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Stigma Among California's Medical Marijuana Patients

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Abstract

The enactment of California's Proposition 215 stipulates that patients may use marijuana for medical reasons, provided that it is recommended by a physician. Yet, medical marijuana patients risk being stigmatized for this practice. This paper examines the way in which medical marijuana patients perceive and process stigma, and how it affects their interactions and experiences with others. Eighteen semi-structured interviews of medical marijuana patients were carried out using a semi-structured interview guide. Most patients circumvented their own physicians in obtaining a recommendation to use medicinal marijuana, and also used a host of strategies in order to justify their medical marijuana use to family, friends and colleagues in order to stave off potential stigma. The stigmatization of medical marijuana thus has a profound effect on how patients seek treatment, and whether they seek medical marijuana treatment at all.

Keywords

Medical Marijuana; Stigma; California; Policy; Qualitative; Patients

In 1996 California voters approved Proposition 215, the “Compassionate Use Act,” to protect seriously and terminally ill patients from state-level prosecution for using marijuana as a medical treatment. This enactment reflects gradual norm shifts regarding marijuana's acceptability, at least as a medicinal drug. Proposition 215 stipulates that patients may use marijuana for medical reasons, provided that it is recommended by a physician, who would also be protected from state-level criminal penalties. However, this state law conflicts with federal restrictions on the sale and use of marijuana.

In the U.S., “marihuana” is listed as a Schedule I Controlled Substance of the hallucinogenic class (United States Department of Justice 2007). Schedule I substances are defined by the Drug Enforcement Administration as the most dangerous drugs, with “no currently accepted medical use and a high potential for abuse” and for dependence (United States Department of Justice n.d.). While California was the first state to legalize medical marijuana, 23 U.S.

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states and the District of Columbia have now legalized marijuana for medical use (National Conference of State Legislatures 2014), and several other states have been proposed such legislation. All current state medical marijuana laws require a patient registry or ID card, and all but California's refer to specific medical conditions for which marijuana may be used medically, although the specific conditions vary somewhat by states (National Conference of State Legislatures 2014). In addition to these comprehensive state medical marijuana laws, a few states have approved medical use of low THC, high cannabidiol (CBD) products, typically to treat seizure disorders in children (National Conference of State Legislatures 2014). Many but not all of the comprehensive state medical marijuana laws allow minor children to qualify as patients, although in most cases requiring parental consent and certification by two physicians (Marijuana Policy Project 2014). Finally, in 2012 the states of Washington and Colorado legalized adult recreational use of marijuana, and state-licensed retail marijuana sales, with no need for medical justification. In August of 2013 the Department of Justice advised state attorneys that although marijuana remains a Schedule I controlled substance and therefore illegal, the federal government will defer to state laws legalizing marijuana, while retaining the right to challenge these laws in future (United States Department of Justice 2013). Since then, the states of Alaska and Oregon, as well as the District of Columbia, have also legalized marijuana for adult recreational use, and it is expected that more states will follow suit in the years to come. The heterogeneity of U.S. marijuana laws illustrates the rapidly changing social landscape of marijuana use in the U.S.

Although an estimated 200,000 people in California have become medical marijuana users (Reinarman et al. 2011), debate exists concerning not only the legal status and practical implementation of medical marijuana laws, but also more fundamental debates concerning marijuana's medicinal value. Studies have demonstrated that marijuana can be effective in treating health maladies, including glaucoma, multiple sclerosis, diabetes, and a host of other ailments (Kalant 2001; Iskedejian et al. 2007). Marijuana has also been used to stimulate appetite in the wake of chemotherapy and other health treatments, as well as treat other side effects of these treatments including nausea (Guzman 2003). Other research shows that marijuana is effective in mitigating severe pain (Woolridge et al. 2005; Iskedejian et al. 2006). However, the literature on marijuana also demonstrates that marijuana use may be associated with certain site-specific cancer risks (Sidney et al. 1997; Hashibe et al. 2005), and may cause cognitive impairment, including short term memory loss. There are also links to the onset of depression, anxiety and schizophrenia in some users (Kalant 2004), particularly adolescents (Hall & Degenhardt 2009). Marijuana has also been found to be a risk factor in the development of and increase in psychotic symptoms, as well as incidence of psychosis (Kuepper et al. 2011). Because of the limited available data (Hashibe et al. 2005) including the lack of large population studies and drug trials to date, marijuana's medicinal value and risks cannot yet be fully assessed. This dearth of definitive evidence, along with the uncertain legal status of state medical marijuana laws vis-à-vis federal law, tends to place marijuana in a medical liminal space, neither legitimate nor illegal. These uncertainties in turn have left medical marijuana patients vulnerable to stigma.

