (Bourdieu, 1979) of such participants that also explains their articulation of what will be described in Chapter Nineteen as the 'practical' type of medicinal cannabis users' discourse. Later chapters will show how other participants who articulate more 'politicised' or 'heretical' types of discourse on the issue articulate discourses that draw on a wider range of discursive resources often within a critically oriented discourse. This is because their engagement with medicinal cannabis in terms of it being a social issue is associated with a tendency to engage with what Gee (1999) calls the Conversation on medicinal cannabis use and to articulate politicised and in some cases critically oriented discursive aspects within their interviews.

In closing, Bourdieu's (1992) discussion of the linguistic habitus is insightful here. He argued that what people say is essentially an outcome of what they have been socially capacitated to be able to say (in terms of linguistic capital or discursive resources if one prefers) and what they are habitually disposed to say (the habitual tendencies in talk, to speak about certain things or not, in certain ways). The habitus as displayed in this chapter by four participants exhibits a tendency towards respectability and a sense of medicinal cannabis use being a largely private matter. It is argued here that this is also true of their engagement with the 'issue' of medicinal cannabis use, which explains the absence of what will be discussed in forthcoming chapters as an 'elaborated', 'politicised' or 'heretical' type of discourse on medicinal cannabis use. These types of discourse are associated with, and in the case of the

latter two, are reciprocally related to, different types of engagement with medicinal cannabis use as a form of practice. The next chapter will focus upon understanding the discursive significance of articulating cannabis in terms of ideas about nature and the natural.

CHAPTER 17

THE SIGNIFICANCE OF TALKING ABOUT THE 'NATURAL' WHEN TALKING ABOUT MEDICINAL CANNABIS USE: NATURE AND 'HETERODOXICAL DISCOURSE'

Introduction

The 'mapping out' chapters (Part Four) showed that articulations of cannabis, 'nature' and the 'natural' are at the core of the discourses on medicinal cannabis use as articulated in the interviews by the majority of participants in this research. This chapter will argue that this is highly significant due to the increasing trend for many members of society to reflect critically upon the society-nature relationship. In doing so, science, technology, government, 'expertise' (Beck, 1992) and commercial interests are increasingly regarded with suspicion and anxiety by many members of society, whilst nature is often understood as being inherently beneficial, safe and gentle (Coward, 1989; cited in Lypton, 1995), with cannabis being articulated in the interviews of the majority of participants in exactly this way.

Using the work of Bourdieu (1992) it will be argued that the widespread prevalence of this view of nature means that medicinal cannabis users' discourses that argue for cannabis as being safe, beneficial, effective and so on, often in discursive opposition to 'chemical', 'man made' or 'artificial' products (including prescribed medicines), may be rhetorically effective in the discursive struggle in which the meaning and value of medicinal cannabis use is contested within the field of health. This is because

it is increasingly accepted as 'common sense' by many in society that natural products are inherently beneficial and preferable (Coward, 1989; cited in Lypton, 1995) to those that are commonly spoken about as being 'man made', 'synthetic', 'artificial' or otherwise. The 'common-sense' status of this shared understanding is the outcome of an increased tendency to reflect upon what are socially constructed as problems of modernisation (Beck, 1992) and to consider alternatives, many of which (e.g. organic food, naturopathic medicine) are understood as more 'natural' in constitution. Finally, it will be argued that this may have significance for the struggle to have cannabis more widely accepted as being a substance of medicinal value, as science's status as the most revered producer of 'truth' becomes increasingly subject to critique and more 'natural' alternatives are increasingly embraced.

Talking about the 'natural' when talking about medicinal cannabis use

The 'mapping out' chapters showed that numerous articulations of 'nature', the 'natural' and cannabis are to be found within the interviews of the majority of participants in this research. To recap, they spoke about:

> Cannabis as contrasted with prescribed medicine, around ideas about risk, effectiveness, iatrogenic effects, preference and being 'man made' or 'artificial'

> Cannabis as contrasted with psychoactive substances prevalently understood as 'hard drugs', such as heroin or 'crack' cocaine, in

relation to ideas about risk and their 'chemical' or 'man made' constitution.

Cannabis as contrasted with various other 'chemical' or 'man made' substances, around ideas about risk and preference.

Homegrown cannabis as safer and preferable to non-home grown cannabis.

Natural substances in general, not just cannabis, contrasted with substances understood as 'chemical' or 'man made' around ideas about preference and risk.

Cannabis as part of a natural system of cures on Earth for human illnesses.

Cannabis-based medicines as somehow less 'natural' and less preferable to cannabis itself.

Articulations of 'nature', the 'natural', cannabis and economic interests, global capitalism, pharmaceutical companies, processed foods, pesticides, genetically modified crops and the environment.

Whilst significant differences exist between what different participants said in their individual interviews (i.e. not all of them talked about all of the issues listed above),

constructions of cannabis, 'nature' and 'the natural' were central to the discourses of the majority of participants. Whilst various approaches to discourse analysis have employed different conceptualisations of discourse; whether it is the notion of the 'interpretative repertoire' (e.g. Potter, 1996) or the 'ideological discursive formation' (e.g. Fairclough, 1995), these varying approaches agree on the significance of discourses (however they are conceptualised) having a central metaphor or idea. In the medicinal cannabis users' discourses of the majority of participants in this research, ideas about cannabis as natural and various associated connotations form this central core of meaning. This chapter will discuss why these articulations about cannabis, 'nature' and the 'natural' are so significant in terms of the critical potential for medicinal cannabis users' discourses within the struggle around medicinal cannabis use.

As has been argued previously, the contemporary period is increasingly characterised by public discourses that problematise the society-nature relationship (Beck, 1992), which manifest in numerous aspects of day-to-day life, lifestyle choices, politics and many aspects of media coverage (global warming being the most prevalent current example). As one part of this, Illich (1995) describes how the medical profession had previously been constructed within narratives of heroes and heroines fighting illness for the good of humanity (one variant of the progress through rationality 'myth') but that, more recently, children are just as likely to portray them within some dystopian vision of science and medicine, for example as a Frankenstein's monster type figure. Illich ties this to concerns around the environment and how science is now seen as meddling with 'nature' and as being a danger as opposed to a benefit for humanity

(this is seen in numerous participants' accounts) with conventional medicine being seen by many as occupying a central place within this.

It has also been argued (Coward, 1989; cited in Lypton, 1995) that people are increasingly attracted to 'alternative' therapies (a category within which medicinal cannabis use could conceivably be placed) because of their representation as being in some way *natural*. Coward has argued that 'nature' has powerful associations with notions of virtue, morality, cleanliness, purity, renewal, vigour and goodness in late capitalist society (Coward, 1989; cited in Lypton, 1995), and the opposition between this and the representations of 'Frankenstein' scientific medicine, with its iatrogenic effects (Illich, 1995), can be seen as exacerbating the appeal of such alternative approaches to health. As Coward continued to argue:

> " ... nature by implication is that which is safe, gentle and has inherent properties which will benefit individuals" (1989: 19; quoted in Lypton, 1995).

Indeed these assumptions about nature, as being safe, gentle and inherently beneficial (Coward, 1989: 19; quoted in Lypton, 1995) are certainly present in the articulations of participants in this research, as listed above, and are extant at the core of the discourses articulated by the majority of participants in this research.

This is very significant, because within the field of health the use of cannabis for medicinal purposes is a highly contested issue and the rhetorical advantages of articulating cannabis as 'natural', as described above by Coward (cited in Lypton, 1995), within this contestation are huge. Fairclough talks about dominant ideological-discursive formations and notes that a characteristic of them is the capacity to win

acceptance as 'common sense' (1995), or 'truth' as Foucault would argue (1980a). However, it is not just dominant ideological-discursive formations that must win and maintain acceptance as 'common sense' or 'truth,' but also those that seek to challenge them within struggles. Bourdieu's (1992) work is key to understanding how this works, whilst also drawing on Foucault (1980a), and this will now be discussed.

Bourdieu and struggle

Bourdieu (1979) argued that social life is characterised by practices that take place within a society that can be theorised as being multi-spatial and made up of various fields (of power relations). These fields are characterised by the unequal distribution of various forms of capital and the conflicts and struggles that are the inevitable outcome of individuals, groups and institutions seeking to maintain or improve their position in a society characterised by self-interest and competition. A key part of this social struggle is the attempt to impose discursive advantage or to resist it. Bourdieu (1979, 1992) argued that all fields are characterised by distributions of capital that render various positions within those fields to be occupied by those who are more powerful or less powerful because of the advantages or disadvantages that the unequal distribution of various forms of capital implies. Fields are characterised by contestation and struggle, with discourse occupying a key role within this. The ability to have an advantageous discourse or set of understandings accepted as 'truth', in the face of competition from other discourses that oppose it, is an increasingly fraught task in the late modern period and the discursive struggle around the medicinal use of

cannabis is certainly just one of many examples of this. Foucault also spoke of this when he noted that:

> "what has emerged in the last ten or fifteen years is a sense of the increasing vulnerability to criticism of things, institutions, practices, discourses." (1980b: 80-81).

Foucault says more about this elsewhere, when he also says:

> "We must make allowances for the complex and unstable process whereby discourse can be both an instrument and an effect of power, *but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy.* Discourse transmits and produces power; it reinforces it, *but also undermines it and exposes it, renders it fragile and makes it possible to thwart it*" (Foucault, 1979: 100-101; quoted in Young, 1981) (my emphasis).

In a society in which more people than ever are literate and go on to further and higher education, in which the media are more diverse than ever and in which technological developments like the internet offer access to an increasing number of different views on all manner of topic and issue, discursive dominance is increasingly difficult to maintain. As Foucault argued in the quote above, the discursive realm can be seen as a potential stumbling block, point of resistance and societal level at which opposing strategies may begin, or at least challenge domination, and this is what has been seen in the interviews of *some* of the participants in this research, to varying degrees. Gee's (1999) concept of D/discourse encourages us to explore the relations between the meta-discourses that characterise individual fields (such as the health field), the powerful institutions and professions that hold dominant positions within such fields and the discourse of individuals and groups, who occupy less powerful positions within them. It is precisely within these relations that the possibilities of resistance or contestation are located, although not all interviews with participants in

this research necessarily feature resistance or contestation. Indeed many do not. Bourdieu (1992) suggested that this might be because of the very characterisation of the linguistic field itself, that the ability to engage with the discursive world is an outcome of the unequal distribution of discursive capital.

In what is, arguably, the definitive Bourdieusian statement on language use, Bourdieu argues that:

> "On the one hand, there are the socially constructed dispositions of the linguistic habitus, which imply a certain propensity to speak and to say determinate things (the expressive interests) and a certain capacity to speak, which involves both the linguistic capacity to generate an infinite number of grammatically correct discourses and the social capacity to use this competence adequately in a determinate situation. On the other hand, there are the structures of the linguistic market, which impose themselves as a system of specific sanctions and censorships." (Bourdieu, 1992: 37).

To paraphrase Bourdieu here, what the individual will say is subject to what he or she is habitually inclined to say and socially capacitated to be *able* to say. This is also subject to the context in which the discourse is to be articulated and to the various "sanctions and censorships" that exist within the discursive realm in relation to any given topic of discussion (far ranging, but including who may be seen to speak credibly on a given subject, as well as a whole range of others).

Such "sanctions and censorships" can be seen as rhetorical strategies, ways in which the discourses of the powerful (or discourses that may have emerged some time ago and continue to maintain advantage for one social group), within any given field (and sometimes across fields), are able to attempt to disqualify opposing discourses, attempt to undercut them, or to deny them the validity of 'truth.' These powerful

discourses can often be seen to have played a significant part within the establishment of the dominance of certain groups within certain fields and within the continuation of this.

Robbins addresses Bourdieu's discussion of this in relation to religion (Bourdieu, 1971; cited in Robbins, 1991), in which Bourdieu argues that religious institutions needed to produce a series of sophisticated ideological distinctions to reinforce the separation of members of such institutions from a lay public who had not been "initiated into the nuances of intellectual debate associated with a range of fields" (Robbins, 1991: 95). The medical field is another such field in which such strategies have historically been deployed. In relation to such ideas, medical discourse can be seen to draw on the discourse of science in a bid to impose dominance and authority over all matters medical, or more accurately medicalised. More specifically, medical discourse can be seen to attempt to disqualify cannabis from being seen as a medicine in a number of key ways and this draws on scientific discourse.

For Bourdieu (1979; 1992) the state of discursive power and dominance within a given field at a given time can be understood in terms of the degree to which the dominant discourse is able to pass as 'common sense', 'natural' or what Foucault would call 'truth' (Foucault, 1980a). If the dominant discourse is able to pass unchallenged or, as Bourdieu puts it, a perfect fit is obtained between the objective structure of the field and all subjective understanding of it (1979), then discursive representation has the status of *doxa.* However, with the contemporary period being characterised by contestation and sources of meaning ever more diverse and easily accessible to an increasingly educated and questioning public, it is doubtful that the

doxic state applies to many, or perhaps even any, areas of knowledge now. As has been argued elsewhere (Chapter Seven), medical knowledge and practice seemingly do not occupy this status either, with alternative and complementary models of practice and corresponding forms of knowledge more popular than ever, science-medicine is sometimes viewed with suspicion by the media and an ever more difficult to satisfy public.

In actuality the state of discursive dominance most common to late modern society within any given field is that of *orthodoxy. Orthodox discourses* (Bourdieu, 1992) may be understood as subject to challenge, but dominant within their field and attached to the dominant group or groups. Scientific-medicine as a set of discourses and practices draws on the meta-discourse of science, itself a set of understandings that occupies only *orthodox* status, but which in a social world characterised by contestation is the closest thing to what may be understood as a "regime of truth" (Foucault, 1980c).

However, science and scientific-medicine are increasingly both subject to contestation in a myriad of ways, with the resultant loss of faith observed being central to the way in which numerous social theorists have come to understand either a different type of modernity (Beck, 1992) or, in terms of a more radical break, post-modernity (Lyotard, 1987). This loss of faith or increased variability of faith (Beck, 1992) involves discourses that challenge the orthodox, which Bourdieu (1979) called *heterodoxical* or *heretical.* Whilst this is all rather straightforward, it is Bourdieu's discussion of the conditions under which such heterodoxical or heretical discourses

might come into being, and perhaps attain relative success in their discursive struggles, which is more interesting and more relevant to this thesis.

Bourdieu and 'heterodoxical' discourse

In discussing the conditions under which heterodoxical discourse may emerge, Bourdieu (1979; 1992) argued that some form of crisis in conjunction with the emergence of a body of critical discourse is necessary in order to expose as arbitrary the discursive representations that had previously passed as 'common sense'. He argued that this crisis must be capable of:

> "...disrupting the close correspondence between the incorporated structures and the objective structures which produce them ..." (Bourdieu, 1992: 128).

By this Bourdieu means that a crisis is required that will rupture the 'fit' between a belief that passes as 'truth' and the objective social conditions to which it is related, and which produce it (discursively accrediting it as 'truth').

In relation to this thesis, it has been discussed elsewhere (Chapter Seven) that chronically ill and / or disabled people occupy, broadly speaking, a relationship to scientific-medicine that can be understood as significantly problematic, or in *crisis,* in a number of senses. Put briefly, scientific-medicine has achieved little in relation to bringing about some kind of 'cure' for chronic illnesses of the type that the participants in this research have. More so than this, it has also been discussed (Chapter Seven) that recent decades have seen the development of a disability

movement that has problematised the medical profession in a number of senses. The symptoms experienced on a day-to-day basis by individuals, such as the participants in this research, are typically reported by them as something that the medical profession cannot provide an efficacious remedy for. This is of course the main reason why participants in this research report using cannabis, see also Coomber, Oliver and Morris (2003). Whilst not all, or probably even most, disabled people will necessarily share this critical outlook, it is significant that many of those who took part in this research did, and in fact were actively involved in the disability movement.

However, Bourdieu argues that objective crisis is not enough, in itself, to bring about the emergence of a heretical body of ideas that can challenge the dominance of orthodox discourse (1979).

> "It is only when the dominated have the material and symbolic means of rejecting the definition of the real that is imposed on them ... that the arbitrary principles of the prevailing classification can appear as such ..." (1979: 169).

Bourdieu (1979) argues then that an effective challenge can only be the outcome of possessing discursive resources that will facilitate the exposure of dominant discourses as not simply the 'truth' but one possible version, which importantly is conducive to maintaining the dominance of another social group over them. Earlier discussion of Bourdieu's work (1979; 1992) suggested that the differential distribution of discursive resources could be understood as related to social class (or more accurately the differential positionings within fields such as education experienced by individuals that tend to characterise groups such as social class by the

differential distribution of various types and amounts of capital). This suggests that those participants who have experienced a biographical trajectory that has led them to possess more complex discursive capital (more discursive resources) will be better equipped and more likely to articulate discourses that more effectively engage with crucial discursive aspects of the 'no medical value' discourse. The 'mapping out' chapters have shown a lot of evidence to support this, with occupational social class being related to discursive tendencies exhibited by participants in the interviews. However, later chapters will make it clear that occupational social class *per se* is not the explanatory factor, in and of itself, rather a range of social class related factors are.

Bourdieu (1992) also argues that not only does heretical discourse need to break with the accepted 'common sense' of that which it challenges, publicly, but it must also produce a:

> "... new common sense and integrate within it the previously tacit or repressed practices and experiences of an entire group ..." (1992: 129).

To be successful, heterodoxical discourse has to produce a *new common sense*. Just as dominant discourse has to pass as 'truth', to become seen and accepted simply as 'common sense', so heterodoxical discourse needs to employ this rhetorical strategy too and the majority of the participants in this research do exactly that. The core aspect of cannabis as 'natural' achieves this rhetorical function and draws on the previously discussed and highly prevalent tendency within contemporary society to see nature as being " ... safe, gentle and has inherent properties which will benefit individuals" (1989: 19; quoted in Lypton, 1995). In fact, one might say that in the late

modern period, nature is understood as *naturally* preferable in numerous ways and in numerous areas (medicine, food, lifestyle, generating electricity etc.), because within a certain usage of English, if something is seen as naturally being the case, this means the same thing as 'common sense'.

So whilst it will later be argued that the discourses of some participants are of a more heretical 'type' because they engage with the 'no medical value' discourse on medicinal cannabis use in critical ways, it is also the case that articulations of 'nature', the 'natural' and cannabis also hold this heterodoxical potential due to the sheer discursive force of 'nature' and 'the natural' tending to be understood as inherently preferable in a range of ways to 'chemical', 'man made' or 'artificial' products and with the prevalence of this reflexivity increasing (Beck, 1992).

Conclusion

This chapter has argued that the core notion of cannabis as natural and nature as inherently beneficial, safe and preferable to non-natural products, that is articulated by the majority of participants, may be rhetorically effective in the discursive struggle in which the meaning and value of medicinal cannabis use is contested within the field of health because it is increasingly accepted as 'common sense' by many in society that natural products are inherently beneficial and preferable (Coward, 1989; cited in Lypton, 1995) and that the widely accepted 'common sense' of this view means it is more difficult to contest in public discourse.

In the next chapter, the discourse of one participant, who tended to engage critically with ideas that are key to the 'no medical value' discourse, will be examined. Whilst this chapter argued that discourses that asserts themselves using the rhetorical power of highly prevalent ideas about nature have some 'heterodoxical' (Bourdieu, 1992) potential, because of their correspondence with socially prevalent ideas about 'nature', it will be argued in the next chapter that those who engage critically with key ideas about science and medicine may hold even more potential and that this type of discursive engagement could be key in the attempt to win acceptance of cannabis as a substance with medicinal value (though this is not necessarily the same as winning acceptance of it as a medicine *per se*).

CHAPTER 18

CRITICAL DISCURSIVE ENGAGEMENTS WITH SCIENCE AND MEDICINE

Introduction

This chapter looks at the discourse of one participant, a discourse that can be understood uniquely as involving a critical engagement with the 'no medical value' discourse on cannabis.

Cannabis as a substance of 'no medical value'

It was argued previously (in Chapter Five) that cannabis has been discursively constructed as a substance of 'no medical value' in a number of ways and it is useful to briefly recap these points now. The development of scientific pharmacology over the span of the nineteenth century greatly changed the common understanding of what could validly be understood as a medicine. In 1800, as Cartwright remarks, the pharmacopoeia was a mixture of the ancient and the modern. It contained substances such as opium, but also " ... Arabs' eyes, pearls, and the 'sacred elixir'" (1977: 134). However, scientific pharmacology arose in the early 1800's and transformed drug-therapy from what Porter (1997) describes as the jumble of the apothecary's backroom to an organised experimental science involving the extraction of active principles from vegetable substances. By 1850, laboratory work had produced a science based around the microscope, vivisection, and chemical investigation:

> " ... and everything else measurable, weighable and testable in its uniquely controlled environment" (Porter, 1997: 320).

During the earlier part of the nineteenth century, the active principles of many of the vegetable substances used in medicine had already been isolated and extracted. For example, between 1818 and 1821 strychnine, brucine, veratrine, cinchonine, quinine and caffeine had been refined. Even earlier, between 1803 and 1804, the crystalline substance later named morphine was refined from raw opium (Porter, 1997). This means that even before cannabis tincture became popular in Western medicine, raw vegetable matter substances tended to have had their active principles extracted and refined and it is these that were used in Western medicine, not the raw vegetable matter. So cannabis in the raw vegetable sense would have been seen as archaic by Western medicine at least as early as the early 1800's. Importantly, when it did become popular in Western medicine, between about 1840 and 1900 (Grinspoon, 1994) it was cannabis as part of a tincture solution that was produced, not simply cannabis *per se*, so modern scientific-medicine has never seen raw vegetable cannabis as a medicine.

Scientific-medicine also discursively constructs a medicine as something that has been produced as the outcome of particular processes, these being clinical development and testing using experimental evidence performed by those accredited as having appropriate expertise. As Foucault argued, each society has " ... techniques and procedures accorded value in the acquisition of truth ..." (1980a: 131) and science privileges knowledge which has been produced using the methods that it endorses. Science also regards knowledge that has not been produced by way of this set of

practices as less valid. Those who have articulated the 'no medical value' discourse have frequently made the distinction between what they describe as the *anecdotal* testimonies of medicinal cannabis users as to cannabis' medical effectiveness, and *scientific proof*.

In a society in which science became the dominant 'regime of truth', although this is increasingly subject to critical reflection (Beck, 1992), the way of producing 'valid' knowledge is the scientific way. Lyotard (1987), to recap, argued that scientists question the validity of narratives (or *anecdotes*) on the basis that they are not subject to validation (proof). Narrative knowledge is hence cast as inferior to scientific knowledge, but this is a function of the different 'language games' of which they are comprised. The science 'language game' requires validation; the narrative 'language game' does not. Scientific discourse is therefore able to undercut non-scientific discourse with the assertion that as it lacks evidence, it is merely anecdotal. In this case, the non-scientific discourse is the *anecdotal* evidence of therapeutic cannabis users that is undercut by those who articulate the scientific demand for 'proof'.

It was also argued earlier (in Chapter Five) that cannabis was increasingly understood to be primarily a 'recreational drug' from the latter half of the twentieth century onwards and that this also contributed to cannabis not being seen as a medicinal substance in popular understanding. It was not until 1964 that pharmacological research isolated the active principle and elucidated the chemical structure of cannabis (Mechoulam and Lander, 1980). However, although thousands of research papers have been published on the pharmacology of cannabis and cannabinoids since then (Mechoulam and Lander, 1980) it is likely that research in this area has been

severely impeded by social anxieties and legal restrictions that have arisen around cannabis due to this 'recreational' use and the social construction of this as a drug 'problem.'

Critical discursive engagement

Whilst the discourse of the majority of participants in this research can be seen as challenging the idea that cannabis is of 'no medical value' by way of the core of articulations relating to cannabis, 'nature' and the 'natural' that most participants' accounts have been shown to contain, the discourse of one participant (participant thirty-five) goes further than this, critically engaging with the 'no medical value' discourse in a number of key senses. This will now be discussed.

Questioning the hierarchy of clinical / anecdotal knowledge

As was discussed in Chapter Twelve, participant thirty-five questions the hierarchical relationship between clinical and 'anecdotal' knowledge. To recap, he has the following to say about this:

> "I respect [people]...who...whose...whose opinions are based on experience rather than something they've read in a book...they're the people who really know...that it [cannabis] helps pain and the people who've got pain...who use it...and get relief...and...we are the only people who actually know that...but somehow our...statements or testimony are...are referred to as anecdotal...which I find is...is kind of odd..." (participant thirty-five: 8).

> "I think really people in charge have another agenda...it simply suits them...to say 'Well, we have no scientific proof'...I'm the living proof...but I can't prove it...and...nor can other people that I know who gained relief...but it...because it's not...I'm not a scientist and I have no...back up of scientific fact...it's ignored...and...people simply say 'Well, you must like it [cannabis]', and then...'that's why you're going on about it'...and somehow that takes the truth out of the statement, it...people...people perceive it as though we're trying something on...instead of it just being...reporting of what happens...this helps me. I get 'Oh, you would say that'...which is awful...'cause it's like being dismissed..." (participant thirty-five: 9).

> "...cannabis has been used over thousands of years...it's been studied...and studied and studied. It's part of...whole cultures...the research has all been done...it's...a question that...now they say that it has to be done by scientists...that otherwise it's just hearsay...this is nonsense..." (participant thirty-five: 43).

What is unique about these excerpts, compared to the interviews of all the other participants, is that this participant clearly displays a sense of how knowledge / power 'plays out' rhetorically in the ways that medicalised discourse is often articulated in attempts to undermine arguments for cannabis' medical efficacy. Whilst other participants recognise the interrelation of power / knowledge around the issue (for example, participants twenty-nine and eighteen) they do not critically engage with it rhetorically, i.e. they do not in turn attempt to undermine it.