With his 1963 work, Stigma: Notes on the Management of Spoiled Identity, Erving Goffman inspired generations of medical anthropologists and sociologists to consider and refine

theories on social interactions labeling and managing non-normative conditions. The expanse and effects of stigma may have far reaching social-psychological effects. As Ahern and colleagues (2007: 189) more recently noted:

> "Stigma is both a social process perpetuated by non-marginalized groups to achieve goals of exclusion and conformity, and a psychosocial process that marginalized groups must navigate and contend with."

Health-related stigma has developed into a burgeoning field of study, particularly in attempting to document its pernicious impacts. Negative health impacts related to stigma have been found, for example, among HIV/AIDS patients (Campbell et al. 2005), obese individuals (Maclean et al. 2009), illicit drug users (Luoma et al. 2014) and those with mental illness (Bolton 2003; Corrigan 2004; Link et al. 1997; Livingston & Boyd 2010; Sirey et al. 2001). Stigmatic conditions that cannot be easily concealed—e.g. obesity—also have an effect on the way people are treated, including teasing (Vaidya 2006), overt discrimination (Stuber, Meyer & Link 2008) and even avoidance and condemnation from others (Rogge et al. 2004). Evidence suggests that people with concealable stigmas often make conscious decisions to hide their stigmatic identity in an effort to escape harm (Corrigan & Matthews 2003). Likewise, those who perceive potential stigma may deny their group status and shun any organization or institution that may indicate the said group status, and may refuse to engage with some institutions that could provide them with health treatment (Corrigan 2004).

For instance, stigma is considered to be "the most formidable obstacle to future progress in the area of mental illness and health" (USDHHS 1999: 29), and it is well documented that perceptions of stigma reduce the utilization of mental health care services (Link et al. 1997; Corrigan 2004; Livingston & Boyd 2010; Mak et al. 2007) and detrimentally impact medical treatment (Sirey et al. 2001; Mak et al. 2007). Sirey and colleagues found that persons with depression were more likely to discontinue treatment (including prescription use) if they perceived stigma from others for their treatment. Similarly, the stigmatizing perceptions of illicit drug users by health care professionals function as a barrier to treatment (Bolton 2003) and negatively affects patient health care outcomes, including length of treatment and overall attrition (Luoma 2014).

Those stigmatized may experience chronic stress (Link et al. 1997; Stuber, Meyer & Link 2008), which may lead to mental and physical health issues related to the stress (Ahern et al. 2007) that manifests as withdrawal and isolation (Link et al. 1997; Stuber, Meyer & Link 2008), thus representing a barrier to recovery (Lloyd 2013). Stigma's public health ramifications have also been found when individuals who are identified with a disease, illness or medical condition are discriminated against by others (Link & Phelan 2006). For example, patients with HIV/AIDS, persons with mental illness, obese individuals, and illicit drug users face varying degrees of stigma and discrimination, which may affect both their mental and physical health as they attempt to navigate through health care systems (Ahern et al. 2007; Campbell et al. 2005; Lloyd 2013; Stuber, Meyer & Link 2008). Illicit drug users and obese individuals, for instance, have been found to face discrimination because their conditions are labeled as "lifestyle choices," and as such, these individuals have been found to receive lesser quality of health care (Luoma et al. 2014; Maclean 2009).