Participant thirty-five's first excerpt features a rhetorical attack on the discounting of experience as anecdotal. The second excerpt features an awareness that the denial of experience – by constructing it as 'anecdotal' - involves issues of power, or an "agenda", and that the alleged lack of "scientific proof" as to cannabis' medicinal value is used as a matter of convenience to argue against its use. In the third excerpt,

he questions the presumed superiority of scientific knowledge as opposed to "thousands of years" of human use of cannabis as a medicinal substance.

Participant thirty-five demonstrates an understanding that talking about medicinal cannabis use involves opposing discourses and opposing interests and that the construction of knowledge is a part of this itself, not simply that knowledge is something neutral and is being used for certain ends. He described how opponents of his view attempt to undermine his discourse by saying that he has no scientific evidence and that he "must like it [cannabis]", with the implication that medicinal cannabis use is a ruse for people to use cannabis simply for pleasurable purposes. He also showed an understanding of this process when he said "somehow that takes the truth out of the statement". Foucault's argument about the political economy of 'truth' and claims for 'truth' being based on a scientific regime of 'truth' is relevant here (Foucault, 1980a). The arguments that the participant describes as used against him assert that he must want to use cannabis for pleasure, because with a lack of scientific evidence for its medical efficacy, surely that can be the only other explanation. In this respect, scientific evidence *is* evidence, the only recognised evidence, and this is articulated as having a 'common sense' quality to it, as the most dominant discourses do because they are able to pass as being self-evident or, as Bourdieu has argued (1992), as 'common sense.' However, this participant, on three occasions, critically engages with these rhetorical tendencies that are often articulated to discredit cannabis' claims to medicinal efficacy. In this sense, his discourse can be seen as 'critical', because, like the aims of a critical discourse analysis, he attempts to expose certain ideas that pass as 'common sense' and to attack them.

Additional aspects to a critical discourse

In addition to the tendency to see scientific-medical forms of knowledge as inherently involving issues of power and seeking to question them, as discussed above, the discourse of this participant involves some additional tendencies that also critically engage with science and medicine around the issue of medicinal cannabis use. These will now be discussed.

Cannabis-based medicines

> "...I'd feel that it was highly intrusive...of any government to try and tell me what's good for me at the age of...nearly sixty years...I don't...see...anyone within that cabinet who has more experience than I have...and if they've been doing their research they'll have come to the same conclusion...truly doing their research...they will found the things I've found out...but it...what tends to happen is that the...government's scientist...will simply say whatever they...they're told to say...you can...you can think about the facts and pull that bit out..." (participant thirty-five: 48).

In this excerpt, the participant employs some interesting rhetorical strategies. He argues that it would be "intrusive" of any government to tell him what is good for him, an argument clearly in the libertarian tradition, and he also challenges their authority on the basis of experience (that he is older than any of them). Having rhetorically attacked their experience he then argues that, if they have done their research correctly, they will have concluded what he does, the implication being that as they do not share his position they must be wrong. Finally he argues that "what tends to happen is that the...government's scientist...will simply say whatever

they...they're told to say" and it is this part of the quotation that is most important for this part of the discussion. Whilst science typically tries to pass itself off within narratives about the objectivity and neutrality of the production of knowledge, many have questioned this (see Gilbert and Mulkay (1984). Participant thirty-five's critique is brief, but it does hint at what Lyotard (1987) has argued, that government and science have an interdependence in which science is often dependent on government in numerous ways, not least of which often relates to funding and that government often depends on science and the production of knowledge to justify decisions that it makes. Participant thirty-five's remarks here question the neutrality and objectivity of the knowledge sometimes resorted to by government to justify its decisions and clearly such questioning is central to a critical engagement with discourses that function to exclude or undermine cannabis' claim to medical efficacy.

Talking about cannabis use using the language of medicine

One other rhetorical strategy that participant thirty-five uses, on numerous occasions, is to describe his use of cannabis by using the 'language of medicine.' This is an interesting strategy, in addition to others that have been described, because it appropriates the language of medicine, which is the legitimised form of discourse in relation to health due to the historical process of medicalisation, and uses it to normalise the idea of cannabis as a medicinal substance when talking about it. He does this by frequently referring to cannabis as "medicine" but also by talking about its use by sometimes using the term "dosage". This strategy can also be understood as

subversion, because the 'language of medicine' is used to describe the use of cannabis, a substance that medicine tends to discredit.

Conclusion

In conclusion, this chapter has argued that pharmacology went through a series of changes in the earlier parts of the 1800's that significantly changed the understanding of what might and might not be considered to be a medicinal substance. The discourses and practices of pharmacology increasingly drew on the idealised processes of the experimental method in which the active principle of a substance would be isolated / synthesised and subjected to experimental work, with the resultant clinical evidence being constructed as a more highly prized form of knowledge than forms which had not been produced in this way.

It has been shown elsewhere in this thesis (Chapter Five) that the Royal Society and the Academy of Medical Sciences (Lachman *et al.*, 1998), the British Medical Association (B.M.A., 1997) and the British government, for example Paul Boateng as Minister for Home Affairs in 1998 (cited in Nando.net, 1998) have all espoused the view that suitable evidence (i.e. clinically produced) is lacking as to cannabis' medicinal efficacy and that the 'anecdotal' evidence provided by the testimonies of medicinal cannabis users is not seen as evidence. Participant thirty-five's interview exhibited a few different ways in which he critically engages with such ideas, by questioning the discursive hierarchy that places clinical evidence above 'anecdotal' evidence, by questioning the presumed neutrality and objectivity of scientific

knowledge called on by government ministers and by subversive use of 'the language of medicine' to describe the use of cannabis itself.

The next and final chapter prior to the overall conclusion will consider the different 'types' of discourse that have been exhibited in the interviews and will attempt to offer an understanding of them.

CHAPTER 19

'TYPES' OF MEDICINAL CANNABIS USERS' DISCOURSE

Introduction

The chapters (Part Four) that 'mapped out' the medicinal cannabis users' discourses suggested that whilst the accounts in the interviews often shared certain similarities there was also great variation between accounts. Accounts featured cannabis and its use being rhetorically constructed in numerous ways by different participants, often via articulations that constructed cannabis in opposition to other substances (including prescribed medicines, alcohol, tobacco or other prohibited substances, often so-called 'hard' drugs like heroin or 'crack' cocaine), in various relatively positive ways. The most commonly articulated set of meanings around cannabis that were exhibited in these interviews related to various constructions of cannabis as 'natural' or around cannabis and 'the natural', often constructed by way of making discursive oppositions between these meanings and meanings around 'man made', 'chemical' or 'synthetic' products (often those listed above).

What is most striking about the picture of different participants' discourses that is provided by the 'mapping out' approach is the degree of difference, in terms of the number of issues discussed and the discursive and rhetorical resources that are used to do so, between different participants' interviews. The data suggests a relationship between factors related to social class and discursive differences, with occupationally middle middle-class and upper middle-class participants tending to talk about a wider set of issues and to draw on a wider set of meanings in doing so. There is also

evidence of a degree of this difference being attributable to vocationally derived types of discourse. This chapter will explore and develop these ideas.

Within this pattern of participants from certain occupationally middle-class fractions tending to talk about a broader range of issues and to draw on a wider range of discursive resources to do so, a smaller number of participants can be seen as exhibiting aspects of a more politicised discourse. The discourse articulated by one participant (see the previous chapter) also seems to take on a more critical engagement with aspects of the dominant discourses in the area of health, those of the medical profession and of scientific-medicine. Whilst, in terms of occupational social class, that participant is not part of the middle-class fractions, he shared more in common with them in terms of educational trajectory than he did with the other occupationally working-class participants. This of course suggests that social class differences *per se* cannot entirely account for discursive differences.

It is apparent that an overly-mechanistic conceptualisation of the relationship between social class and language would be unhelpful as there are also clear instances of other occupationally working-class participants exhibiting discourse that shows some degree of drawing on range of discursive resources inter-textually and a critical stance. However, working-class participants tended to exhibit this type of discourse far less often, with most working-class participants not doing so at all. Yet the incidences of this type of discourse being exhibited by some occupationally working-class participants are far from insignificant and lend support to the idea that social class *per se* is not simply or exclusively explanatory of the differences between the discursive resources, rhetorical strategies, broadness of what was discussed and other

differences between different participants' accounts. An explanation of these differences is to be found in the complex interaction between a number of social class related factors, which will be clarified in this chapter.

Subsequent analytical chapters sought to explore a number of issues in more depth. Chapter Sixteen noted that there are a small number of participants whose accounts often appeared to be greatly concerned with impression management, if language use is thought about in terms of what a participant is *doing* with discourse. Chapter Fifteen noted that a number of participants spoke about doing personal research (reading books, using the internet and in at least one case reading academic journal articles) into medicinal cannabis use and how these users are typically of vocational and in some cases more broadly social class backgrounds who would fit with the notion of having a life trajectory (Bourdieu, 1979) that would endow an individual with the disposition to want to understand the issue of medicinal cannabis use. Chapter Seventeen argued that within the discourses of the majority of participants there is a core notion of cannabis as natural and nature as inherently beneficial, safe and preferable to non-natural products. This may be rhetorically effective in the struggle in which the meaning and value of medicinal cannabis use is contested within the field of health, because it is increasingly accepted as 'common sense' by many in society that natural products are inherently beneficial and preferable (Coward, 1989; cited in Lypton, 1995). It was also argued that the widely accepted 'common sense' of this view means it is more difficult to contest in public discourse. In Chapter Eighteen, one participant was seen to critically engage with the 'no medical value' discourse on cannabis by questioning the discursive hierarchy that places clinical evidence above 'anecdotal' evidence, by questioning the presumed

neutrality and objectivity of scientific knowledge called on by government ministers and by subversive use of 'the language of medicine' to describe the use of cannabis itself.

The present chapter aims to pull all of this together into an analysis that argues for the existence of a number of 'types' of medicinal cannabis users' discourses and to offer an explanation as to how such discourses come to be articulated by different participants in the interviews, this being one of the major aims of the thesis. However, before this can be done, a brief discussion of the hazards of arguing for 'types' of discourse must be undertaken.

The potential problems with the concept of 'types' of medicinal cannabis users' discourses

There are at least two potential problems with arguing for the existence of 'types' of medicinal cannabis users' discourses that must addressed. The first and most obvious is, what exactly is meant by 'type'? If one is to argue very simply for the existence of types of discourse, with each participant discretely articulating one of them, then this is potentially problematic. The complexity of the social constitution of discourse and of an individual's use of language by way of the particularistic demands of the situated and contextually specific situations within which articulations are produced means that language in use in the social world is infinitely complex and this complexity problematises the constitution of simple categorisation. To put this in context, the actual discourse of participants produced in the interviews defies such

simple categorisation as soon as one asks questions such as does a given participant's discourse entirely fit any one 'type' of discourse that a researcher could produce from the data obtained, or whether it fits such a category to the same extent as another participant's discourse and if they differ, as they will, what does this suggest for the validity of that categorisation?

However, these are not new methodological problems and worrying indefinitely at the infinite degree of complexity inherent in real world cases of any given social phenomena ought not to be allowed to stop one from trying to understand the social world around us. We just have to recognise the limits of knowledge. Max Weber (1949) developed the methodological concept of the *ideal type* in relation to such issues and it is his work that will be drawn on here. For Weber (1949) the ideal type is an idea of a phenomenon, not an actual individual instance of that phenomenon from the real world. This being the case, real world instances will differ in infinite variation from an ideal type, due simply to the complexity of the social world that the sociologist must engage with. An ideal type is an abstraction, a distillation of whatever the researcher sees as the most important points of that which it is an abstraction of. Whilst this may initially appear to be a concern, let us admit that all analytical accounts are only ever versions of reality, attempts to apprehend, and that the best we can do is to try to ground the construction of such abstractions in reality, by way of practicing rigour and reflexivity.

With this approach in mind this chapter will outline a number of ideal types of medicinal cannabis users' discourses as produced by way of analysis (from Chapter Nine onwards) that is grounded in the data. As discussed above, they will be

abstractions and it will not be argued that the reality of any given participant's discourse simply or neatly fits into any given 'type', but that any given participant's discourse can be understood as most closely resembling one 'type' or another.

The other main potential problem with the formulation of a series of discursive 'types' relates to how one might think about them collectively, particularly about whether they should be considered in terms of a hierarchy? This is a rather serious issue in terms of producing a robust analysis and in terms of the 'politics of research.' It would be very easy for a researcher with an interest in the political potential of medicinal cannabis users' discourses to implicitly construct a hierarchy in which 'types' of discourse with seemingly less potential for political advantage, in the contestation that surrounds the medicinal use of cannabis, are discussed in relatively negative ways in comparison to those that seemingly offer more potential. Where social class and language are concerned this can easily happen. For example, Robson (2004) has noted how Bernstein's body of work on this topic has often been misunderstood as a theory of the deficit of working-class language rather than a theory that recognises working-class language as being uniquely suited to working-class cultures. This thesis takes the view that rather than the socially constituted discursive capacities and dispositions (Bourdieu, 1979; 1991) of working-class participants being deficient, they *tend* to be less well suited and less conducive to the production and articulation of the types of discourse more likely to offer advantage in the contestation around the medicinal efficacy of cannabis for some chronically ill and / or disabled people. This is primarily an outcome of the unequal distribution of educational opportunities and, in turn, the vocational opportunities that this tends to

provide or deny, and the relationship between these issues, social structuration and the social constitution of the individual.

The 'types' of medicinal cannabis users' discourses

In line with the arguments made above, it will be argued in this chapter that participants' discourses, as exhibited in the interviews, correspond to the following types of discourse:

'Practical',

'Elaborated',

'Politicised',

'Heretical'.

Each will now be discussed briefly (to give the reader a sense of their relation to one another) and then in greater depth.

'Practical' discourse on medicinal cannabis use

This type of discourse involved talking about the actual practical use of cannabis only. Whilst this type of discussion was what the interview schedule largely elicited, there were some questions that opened up the possibility of discussing issues of power and politics if the participant had anything to say about these issues in relation

to medicinal cannabis use. In the in-depth qualitative interviews, conducted in a very relaxed and cordial fashion, participants were invited to discuss anything else that they took to be relevant, at any point. However, participants whose accounts are taken to correspond to the 'practical' discourse type did not deviate from simply discussing the practical experience of using cannabis in the interviews. Having said this, all but one participant whose accounts most closely resemble this 'type' of discourse elaborated on their discussion of the practical use issues of cannabis by drawing on 'sources of meaning' from outside of their immediate experience when talking about their own cannabis use.

Of the thirty-two participants in this research, twelve produced accounts that are taken to correspond most closely to this 'type' of discourse. Of the twelve, nine were occupationally middle-class and three were occupationally working-class. In terms of occupationally working-class participants, this was half of them (there were six in total). Of the nine occupationally middle-class participants within this category, seven were of the lower middle-class group, as opposed to middle-middle or upper-middle. The significance of this will be discussed further below.

'Elaborated' discourse on medicinal cannabis use

This type of discourse involved talking about the practical issues of medicinal cannabis use but also elaborating (Bernstein, 1975), by not entirely remaining within the immediate and particular context of the interview schedule, and producing an account that articulated other relevant meanings inter-textually. However, whilst this

type of discourse talks about issues or ideas not immediately within the scope of the interview schedule, this does not include issues related to politics or power.

Of the thirty-two participants in this research, twelve produced accounts that were taken to correspond most closely to this 'type' of discourse. Of these participants, all but one were occupationally middle-class, with eight of these being members of the middle-middle and upper-middle classes. It will be argued further below as to why this might be the case.

'Politicised' discourse on medicinal cannabis use

This type of discourse involved talking about the practical issues of medicinal cannabis use but also elaborating (Bernstein, 1975), by not entirely remaining within the immediate and particular context of the interview schedule, and producing an account that articulated other relevant meanings inter-textually. Such elaborations would also include talking about issues relating to power, politics and the medicinal use of cannabis.

Of the thirty-two participants in this research, seven produced accounts that were taken to correspond most closely to this 'type' of discourse. Of these participants, all but one were occupationally middle-class and all the occupationally middle-class participants were actually from the middle-middle class fraction. It will be argued further below as to why this might be the case.

'Heretical' discourse on medicinal cannabis use

This type of discourse involves talking about the practical issues of medicinal cannabis use but also elaborating (Bernstein, 1975), by not entirely remaining within the immediate and particular context of the interview schedule, and producing an account that articulates other relevant meanings inter-textually. Such elaborations would include talking about issues relating to power, politics and the medicinal use of cannabis, as well as critically engaging with the 'no medical value' discourse on medicinal cannabis use (this type of discourse does not just recognise issues of power, but rhetorically engages with them in critical ways).

Of the thirty-two participants in this research, one produced an account that was taken to correspond most closely to this 'type' of discourse. This participant was occupationally working-class but, as has been argued elsewhere, his educational trajectory through grammar school and then art-college suggests more in common with occupationally middle-class participants than other occupationally working-class participants.

In this brief overview of the types of discourse, a relationship between occupational social class and discourse seems to be evident. Explanatory factors related to social class will now be discussed in more depth and with a more analytical and less descriptive approach.

Accounting for 'types' of medicinal cannabis users' discourses

The remainder of this chapter will focus on attempting to account for the possibility of the different types of discourse that have been outlined above.

'Practical' discourse on medicinal cannabis use

Whilst social class and its associated issues of educational background and types of current and / or former employment can account for why many of the participants who exhibited this type of discourse did so, it cannot do so for all and it cannot do so in any simple way. This is due to two main reasons, the complexity of social class in contemporary society and the complexity of how class relates to discursive capacities and dispositions.

Initially, it might appear that accounting for the three occupationally working-class participants out of the overall twelve participants whose accounts correspond to this type of discourse might be relatively easy. Two share 'profiles' of compulsory education plus vocational F.E. courses progressing into skilled manual labour, carpentry and mechanics (the final participant did not complete compulsory education due to a diagnosis of M.S. at fifteen years of age). Bernstein's concept of restricted orientation to meaning, with its tendency towards the "particularistic, local and context dependent" (Bernstein, 1990: 96; quoted in Chouliaraki and Fairclough, 2005) seems to explain why these participants might offer little deviation from the questions asked in the interview. However, two of them did elaborate in terms of

drawing on 'other sources of meaning' when articulating on their use of cannabis. They did not deviate from what they were asked, but in talking about it they drew on meanings from outside of their own experience to do so. In no simple sense is this restricted linguistic code then.

Bourdieu's (1979; 1992) ideas about linguistic capital are, again, in no simple sense, the explanation for these three participants' practical 'type' of discourse either. It would be relatively easy to argue that these three participants would be expected to articulate this type of discourse due to how shared linguistic capital positions them as being less likely to possess a linguistic habitus (Bourdieu, 1992) that is capacitated and disposed to engage in the type of discussion of such issues that one might expect from participants who have had the benefit of a more prolonged education or alternatively an educational experience that endows them with more of a likelihood to engage linguistically with the abstract, i.e. higher education. However, Bourdieu's position on this issue is clearly one of tendency as opposed to anything more deterministic. He essentially argues that working-class fractions will *tend* to exhibit certain linguistic tendencies due to shared forms of the different types of capital and the social processes that are associated with this, not that the relationship is deterministic or anything more than a tendency (1979; 1992). Importantly, this helps to account for why, whilst these three occupationally working-class participants articulate this 'type' of discourse, the remaining three do not. For Bourdieu (1979, 1992), it is likely that they would, but not problematic that three further participants, two of whom were very similar to them in educational experience and vocational types of experience, do not.

There is also one more aspect to an explanation of the above three participants. Whilst Bernstein (1975) and Bourdieu's (1979; 1992) work suggests that participants from working-class fractions will probably (but not definitely) articulate discourses that are likely to reflect an orientation to meaning (Bernstein, 1975), and a habituated linguistic capacity and tendency (Bourdieu, 1992), that are the outcome (although not in simple ways) of inequalities within social structuration and in turn its relationship to probable educational and vocational trajectories, there is also the question of what van Dijk (2003) calls 'relevance.' van Dijk (2003) argues that part of the explanation as to what people do or do not say in a given social encounter is an outcome of the inter-subjective construction of the social situation and their understanding of what would be *relevant* to discuss. van Dijk's argument can usefully be employed here in relation to another aspect to Bourdieu's discussion of habitus (1979, 1992), in the respect that what an individual might be disposed to say could also be an outcome of their habituated (and probably unconscious) understanding of what would be relevant or not to talk about. This thesis takes the view that in relatively formal situations (like an interview) members of certain social class fractions may have different conceptualisations of what is relevant (van Dijk, 2003) to talk about and that this could relate to numerous factors. These might include prior and habituated experience of formal discussions in which the other party seems to be inter-subjectively constructing an expectation that they are interested to hear the individual's expansive thoughts on a range of issues. It is the contention of this researcher that participants from occupationally middle middle-class and upper middle-class fractions are more likely to find themselves, and to be confident and comfortable, in such scenarios (due to their everyday vocational experiences) than are members of 'lower' occupational social class fractions and that this could also be explanatorily useful here. To put it

simply, occupationally middle-middle and upper-middle class individuals are more used to being in formal situations in which those directing the discussion are interested in hearing what they have to say.

Further analysis of participants who articulated this type of discourse does complicate any *simple* social class based explanation. Nine of the twelve participants who articulated this 'type' of discourse were occupationally middle-class. Again, the complexity of social class must be considered, because seven of these nine were part of the occupationally lower middle-class fraction, with educational backgrounds very similar to the occupationally working-class participants (who also articulated this 'type' of discourse) and typically lower middle-class vocational backgrounds such as bank clerk, legal secretary (unqualified), routine administrators and so on. This being the case, little if any difference may necessarily exist between them and the occupationally working-class participants in terms of linguistic capacitation and disposition that might have led to a significantly different type of discourse being articulated in the interviews.

However, the remaining two participants whose accounts correspond to this 'type' of discourse had been, or at the time of the interviews were, at university and one had run a very successful accountancy practice. These participants, particularly the latter, trouble any simple conceptualisation of the relationship between social class and discourse because they would generally be recognised as likely to possess different types of linguistic capital, with a linguistic habitus capacitated and disposed to engaging in what would correspond to Berstein's elaborated orientation, i.e.

"universalistic, less local and more context independent" (Bernstein, 1990: 96; quoted in Chouliaraki and Fairclough, 2005) and likely to be more expansive.

What does explain the correspondence of the three occupationally working-class participants' accounts to this 'type' of discourse as well as the nine occupationally middle-class participants to this type of discourse and the two other working-class participants to other types, is the type of *engagement* that they have with the medicinal use of cannabis. The question of engagement is a question of what the medicinal use of cannabis appears to be about for an individual, or, how they *do* medicinal cannabis use (to view it as a form of social practice). None of the participants whose accounts corresponded to the 'practical' type of discourse offered any evidence in their interviews of being particularly interested in the issue of medicinal cannabis use outside of the immediate benefits of dealing with their illness and / or impairment that it gave them. Also, none of them were members of groups such as the Alliance for Cannabis Therapeutics, nor were they involved with groups that took a particularly politicised view of medicinal cannabis use. To put this another way, they did not *engage* with medicinal cannabis use as a broad social practice in anything more than a *practical* or pragmatic way. To relate this to discussion in Chapter Fifteen, none of the participants whose accounts correspond to the 'practical' type of discourse discussed having done any personal research into the medicinal use of cannabis in the way that the participants featured in that chapter did. It is also interesting to note that of the four participants featured in the chapter on 'impression management' (Chapter Sixteen) three of the participants discussed in that chapter articulated 'types' of discourse that correspond to the 'practical' type. These

participants were not only often apparently very concerned with 'impression management' (Goffman, 1959) but also said, in the words of one participant, that:

> "... nobody really talks about it [cannabis], you just ... it's just there and it works. You can't stand on a corner and talk about it because it's just not on, is it?" (participant three: 28-29).

One might therefore argue that this type of engagement with medicinal cannabis use is likely to be the opposite of a public and / or organised group engagement. As later sections in this chapter will show, such types of engagement are associated with more elaborated, politicised and heretical types of discourse, because talking about medicinal cannabis use tends to correspond with how an individual engages with the issue (or how an individual *does* medicinal cannabis use as a social practice). So whilst there is a relationship between the occupational social class of participants and the tendency to exhibit this type of discourse, this is not straightforward and an understanding of discourse as strongly related to (as well as being a part of) social practice is important when making sense of why the participants who articulated this type of discourse did so.

'Elaborated' discourse on medicinal cannabis use

It is arguably the case that the differences between the previously discussed 'practical' type of discourse and what will now be discussed as the 'elaborated' type of discourse are not entirely unproblematic. It has already been discussed how the 'types' of discourse that are being discussed here are abstractions or ideal types (Weber, 1949), to which the actual discourses of individual participants correspond to

differing degrees. If this analysis presented these heuristic schemes as unproblematic in any sense then this would suggest an analytical oversimplification or naivety. There is a difference between the two 'types' of discourse. The 'practical' type of discourse does not feature a divergence from the questions as asked in the interviews, whereas the 'elaborated' discourse does (to different degrees with different participants). Both discourse 'types', as was previously discussed, feature elaboration. In the case of this type of discourse, the elaboration is not just elaboration of personal experience by inter-textually drawing on discursive resources to talk about personal experience of using cannabis, but also discussing issues other than those about which the participant was specifically asked.

However, an analysis of the participants included in this and the previous section could also see them as part of one continuum, from the one participant who does not elaborate at all when discussing the practicalities of medicinal cannabis use (participant nine) to the participant whose elaboration is most prevalent and expansive (participant twenty-eight). The participants at either end of this continuum also occupy something akin to opposite ends of a continuum in terms of occupational social class, educational experience and vocational experience. Participant nine was from an occupationally lower working-class background, had never worked and was unable to complete compulsory education (both due to multiple sclerosis developing in her teenage years). Participant twenty-eight was from an upper middle-class background, attended a prestigious public school and had been an army officer.

Yet none of the participants who articulate this type of discourse explicitly or in any depth engage with issues of power or politics in their accounts. As this thesis has, as

one of its aims, an interest in the potential that different medicinal cannabis users' discourses have in relation to the contestation around the issue, the difficulty in whether to understand 'practical' and 'elaborated' discourses as part of one continuum or as being qualitatively different is not one that the researcher intends to be detained by. By not engaging with the issue in terms of 'the political', issues of power or articulating a discourse that critically engages with key aspects of the 'no medical value' discourse, the discourses of all participants in this section and the previous one offer less prospect of success within the struggle, except for in one important way (that most of them do emphasise in different ways and to different degrees the naturalness of cannabis). It has already been discussed that this confers many discursive advantages and therefore that any accounts drawing on such commonly existing notions of nature as preferable to 'man-made' / 'chemical' / 'synthetic' etc. products, hold some degree of discursive potential in relation to asserting the medicinally beneficial character of cannabis.

To return to an analysis of this group for the moment, three of the twelve participants articulating discourses that corresponded to this discursive 'type' were understood to be members of the occupationally lower middle-class fraction, having held clerical type vocational positions when they had worked. However, one of these participants had dropped out of doing 'A' levels and gone into routine office work due to ill health and another had undertaken temporary contracts within laboratory work, so two of the three could be viewed as likely to have been capacitated and disposed towards offering more elaborated accounts than most of their fellow occupationally lower-middle class fraction participants.

The single working-class participant (twenty-two) whose discourse corresponds to this type is an interesting case with regard to the arguments being advanced. In terms of a simple social class – language analysis, he would be difficult to account for. From a working-class background and a problematic family life when younger, he had worked as a mechanic and in his interview he disclosed, at the age of 39, to being dyslexic and having been practically illiterate until a few years earlier. A simple social class / educational background / vocational background analysis might expect this participant to produce a rather restricted 'practical' type discourse. In fact his discourse can be seen as among the more elaborated. Again, engagement with the issue of medicinal cannabis use seems to be the key to accounting for participants' discourses, in addition to a more complex understanding of the relationship between social class and discourse. This participant is a classic case of the working-class autodidact. In his interview he told the researcher how his son had developed autism at a young age and how he strongly believed that this was as an outcome of receiving the M.M.R. vaccination (the link between the two was for some time debated in public discourse). The participant said that in order to do personal research into the possible link between the condition and the vaccination he had learnt to read. In turn, the participant had developed a very strong distrust of conventional medicine, processed food and numerous other lifestyle aspects involving 'man-made' products. He and his family had very enthusiastically embraced an organic and more 'natural' lifestyle in terms of the products they consumed and his strong emphasis of the benefits of cannabis due to it being 'natural' appears to be a part of this. Again, a participant's engagement with cannabis is seen to correspond to his discourse on it and in relation to this participant there is a very strong 'risk' type reflexivity (Beck, 1992) involved.

However, participants' accounts that problematised the 'man-made' / 'synthetic' / 'chemical' were shown to be common in the 'mapping out' chapters and Chapter Seventeen, and in fact the majority of participants articulated such views. Interestingly, whilst only six of the twelve participants' discourses taken to correspond to the 'practical' discourse type addressed the issues associated with the discursive oppositions between the 'natural' and the 'man-made', ten of the twelve participants' discourses taken to correspond to the 'elaborated' type addressed these issues. In fact, it is the case that talking about cannabis as 'natural' and the variations on this theme tended to be one of the main ways in which these accounts were elaborated, that is to say that it was about this that they often had the most to say. As has been discussed earlier, the majority of participants articulated this theme in one way or another and it has been taken to be the core theme of the medicinal cannabis users' discourses overall, for most users. This is further evidence that a participant's engagement with the medicinal use of cannabis, broadly speaking how they *do* medicinal cannabis use as a social practice, corresponds to how they talk about it. As has been argued elsewhere in this thesis, the discourses that problematise the 'man-made' / 'synthetic' / 'chemical' aspects of life and indeed increasingly science, technology, medicine and 'expertise' (Beck, 1992) are so commonly distributed in society, in an age in which some sociologists even define the period in reference to such ideas, e.g. Beck's branding of the contemporary period as a (coming) 'risk' society (1992), that they are not the preserve as discursive resources of any single social group. With the growth of organic foods, as just one example of lifestyle practices associated with such views, it appears that such associated lifestyle practices are also not the preserve of any particular social group or social class.

The remaining eight participants whose accounts correspond to this 'type' of discourse produced among the most elaborated of accounts. That is to say that they tended to say the most on the most topics, within this group of participants. Four of them held vocational positions that offered the possibility of vocationally derived discursive resources that accounted for a more 'elaborated' type of discourse when talking about medicinal cannabis use, two working in social work, one as a nurse and one as a disability assistant / sociology student. In terms of Bourdieu's notion of trajectory (1979), these participants had occupied the types of vocation that had endowed them with various discursive resources with which to talk in various ways about the issues related to medicinal cannabis use (this is discussed in Chapter Thirteen). In terms of developing arguments about a participant's discourse corresponding to their engagement with medicinal cannabis use, such participants would perhaps be expected to reflect more on the issues of medicinal cannabis use and unsurprisingly to discuss them by, at times, drawing on such vocationally derived discursive resources, where relevant.

Social class and higher educational background seem to play a role here, as the remaining four are the four most privileged in terms of education (two graduates, one PhD and a public school educated fourth). However, there is also even more evidence for the significance of engagement. With reference to the chapter on 'processes in the engagement with discursive resources' (Chapter Fifteen), three of the four participants discussed in their interviews having undertaken personal research into medicinal cannabis use via the internet and books and one of these was also a professional media researcher (participant thirty-two). Also, of the four participants,

two of them were members of the Alliance for Cannabis Therapeutics. So engaging with the issue of medicinal cannabis use as something that one wants to become fairly 'well-informed' (Scutz, 1964) about and engage with in an organised way as a social issue corresponds with developing an expansive discourse on the topic. In turn, having the disposition to do lay research into an issue does not appear to be equally distributed within society and an argument will now be made that it is related to social class via the individual's trajectory through education and vocation and how this structures and re-structures dispositions and perhaps more so, attitudes towards the accumulation of knowledge and the capacity and disposition to engage with it.

The Bourdieusian concept of *trajectory* (1979) is significant here. It is helpful when considering the relationship between habitus, field and biography and specifically how some individuals may be socially constituted to be more disposed to want to do personal research than others, as with the participants above, as the trajectory of their life takes them through different educational and vocational positions. This involves the restructuring of the habitus (Bourdieu, 1992) and the development (in which the individual actively participates) of an inclination towards wanting to be 'well-informed' (Scutz, 1964). Just as various positions within different fields offer access to particular discourses (i.e. doing certain jobs leads to the possession of certain types of discourse, e.g. being a sociologist involves the development of a linguistic habitus that is inclined in particular ways), so certain fields reward and encourage the development of a reflexive capacity (Bourdieu and Wacquant, 1992; cited in Schirato and Webb, 2002). This happens, over time, through "mechanisms of training, dialogue and critical evaluation" (Bourdieu and Wacquant, 1992: 41; quoted in Schirato and Webb, 2002) that are part of the everyday experience of certain

educational and vocational positions and experiences. Whilst a sensible view of reflexivity and reflexive knowledge would recognise that, to some degree, most individuals in contemporary society possess some level of them, it is likely that, just as with all other social resources, distribution of such tendencies and capacities is unequal.

Schutz's (1964) discussion of three ideal types of knowledge contains some useful ideas that may contribute towards an understanding of socially constructed inclinations towards knowledge and therefore towards explaining why the most elaborate of the 'elaborated' type of discourse accounts were articulated by the individuals that produced them. In a discussion of the relationship between individuals and knowledge, Schutz (1964) discussed three ideal types, 'the expert', 'the man in the street' and 'the well-informed citizen.' Using Weber's (1949) concept of the ideal type, Schutz did not argue that people can be entirely fitted into one of the three types, but that many people will adopt two or three of these attitudes towards different areas of knowledge, subject to their interests (which can of course change over time). He defined the difference between the three types as one of readiness to take knowledge for granted. 'The expert', argued Schutz (1964), has the relevance of what he or she ought to know imposed on him or her by their field. 'The man in the street' is interested only in practical knowledge "sentiments and passions" (1964: 122). 'The well-informed citizen' aims at achieving "reasonably founded opinions" (1964: 122).

Arguably the two most interesting points about Schutz's ideas (1964), in relation to this thesis, are that he also argued that the ability to question what people do not

know is dependent on the stock of knowledge about what they *do* know. This suggests that more knowledgeable individuals, or those in possession of certain knowledge related forms of capital, may be better placed to engage with orthodox (dominant) discourses (Bourdieu, 1992). Secondly, and more relevant to this section, one might wonder whether it is reasonable to presume that individuals who might exhibit a higher level of desire to be knowledgeable, to be 'well-informed citizens', do so because they have been socially constituted as such, due to the particularities of their biography or trajectory? To put it another way, at some stage in life, a 'thirst for knowledge' becomes habituated and habitual to them, it is socially constituted.

If we look at three of the four participants who articulate the most elaborate of the 'elaborated' type discourse, three of them professed to having spent time researching the issue (as discussed further in Chapter Fifteen). Of the three, one had a PhD in electronic science and one was a graduate with a career in television research and production. Both fields reward and encourage the development of a reflexive capacity (Bourdieu and Wacquant, 1992; cited in Schirato and Webb, 2002), and both could well have a low readiness to take knowledge for granted (Schutz, 1964). Whilst the fourth participant did not profess to having spent time doing lay research, he was a university lecturer, so it is reasonable to assume that he may well have spent time researching / reflecting upon the issues.

Of course this issue also relates to the developing explanatory concept of engagement, because in a sense these participants engage with the issue of medicinal cannabis use *as* the reflexive and 'well-informed' individual that Bourdieu and Wacquant (1992; cited in Schirato and Webb, 2002) and Schutz (1964), respectively,

discuss. This is how they *do* medicinal cannabis use, as a social practice and indeed one may extend this argument by suggesting that it may well be a more generalised trait of their engagement with other aspects of knowledge and social life too, or at least in some areas. That is to say that, in a crude sense, this is how they are as individuals.

So far, however, the inclination of these few participants (whose accounts were the most elaborated of the 'elaborated' type of discourse) to knowledge, as part of their engagement with the medicinal use of cannabis as a form of social practice, has been accounted for, but not the relatively broad set of issues that they drew on in relation to what they had to say. This is important and has, to a degree, been addressed already. This chapter and the chapter on processes in the engagement with discursive resources (Chapter Fifteen) have both touched on how these participants used specialist or public libraries as well as the internet to undertake lay research into the medicinal use of cannabis. This section will now discuss this further.

In a discussion of discourse in the late modern period, Chouliaraki and Fairclough (2005) employ Bernstein's (1990) argument that the media may be understood as a repository of meanings that go beyond the immediate context of individuals to a transcendental space / time context, that meanings from outside of their immediate experience can, now more than ever historically, be engaged with. With so many of the participants indicating that they came to use cannabis initially from reading a newspaper article or seeing a programme, and some drawing on ideas found in much of what is often said about medicinal cannabis use on the internet, in books and so on, this idea that the media is a repository of ideas that can be drawn on in the articulation

of meaning is a significant one. It also has implications for Bourdieu's (1992) argument that a heretical discourse can only be produced if suitable discursive resources are available (the media clearly is such a source of availability).

Bernstein's ideas here can also be considered in relation to Gee's (1999) concept of Conversation (the capital 'C' being deliberate). Gee's concept of Conversation is useful but also conveys a sense, that is more dynamic than the concept of discourse, of seeing the media as a repository (discourse and media seeming more static than 'Conversation'). Gee defines Conversations as:

> " ... long-running and important themes or motifs that have been the focus of a variety of different texts and interaction through a significant stretch of time and across an array of institutions" (Gee, 1999: 13).

The societal Conversation that has taken place about the medicinal use of cannabis fulfils Gee's criteria, as stated above. He also argues that Conversations can be seen as occurring between and among Discourses (meta-discourses) as well as among individuals (1999). So the meanings produced in various types of media at various times can be seen as a Conversation about medicinal cannabis use, which various people contribute to in writing about the issue or in other ways of making statements (e.g. reports of politicians' statements). In the late modern period much of this is, more than ever, easily available due to the existence of the internet. In relation to such ideas, the media can be understood as a repository of meanings that may have emerged from the thoughts, writings or discussions of people geographically and / or chronologically distant, but these meanings can be drawn on in the late modern

period, *potentially*, by anyone who can access them *or has the habitual disposition to do so and the linguistic capital to engage with such meanings.*

The argument here then is that those participants who are inclined towards being 'well-informed' on the issue of medicinal cannabis use, because of their particular engagement with the issue or a more general disposition to being 'well-informed' in general, are more likely to be so, in the first place, due to having had educational and vocational experiences that have been involved in the constitution of them as such (this argument was made above). This suggests the probability, but no more than this, that they will be of a certain educational background (possibly graduates) and of a certain vocational background, as certain types of employment reward and encourage reflexivity. In turn, such a trajectory (Bourdieu, 1979) tends to be associated with the possession of powerful discursive resources and what Bernstein describes as an elaborated orientation to meaning "universalistic, less local and more context independent" (Bernstein, 1990: 96; quoted in Chouliaraki and Fairclough, 2005). Such individuals are 'equipped' with the disposition to engage with complex sets of meaning, perhaps outside of their personal experience, and the habituated linguistic capacity to be able to incorporate such meanings and to later articulate them themselves, albeit it in situated and specific ways, such as in the interviews for this research or when talking to the media, as some of these participants reported doing. This means that they are more likely to be able to articulate expansive and compelling arguments. Of this, Bernstein said that the "potential for such meanings is disorder, incoherence; a new order, a new coherence" (Bernstein, 1990; quoted in Chouliaraki and Fairclough, 2005). The significance of this comment for this thesis is that such participants can be seen as being able to attempt to produce accounts that make a

challenge in the public domain of the media when they talk about the issue, that they can attempt to establish "a new order, a new coherence" (Bernstein, 1990; quoted in Chouliaraki and Fairclough, 2005). These contributions to the societal Conversation (Gee, 1999), by such medicinal cannabis users, contribute to the growth of the discursive resources deposited in the societal Conversation about medicinal cannabis use, which in turn become available to others to articulate.

However, as the prevalence of the distribution of discursive resources that assert the medicinal usefulness of cannabis continues to grow, individuals are increasingly likely to come across them, even if they are not necessarily habitually constituted to doing personal research or to be the 'well-informed' individual (Schutz, 1964). As has been noted previously, Bourdieu has argued that:

> "It is only when the dominated have the material and symbolic means of rejecting the definition of the real that is imposed on them ... that the arbitrary principles of the prevailing classification can appear as such ..." (1979: 169).

It may well be the case that in the late modern period, with the increasing growth of the internet and increased access to it (as well as the growth of access to higher education), that the "dominated" will increasingly have the "symbolic means", or more precisely the discursive means, to engage in such struggles. It is also worth bearing in mind the convenience and popularity of the internet with disabled and chronically ill people, due to a lack of many of the physically and socially excluding barriers that the 'real' world often confronts them with. This being the case, the repository of the largest and most diverse amounts of knowledge about medicinal

cannabis use (and the most powerful discursive resources) is also the most convenient for many medicinal cannabis users to engage with.

'Politicised' discourse on medicinal cannabis use

Whereas the 'elaborated' type discourse corresponds to, or is an heuristic abstraction of, accounts that feature articulations around issues not necessarily directed by the interview schedule, the 'politicised' type of discourse corresponds to accounts that also do this, but in addition include elaborations on issues and themes of power and politics. This is particularly significant for this thesis as it adopts a critical discourse analysis approach and is interested in the potential that different identifiable types of discourse might have in relation to the contestation around the medicinal cannabis. Whilst some of the more elaborated type accounts, such as those discussed immediately above, may be seen as bringing a certain rhetorical force by way of the broad range of discursive resources that they articulate, they do not explicitly engage with issues of power and politics. This thesis takes the position that a 'politicised' account and corresponding 'politicised' engagement on the issue of medicinal cannabis use contains a different potential for change because of its recognition of the inherent political / power-related 'nature' of the issue.

Of the seven participants whose accounts are taken to correspond most closely to the 'politicised' type discourse, six were occupationally middle-class (all from the middle-middle class fraction) and one was occupationally working-class. Whilst it

seems reasonable to argue that the educational and vocational experiences and discourses more common to the middle-middle class fractions than the working class fractions are perhaps more likely to be inclined towards discussions involving issues of power and politics (though not in any sense exclusively so), analytically simple correspondences between social class and discourse have been avoided and would not be supported by the data. As has been seen above, many occupationally middle-class participants (albeit it more typically of the lower-middle class fraction) articulate a discourse best understood as 'practical' or 'elaborated' in terms of types. However, whilst this is so, it might also be argued that a more typically middle middle-class fraction linguistic habitus (Bourdieu, 1992), dispositions and capital, and a more elaborated orientation to meaning (Bernstein, 1975), tend to increase the likelihood of an individual being able to speak about such things. Yet other factors are also involved in accounting for the discourse of the seven participants in this section. As has also been the case above, an individual's discourse again appears to be strongly related to their engagement with the medicinal use of cannabis or as it has been described above, how they *do* cannabis as a form of social practice.

For four of the seven participants, this is grounded within their vocational practice. These four participants were vocationally involved in the field of disability. To qualify this more precisely, they all worked for disabled peoples' groups that were run by-and-for disabled people (as opposed to groups run by non-disabled medical 'experts' for disabled people, which have been problematised by some in the disability movement in various ways, this having been discussed in the Chapter Seven). It is perhaps inherent within these groups to hold a critical ideological view of disability, medicalisation and issues of power and so it is unsurprising that

participants who are members of such groups would hold a 'politicised' type discourse on the medicinal use of cannabis. The four participants were a disability Equalities Advisor, a Head of Policy at a disabled peoples' group, a Disability Awareness Trainer and a general disability group worker. All four of them had spoken in a way that problematised the relationship between medicine and disabled people and two had explicitly spoken about the 'medical model' of disability (see Chapter Twelve). Three of the four were graduates, with these three also having post-graduate qualifications, so education (in particular higher education in this instance) can be seen as capacitating such articulation with vocational practice having informed their discourse in more specific ways.

Of the remaining three participants, participant eighteen spoke critically about doctors and issues of power and is a participant who was often mentioned in the 'mapping' chapters for the complexity of his account (as well as the participant whose account provided part of the title of this thesis). Unlike the four participants mentioned above, he had no vocational involvement with disability politics and his account appears to be the product of a well-educated and articulate man simply able to recognise the issues of power and interest that are involved in the medicinal use of cannabis.

Participant forty-one, unlike the other six participants in this group, was a working-class male who had not participated in post-compulsory education and said in his interview that he had chosen manual work as an outcome of lifestyle choices (he was heavily tattooed and said he would not have obtained other forms of employment due to his appearance, this probably being true in the researcher's estimation). So the social class, education and vocation elements of the construction and reconstruction

of linguistic habitus (Bourdieu, 1992) do not seem to yield a fruitful explanation of this individual's 'politicised' type discourse. However, the notion of the working-class autodidact has been used explanatorily in relation to a previous participant and the interview with participant forty-one mentioned his involvement with a national disabled peoples' bikers group and hints at a politicised type of engagement with issues around disability. The reader may recall discussion of his accounts on cannabis being a political problem not a drug problem and also what can clearly be discerned as a materialist type view of disability and the economy (see Chapter Nine).

Participant twenty-nine is an example of a highly politicised type of engagement with the issue of medicinal cannabis use. A member of the Alliance for Cannabis Therapeutics, his interviews reveal a one-man campaign targeting government ministers, talking to national and international media as well as an ongoing campaign aimed at the British Medical Association. His account articulates a discourse that is correspondingly critical of the medical profession as well as the government over the issue of medicinal cannabis use. This participant's account is further evidence of the correspondence between engagement with the issue and discourse when talking about it. The broadness of the discursive resources that he drew on, which was probably the broadest range of historical and contemporary issues within the medicinal cannabis debate exhibited by any participant, and his self-confessed personal researching of the issue, relates him to other participants discussed above who have developed a disposition towards being 'well-informed' (Schutz, 1964) on the issue.

As has been discussed already, the ultimate goal of much critical discourse analysis lies in understanding the relations between language and issues of power and how

they might be related to the prospects of social change. It is the view of this research that the 'politicised' type discourse articulated by these participants brings a critical and questioning edge to discussion of the issue and that in being able to position the issue within a context of power and interest this type of discourse offers an element of promise perhaps not seen in most other articulations of the topic. However, whilst all seven of the participants addressed in this section recognise the issues of power and politics involved in the medicinal cannabis use issue within their accounts, they all stop short of a critical engagement at a rhetorical discursive level.

'Heretical' discourse on medicinal cannabis use

As was discussed in Chapter Eighteen, participant thirty-five's interview involved questioning the hierarchically constituted relationship between 'clinical' and 'anecdotal' knowledge, questioning the presumed neutrality and objectivity of scientific knowledge called on by government ministers and a subversive use of the language of medicine to describe the use of cannabis itself. It has been argued that his discourse, in relation to the first two aspects noted above, can be seen as unique in relation to all other participants' accounts. Whilst the accounts of the seven participants, who were addressed in the previous section and understood as corresponding with a 'politicised' type of discourse, share a recognition of some of the ways in which power is involved in the issue of the medicinal use of cannabis, participant thirty-five's account went one crucial step further. He critically engaged with key aspects of the 'no medical value' discourse, as it was often articulated to him (when he engaged in public debates, often in the media), not just making it visible (as

the previous seven participants did in various ways), but also by attempting to oppose and undermine it. In this respect, his discourse is closest to what might be understood as a full critical discursive engagement with the issue.

Participant thirty-five, however, is not a straightforward individual to account for in terms of why he exhibited what is the most critical type of discourse of all the participants, at least in terms of simple occupational social class position (lower working-class). He had described his origins as working-class, although people's ideas about their own social class position are complicated and need to be recognised as discursive and rhetorical constructions in themselves (Savage, 2000). His educational trajectory involved attending grammar school and then art college, which suggests some restructuring of the habitus (Bourdieu, 1979) in terms of cultural and linguistic capital and associated dispositions. He reported in his interview that when he was younger he found the art world to be objectionably pretentious and that he had preferred and actively sought out what he saw as the more genuine way of life and working-class companionship of manual labour. This participant makes more sense in terms of Bourdieu's view of social class not as occupational class but as the possession of amounts and types of capital (economic, social, cultural and linguistic) (1979; 1992). His educational trajectory and vocational choices do not seem as closely related as those of other participants (e.g. compulsory education and manual labour / routine administration work or higher education and a career in the professions or intermediate vocations), and the discourse that he articulated seems to have more in common with that of the occupationally middle-middle class participants than with occupationally working-class participants. This is because he shares more in common with the former in terms of the possession of linguistic

capital and dispositions (Bourdieu, 1992), than the latter, and these factors are more immediately explanatory than social class alone. Accounting for his disposition and capacity to articulate this type of discourse is only difficult if using an overly simplistic notion of social class not enhanced by consideration of educational and vocational trajectory and how these relate to the possession of certain amounts and types of capital.

However, the arguments around engagement that have been developed over a number of chapters are again useful here and it is his engagement with the issue of medicinal cannabis use which is most important of all in accounting for the type of discourse that he articulates. This participant was a member of the Alliance for Cannabis Therapeutics and had engaged with the media on the issue of medicinal cannabis use. As with other members, he had articulated a wide range of issues in his interview (among the widest) and it is hard to account for why this particular participant's discourse is distinct from that of other participants. Perhaps the seven participants whose discourse has been taken to correspond to the 'politicised' type could have spoken about these issues too but simply did not see such arguments as relevant (van Dijk, 2003) to the interview. Maybe they were not disposed to discuss such issues, or perhaps they simply did not possess the discursive resources to be able to articulate such ideas. No certainty can be reached as to why participant thirty-five alone articulated a 'heretical' type discourse as he is not obviously advantaged in any particular way over some of the other A.C.T. members who took part in the interviews. Such a difference could of course be as simple as him having come across one source of information about science, knowledge and power that might have made the difference in terms of being able to articulate such arguments.

However, there is one last possible explanation. Of all the participants who emphasised the importance of cannabis being, as they understood it, a 'natural' substance or who articulated the importance of the 'natural', participant thirty-five did so more than most, if not all. In fact, the significance of the 'natural' within his life seemed to be far broader than just the medicinal use of cannabis. He commented in the interview how himself, his wife and most of his friends were vegetarians, inclined towards herbal medicine and how he saw cannabis as part of a whole system of cures on Earth deliberately for humans to use (this was discussed further in Chapter Eleven). This could be seen as a matter of broad lifestyle. During the interview, the interviewer observed how the participant had many shelves full of books on alternative remedies and medicines. He also remarked in the interview that herbal medicines:

> "... gave me the *framework* to accept that there are ways other than pills ..." (my emphasis) (participant thirty-five: 19-20).

This comment suggests that he had read some material that provided him with an alternative "framework" for thinking about medicine other than "pills" and perhaps a framework for thinking about "pills" (scientific-medicine) that also provided the discursive resources to articulate a critical engagement with certain key aspects of science and medicine as they pertain to the medicinal use of cannabis. Whilst this is of course speculation, discourse is like any other form of capital in the respect that an individual can only use the capital that they possess. The meanings that he articulates, that distinguish his discourse from those of all the other participants, had to have come from somewhere and where better than the books in his own living room? This

idea is further supported by the tendency previously observed that A.C.T. members tended to have done personal research into the issue of the medicinal use of cannabis and to have articulated relatively broad discourses on the basis of this.

Conclusion

Whilst this chapter has argued for the existence of certain 'types' of discourse articulated by the participants in their interviews, it has not employed the idea of 'types' of discourse in an un-reflexive manner. The notion of ideal types (Weber, 1949) was employed here in an attempt to address a methodological concern. It was also made clear that the different 'types' of discourse are not being considered in a simplistic hierarchy of discourses that implies linguistic inferiority or superiority. The discursive 'types' reflect a difference in terms of the potential for critical engagement in the contestation that occurs around the medicinal use of cannabis. However, as has already been remarked in Chapter Seventeen, any discourse on the topic that emphasises the 'naturalness' of cannabis, in opposition to commonly held concerns about scientific-medicine and its use of 'man-made', 'chemical' or 'synthetic' products, will probably carry a certain rhetorical force. This is due to the prevalence of ideas in contemporary society about nature being safer, gentler and more efficacious than what scientific-medicine has to offer (Coward, 1989; cited in Lypton, 1995) and the growing prevalence of critical reflection on pharmaceutical medicine as part of science, technology and 'expertise' (Beck, 1992). The following chapter will collate the arguments that have been made in this thesis in a conclusion.

CHAPTER 20

CONCLUSION

This thesis arose from time spent involved in previous research, which led to Coomber, Oliver and Morris (2003), and initial curiosities that were outside of the focus of that work but which the researcher was greatly intrigued by. In this thesis, the discourse of the participants has been the *topic*. An interest in why 'nature' and 'the natural' seemed to feature so often in so many of the participants' interviews; why some participants' accounts featured so much in terms of themes discussed, discursive resources and rhetorical strategies and others featured relatively little, and what prospects different discourses might hold for the ongoing contestation around the medicinal use of cannabis were present from the start, but solidified over the various stages of thinking, reading, questioning and analysing. Along with the broad interest in discourse as *topic,* it is these three questions that have made up the aims of this thesis.

Previous chapters showed that articulations of cannabis, 'nature' and the 'natural' are at the core of the discourse on medicinal cannabis use, as articulated in the interviews of the majority of participants in this research. An argument has also been advanced (see Chapters Six and Seven) that the contemporary period increasingly exhibits a tendency for many members of society to reflect critically upon the society-nature relationship, in which science, technology, government, expertise (Beck, 1992) and commercial interests are regarded with suspicion and anxiety by many. At the same time, nature is increasingly understood as being inherently beneficial, safe and gentle (Coward, 1989; cited in Lypton, 1995), with cannabis being articulated in the

interviews of the majority of participants in this way. These changes, it has been argued, have brought about the possibility of cannabis and its medicinal efficacy, when understood in terms of these ideas about 'nature', being increasingly understood by many members of society as a 'common sense' choice and, as such, mounting some degree of challenge to the 'no medical value' discourse on cannabis. We live in a social world in which it is increasingly accepted by more and more people that naturopathic lifestyles and products are inherently safer and more effective than ones involving products that are understood as being 'man-made', 'artificial' and 'synthetic.' Such products and lifestyles are increasingly reflected upon in terms of 'risk' (Beck, 1992) and choosing the more 'natural' is commonly understood as choosing the less 'risky'. As well as the broad shift towards more naturopathic lifestyles and products, it has also been argued that disabled and / or chronically ill people may be understood, for various reasons, as being particularly likely to embrace alternative medical approaches to those offered by scientific medicine (see Chapter Seven).

In relation to Bourdieu's (1979, 1992) discussion on discursive dominance and the conditions necessary to its contestation, the societally broad disputations, as well as those more particular to many chronically ill and / or disabled people, of the authority of scientific medicine, as well as the possession of a new 'common sense', i.e. that cannabis must be efficacious because it is natural, constitute the conditions necessary to disrupt the dominance of the 'no medical value' discourse. They also constitute the necessary conditions to impose a new 'truth', in which cannabis, when understood as 'natural', is understood by many to be inherently safer and therefore preferable than scientific medicine's 'man-made' alternatives.

In light of these ideas, the prevalence of talking about cannabis, 'nature' and 'the natural' within the interviews, and the significance of such ideas in relation to the contestation around medicinal cannabis use, can be explained by the already extant discursive and rhetorical force of 'the natural' as inherently preferable and its presence within many societal Conversations (Gee, 1999), for example about organic foods and fears around genetically modified products, and the increasing prevalence and intensity of these public discourses. Many of the participants explicitly stated, in various ways, that they preferred cannabis because it was more 'natural', and this is one of the main reasons why they use it *and* why they also construct it as preferable within their own articulations. The compelling character of the idea that 'the natural' is preferable accounts, to a fair degree, for their use of cannabis medicinally, as well as for their assertion that it is preferable (although it is also obviously important that they find it to be effective).

The thesis also set out to account for the intriguing differences between some participants' accounts, in terms of themes discussed, discursive resources, rhetorical strategies and so on. It was argued that four abstractions or ideal types (Weber, 1949) of medicinal cannabis users' discourse could be identified – 'practical', 'elaborated', 'politicised' and 'heretical'. An attempt to account for why certain participants articulated a particular type of discourse will be discussed in concluding now. Whilst six of the eight participants who articulated a 'politicised' or 'heretical' type of discourse were from the occupationally intermediate middle-middle class or the occupationally professional upper-middle class (suggesting a strong significance for social class related explanatory factors), the most important factor in accounting for

differences between participants' discourses is the concept that has been described as *engagement.* Of the eight participants who articulated a 'politicised' or 'heretical' type of discourse, four worked for disabled peoples' groups and three were members of the Alliance for Cannabis Therapeutics. It has been argued that their articulation of particular types of discourse corresponds to their engagement with the issue of medicinal cannabis use, or how it may be understood as a form of social practice, of which talking about the issue is an integral part. It was also described how such individuals typically had engaged in personal research into the issue, giving them a broader set of discursive material to articulate. Underpinning this, though, is a relationship between social class, linguistic capacity and disposition (Bourdieu, 1992) but not a simple one. Articulators of the 'practical' discourse were nearly all from the occupationally lower-middle class fraction or the occupationally working-class, for the 'elaborated' discourse most were from the occupationally middle-middle class fraction. For the 'politicised' discourse, all but one were from the occupationally middle-middle class fraction, and for the 'heretical' discourse the single participant was occupationally working-class but his educational trajectory and linguistic habitus (Bourdieu, 1992) shared more in common with occupationally middle-middle class participants. Any naïve notion of a simple social class – language relationship would have been overly simplistic and unsupported by the data. One occupationally working-class participant exhibited a 'politicised' discourse, one a heretical discourse and one occupationally upper-middle class participant articulated a 'practical' discourse. However, these were exceptions to the trend and were accounted for. The relationship between social class and discursive 'type' was ultimately mediated by the individual's engagement with the issue of medicinal cannabis use. It must be borne in mind, though, that whilst the sample size of thirty-two participants was not

problematic, overall the fact that there were only six occupationally working-class participants does necessitate caution. It should also be considered that the thesis did not set out to investigate social class and that the patterning found in relation to it is probably what would have been expected anyway.

So, in sum, what does this all tell us? Occupational social class in and of itself does not necessarily tell us anything at all. In most cases, participants' educational trajectories led them into the kinds of vocational trajectories that one might predict. Compulsory education only or vocational further education led to occupationally working-class or lower middle-class routine office work or shop work. Higher education led in one case to the latter as well, but typically to intermediate or professional vocations. If this relatively predictable pattern occurs, occupational social class can be a tentative starting point, and if patterns relating it to the type of discourse articulated do emerge, this is often accompanied by evidence for certain vocations involving the habituation of tendencies towards doing personal research into issues, or certain vocations providing the possibility of particular discursive resources, as this thesis has found. However, as was found in the case of perhaps the most interesting participant's discourse, there may not be a concordance between social class in terms of a simple occupational type and the possession of certain types and amounts of cultural and linguistic capital and discursive resources. In an increasingly complex and fragmented society this ought not to surprise us and the thesis has found that it is the *engagement* with the issue of medicinal cannabis use that tends to explain why certain participants spoke about medicinal cannabis use in the ways that they did more than any other factors. Participants tended to talk about medicinal cannabis use in ways strongly related to how they *did* medicinal cannabis

use, i.e. how they *engaged* with medicinal cannabis use as a social practice. However, this was underpinned by, and was a mediating factor of, the socially constituted capacity and disposition to habitually use discourse when talking about the issue.

It was also an aim of this thesis to be able to say something about the potential for social change that the participants' discourses, which sometimes contribute to the public discourse or societal Conversation (Gee, 1999) about medicinal cannabis, might hold. It has been argued that, of the 'types' of discourse that this thesis identified, the 'political' and 'heretical' types appear to offer some potential for change, as well as any representations of the issue that emphasize the 'naturalness' of medicinal cannabis use. The rhetorical force of the argument that medicinal cannabis use is efficacious and safe because it is 'natural' and that this is in concordance with, and part of, a broader social mood increasingly inclined towards a questioning of science, technology and 'expertise' (Beck, 1992) has been discussed already in this conclusion. The growing status of this discourse as part of a new 'common sense' (Bourdieu, 1979; 1992) does suggest that discursive constructions of medicinal cannabis use that emphasize such ideas may be convincing to many members of society.

In relation to the 'politicised' and 'heretical' types of medicinal cannabis users' discourse, further consideration of Bourdieu's ideas about the conditions under which orthodox discourses might be challenged might yield some useful conclusions.

> "It is only when the dominated have the material and symbolic means of rejecting the definition of the real that is imposed on them ... that the arbitrary principles of the prevailing classification can appear as such ..." (1979: 169).

The 'politicised' type of medicinal cannabis users' discourse was distinguished from the 'elaborated' type discourse due to its characteristic and explicit recognition of some of the contexts of power as they pertained to the issue of medicinal cannabis use. However, articulations of this type of discourse failed to engage with these contexts critically and most importantly failed to engage critically with the 'no medical value' discourse on medicinal cannabis use. Yet making visible, and therefore possibly subject to contestation, the " ... arbitrary principles of the prevailing classification ..." (Bourdieu, 1979: 169) of orthodox discourse is an important stage of contestation.

One might argue, though, that, on the face of it, only those who articulate what in this thesis has been described as a 'heretical' type of discourse really engage with the 'no medical value' discourse on cannabis in a critical fashion, with the prospect of undermining it to some degree. The problem is that the analysis in this thesis suggests that individuals are less likely to articulate such a discourse unless they possess certain discursive resources and are habituated to engage with personal research; become involved with an organised and politicised group, and participate in the public discourse on the matter. On the basis of this analysis at least, this is far from the majority of medicinal cannabis users.

However, this particular type of discursive confrontation is not necessarily the most advantageous and analysis of the participant in question's account (participant thirty-five) suggests that on some level he knew this. Chapter Eighteen was devoted to his account and the reader will recall that he spoke about how his arguments are often

undermined and denied by being dismissed as merely 'anecdotal'. This relates to Lyotard's (1987) discussion of how scientists question the validity of narratives (or *anecdotes*) on the basis that they are not subject to validation (proof). Narrative knowledge is hence cast as inferior to scientific knowledge, but this is a function of the different 'language games' (Wittgenstein, 1976; Lyotard, 1987) which they comprise. The science 'language game' requires validation; the narrative 'language game' does not. Scientific discourse is therefore able to undercut non-scientific discourse with the rhetorical assertion that it is 'unscientific' because it lacks proof.

The solution may simply be not to 'play' a 'game' that you cannot win. Scientific-medicine, despite its contestation on numerous fronts, and what may be a growing disenchantment among a proportion of the public, maintains its dominant position in the field of health and looks likely to do so in the foreseeable future. It provides the dominant discursive pronouncement on medicinal cannabis use: that it is only of medical value as a starting point for the development of synthesised or extractive and clinically developed medicinal products. However, nowhere did any of the participants explicitly say that they want cannabis recognised as a medicine (even though a small number talk about it using the term 'medicine'). This researcher's view is that, whilst the consumption of cannabis is clearly mediated in discursive ways (with the notion of cannabis as preferable because it is 'natural' as most important of all to most participants), medicinal cannabis users are above all pragmatists. They are people with impairments and / or illnesses, made more problematic by a disabling society, who use cannabis medicinally primarily because it works better than prescribed medicines (Coomber, Oliver and Morris, 2003; Ware *et al.*, 2005) even though its 'naturalness' is an important aspect for the majority of them

as well. What they want is access to legally available and free or reasonably priced cannabis of a predictable strength in terms of T.H.C. content and to know (for many) that it has been produced under safe and controlled conditions (although many participants in this research would prefer it to also be an organic product).

This does not, however, necessitate undermining the dominant notion of what a medicine is and it does not necessitate the involvement of the pharmaceutical industry at all. This simply need involve legal production and supply. The scientific-medical language game (Wittgenstein, 1976; Lyotard, 1987) does not need to be 'played'. Instead, this issue could be approached on compassionate grounds, as it is in Holland and Canada (Coomber, Oliver and Morris, 2003) where those whose illness cannot be treated effectively with conventional medicines and for whom the benefits are considered to outweigh the risks of using cannabis are allowed to consume the substance legally. This type of change in U.K. law would also be in keeping with the sentiments of the House of Lords Selects Committee's report (House of Lords, 1998) which suggested that the government should change the law on compassionate grounds to allow doctors to prescribe cannabis (whole plant) on a named-patient basis as an unlicensed medicine, at least until research into cannabis-based medicines had been completed (see Chapter Two).

As the thesis nears completion (December 2007) this issue appears more pressing than it has been for some time. For the last few years, cannabis has been controlled as a class 'C' substance and the practical outcome of this is that it has been lower down the list of priorities of the police in the U.K. Tony Blair's successor, Gordon Brown, has been reported in the media to be considering the reclassification of cannabis, with

the possibility of returning it to a class 'B' controlled substance once more. If this happens, the penalties for the possession of cannabis and more serious related offences (such as cultivation) may increase and medicinal cannabis users will once again be subject to the increased possibility of criminalisation. The last word on this matter should be given to Grinspoon and Bakalar (1993) who have argued that, once chronically ill and / or disabled people have tried the range of prescribed substances available via scientific-medicine, the individual should have the *right* to use cannabis if it produces more successful management of their symptoms.

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APPENDIX A (Interview schedule)

Interview schedule

Participants to be made aware of:

- what the aims of the research are,

- measures in place to ensure anonymity and confidentiality, during research stage and in publishing,

- why interview is recorded and who will have access to the data,

- the right to refusal at any point.

REMEMBER TO TURN OFF MOBILE PHONE BEFORE TAPING STARTS.

Participant number?

Gender?

Age?

Ethnicity, tick box.

White	Black Caribbean	Black African	Black Other
[]	[]	[]	[]

Indian	Pakistani	Bangladeshi	Chinese	Other Asia
[]	[]	[]	[]	[]

Other
[]

Additional remarks on ethnicity ...

Nature of impairment or illness?

Occupation?

Biographical information (try to keep this brief)

- Where were you born?

- Where did you grow up?

- Can you tell me a bit about your family background?

- What type of education have you had?

- What types of work have you done, if any?

- When and how did you acquire your impairment / illness?

- Do you have a job at the moment?

- Do you have a partner at the moment?

- What other types of relationships are you involved in, e.g. socially?

- Do you have any children?

- What are your accommodation arrangements?

- Do you have any personal assistants who come to your home?

- Do you know any other disabled people / people with illnesses?

- To what degree would you say you are involved with disability / chronic illness groups and / or issues?

Details of respondents cannabis use

- How much do you typically use?

- How often do you use it?

- When do you use it?

- How do you use it, do you eat it, smoke it, or both?

- How do you feel about using cannabis by way of smoking it?

- How do you feel about using cannabis by way of eating it?

- How do you know when you have had an ample or effective dose?

The pathway to therapeutic cannabis use

- What did you think about cannabis prior to your first ever use of it?

- Who and what do you think were the influences on these ideas?

- Do or did you know anyone else who used cannabis either as a medicine or recreationally?

[To explore possible peer group influences]

- Did you use cannabis therapeutically from the start, or did you first use it recreationally? [only once, regularly? needs details]

- Please describe how you became aware of cannabis' therapeutic properties.

[Did someone tell them? media? through some organisation? by way of healthcare? did they use cannabis anyway so found out themselves? some other way?]

- <u>IF participant knows any other disabled people / people with illnesses</u>, do they use cannabis?

- <u>IF participant knows any other disabled people / people with illnesses,</u> what is the history of your relationship with them?

- What were your initial thoughts about cannabis as a medicine?

[Some accounts of therapeutic users relate an initial doubt as to how a 'drug of abuse' can be beneficial. Marginalised members of

society may be even more prone to accepting this prevalent discourse than others.]

- Do you also use cannabis recreationally?

-<u>IF yes to above,</u> how long have you used cannabis recreationally for?

- How long have you used cannabis therapeutically for?

- Please describe your earliest uses of cannabis (when, where, with whom? what it was like?). Obviously I do not need names etc.

- Did you have any problems with the actual use during your early experiences with cannabis? [i.e. unpleasent effects etc]

- What are the effects of cannabis that you experience? [try to get as much detail as possible].

- Do you need to feel what some have described as 'high' in order to obtain the therapeutic benefits that you use cannabis for?

- How, if at all, do you think your use of cannabis has changed between your earliest therapeutic uses and now?

[amount, when used, how often, method of administration]

The therapeutic purpose of using cannabis

- Could you describe the ways that cannabis helps you, in particular how effective do you feel it is for dealing with each of the symptoms for which you use it?

- What were your reasons for wanting to try cannabis as a medicinal substance? [particularly, were they dissatisfied with their prescribed medicine(s), IF RELEVANT]

- If a medicine was legally available which gave you all the physical benefits of cannabis but not the 'high', would you still use cannabis?

[I am trying to examine the importance of the 'high' within the general feeling of well being, and whether they also like to use cannabis or do not]

- How do you think cannabis compares to other medicines you may use, or may have used in terms of effectiveness and drawbacks?

The broad consequences of cannabis use

- What impact, if any, do you feel cannabis' illegality has had on your decision to use it?

- Without giving me names and places, how do you obtain your cannabis?

- What problems, if any, does this present?

- If your current supplier of cannabis changed, or the person who gets it for you could not continue to do so, would you continue to use cannabis?

- To what extent would you go to in order to obtain cannabis?

- What do you think about the prosecutions and attempted prosecution of therapeutic users of cannabis?

- What do you think the legitimate uses of cannabis are?

[Legalisation, decriminalisation, or prescription?]

- What prescribed medicine do you take, if any?

- <u>IF respondent uses any prescribed medicines,</u> does the use of cannabis, in your opinion, cause any problems in relation to your prescribed medicine?

- Have you had <u>any</u> problems because of your use of cannabis?

[Need to address each of the following]

Doctors Nurses Personal assistants

Family

Police Dealers Friends

Others disabled users Cost

Availability

Problems for who gets it (and how does respondent feel about this?)

- How do you think your use of cannabis effects relationships with those who live with / near to you, if at all?

- <u>IF participant has a job at present,</u> does using cannabis effect this in any way, if at all?

- <u>IF participant has children,</u> how do you handle your cannabis use in relation to your children?

- <u>IF participant has a personal assistant,</u> how does your use of cannabis effect your relationship with them

To evaluate the effect on negotiated healthcare

- What types of medical treatment, if any, do you have at present?

- Can you tell me which types of healthcare professionals you have <u>any</u> contact with? [You need to write a list here to ensure all are covered]

LIST:

- For each one of these, can you please tell me whether you have told them about your use of cannabis?

- For those you did not tell, why was this?

- What do you think are the benefits to not telling them?

- What do you think are the problems from not telling them?

- Would you like to be able to tell them?

- For those that you did tell, what was there reaction?

- In hindsight, was it a good idea to tell them?

- What do you think are the problems from telling them?

- What do you think are the benefits from telling them?

Feelings about the current situation

- Do you believe that the prohibition of cannabis for therapeutic uses is simply a consequence of its general prohibition, or do you feel that in some way there is more to it than this?

[I am interested in exploring whether they conceptualise the illegality of cannabis to be used medicinally as simply a consequence of the general prohibition of cannabis, or whether they have some other notion of this. For example, do they view it as a further facet of exclusion?]

- The government and the medical establishment have refused to accept the testimony of disabled people and ill people as to cannabis' therapeutic effectiveness.

What, do you think, are the reasons for this?

[I am interested here in exploring whether, to any degree, they have what we may see as a politicised view of types of knowledge, i.e. that their 'knowledge' of cannabis is denied validity whilst the

prevalent medical discourse is accepted, at least formally. They are denied the role of 'knowers'.]

- If it became apparent that cannabis was never going to be legally available for therapeutic uses, in what way, if at all, would this affect your life / make you feel?

- If cannabis supplies 'dried up' for some period of time, how would this affect you? [talk about short period and long period].

APPENDIX B (Participant categorisation information form)

PhD analysis – participant categorisation information

Respondent #

Family background

Type / level of education

Job(s) / career(s)

Type of accommodation / area lived in

Gender: Male / Female

Age:

Nature of disability or illness:

Used cannabis recreationally prior to therapeutic use? Yes / No

Know other disabled / chronically ill people? Yes / No

Involved with disabled people's / chronic illness groups / issues? Yes / No

How did they first become aware of cannabis' therapeutic properties? [Formative influence on meanings]

.....

.....

.....

APPENDIX C (Table describing characteristics of participant sample)

Participant number	Description of chronic illness and / or impairment	Gender	Ethnicity	Age	Occupational social class	Current / former employment	Highest level of education completed
One	Respiratory and muscular weakness	Male	White Irish	38	Middle middle class	Disabilities equality trainer	Compulsory
Three	Multiple Sclerosis	Female	White British	58	Lower middle class	Bank clerk	Compulsory
Four	Rheumatoid Arthritis	Female	White British	27	Middle middle class	Social worker	Masters degree
Five	Rheumatoid Arthritis	Female	White British	41	Middle middle class	Head of Policy, disability group	Postgraduate diploma
Six	Rheumatoid Arthritis	Female	White Irish	45	Middle middle class	Social worker	Graduate
Nine	Multiple Sclerosis	Female	White British	34	Lower working class	None	Incomplete compulsory education due to illness
Eleven	Multiple Sclerosis	Male	White British	46	Lower middle class	Office work	Compulsory
Thirteen	Multiple Sclerosis	Male	White British	42	Upper middle class	Manager / owner of accountancy firm	Graduate
Fifteen	Arthritis and stroke	Female	White British	61	Lower middle class	Doctor's receptionist	Vocational Further Education
Sixteen	Multiple Sclerosis	Female	White British	43	Middle middle class	Nurse	Vocational training
Seventeen	Multiple Sclerosis	Female	White British	56	Lower middle class	Bank clerk	Compulsory
Eighteen	Orthapaedic problems	Male	White British	50	Middle middle class	Owned antique shop	Graduate
Twenty two	Poly arthritic	Male	White British	39	Upper working class	Car mechanic	Compulsory

Twenty three	Multiple Sclerosis	Female	White British	65	Middle middle class	Nurse	Graduate
Twenty four	Multiple Sclerosis	Male	White British	34	Upper working class	Carpenter	Vocational Further Education
Twenty six	Multiple Sclerosis	Female	White British	38	Middle middle class	Disability group worker	Graduate
Twenty eight	Multiple Sclerosis	Male	White British	41	Upper middle class	Commissioned army officer	Compulsory (public school)
Twenty nine	Multiple Sclerosis	Male	White British	56	Middle middle class	Senior engineer	Compulsory
Thirty	Spinal chord injury	Male	White British	51	Middle middle class	Electronics researcher	Doctoral
Thirty one	Myalgic Encephalopathy	Female	White British	52	Middle middle class	Nurse	Postgraduate diploma
Thirty two	Multiple Sclerosis	Female	White British	43	Middle middle class	Television producer	Graduate
Thirty five	Spondalitis	Male	White British	59	Lower working class	Labouring	Art College
Thirty eight	Fybromyalgia	Female	White British	32	Middle middle class	Disability assistant / qualified BSL signer	Graduate
Thirty nine	Congenital Fibrosis / Arthritis	Female	White British	38	Upper working class	Motorcycle mechanic	Vocational Further Education
Forty one	Spinal Chord Injury	Male	White British	34	Lower working class	Heavy manual	Compulsory
Forty four	Myalgic Encephalopathy	Female	White British	43	Lower middle class	Unqualified languages teacher	Compulsory
Forty five	Fibro Myalgia / Arthritis	Female	White British	49	Lower middle class	Office worker	Compulsory
Forty six	Cerrebellar Ataxia	Male	White British	28	Lower middle class	Officer worker	Compulsory
Forty seven	Arthritis	Female	White British	46	Lower middle class	Clerical work	Compulsory

Forty eight	Irritable Bowel Syndrome (chronic level)	Female	White British	41	Lower middle class	Office worker	Graduate
Forty nine	Multiple Sclerosis	Female	White British	46	Lower middle class	Unqualified legal secretary	Compulsory
Fifty	Multiple Sclerosis	Male	White British	50	Middle middle class	University lecturer	Postgraduate