Although to a lesser extent than other illicit drug use, marijuana consumption tends to be stigmatized in the U.S. and more globally (Hathaway 2004). Two recent studies based on interviews with medical marijuana users in Norway (Sandberg 2012) and Canada (Hathaway et al. 2011) suggest that medical marijuana users are actively reclaiming normality and minimizing stigma through redefining acceptable substance use. Nevertheless, little is known of the status of medical marijuana patients and how they may perceive risk, concern or overall stigma of their marijuana use, and how this stigma may affect their health care. The present study explores this shifting landscape from the perspective of medical marijuana patients in one California community.

METHODS

We conducted 18 semi-structured interviews with medical marijuana users in California in 2009. Potential respondents were identified through participation in medical marijuana conferences and gatherings, through references from medical marijuana advocates, from Craigslist, and by snowball referrals.

The majority of respondents lived in the San Francisco Bay Area, including staff and proprietors from three dispensaries located in Oakland and Berkeley, CA. Respondents' ages ranged from 19 to 66 with a median age of 41. Of those interviewed, 13 (72%) were male and 5 (28%) were female, consistent with Reinerman and colleagues' (2011) findings that three-fourths of medical marijuana patients were male. We did not ask respondents to report their race/ethnic identity or employment status. Maladies for which respondents used medical marijuana included migraine headaches, depression, chemotherapy and radiation treatment effects, chronic pain, and asthma, with the majority citing chronic and severe pain. By their own admission these health issues ranged from acute to mild.

Interviews were conducted either in person or by phone by the first author. The semi-structured interview guide was designed to elicit "thick descriptions" (Geertz 1973) of users' accounts of their histories of marijuana use, including reasons for using marijuana as a treatment, as well as their views on the process of obtaining medical marijuana, issues faced as a patient, and perceptions of use as it pertained to their medical condition. We also discussed respondents' medical history as it pertained to medical marijuana use, the relationship and types of interactions with their physician or healthcare provider and their medical marijuana-related interactions with others. The length of interviews ranged from 35 to 75 minutes. All interviews were confidential and digitally recorded for later transcription. All methods were approved by the Institutional Review Board of the Pacific Institute for Research and Evaluation.

One researcher coded all the transcripts and made analytic notations on general patterns, themes and categories, and also extracted illustrative quotes from the interview data (Corbin & Strauss 2008). The coded data and analytic notes were the basis of a quasi-inductive, pattern level analysis that considered the contextual factors of items across all interview data (Denzin 2003), and data were then examined for recurring themes and analyzed contextually. Initial categories from the emergent patterns were modified during the analytic process, and after all data were coded and analyzed, summary and analytical narratives were

created. As part of the analytical process, a second researcher independently identified the themes as well, concurring with the initial conclusions from the overall analysis. The results were then compared and contrasted with findings in existing literature (Patton 2006).

RESULTS

Stigma emerged as a primary and recurring issue as it related to both the process of becoming a medical marijuana user, and remaining one. This stigma meant that patients had to decide if and when to reveal their medical marijuana use, whether others already knew of their medical marijuana use and, finally, whether others would be accepting of their medical marijuana use.

The Perception of Being a Medical Marijuana User

Almost every respondent acknowledged the stereotype that “patients” were viewed by many as simply “stoners” who took advantage of the law. This was the case for those who used marijuana as part of their cancer treatment as well as those who used it for less severe health conditions. Either way, patients suggested that they were almost always mindful about letting people know about their “patient” status.

> There was obviously that kind of negative stigma of using marijuana that I'd be looked upon as kind of an addict or a drug user more than a patient.

The perceived stigma of being a medical marijuana user was profound enough that the majority of respondents never asked their regular physician about the possibility of using marijuana to help treat their health condition, but instead sought entrepreneurial “medical cannabis consultants” and “medical cannabis clinics” in order to obtain a doctor's recommendation and a valid patient ID card. This method, according to the patients, seemed one way to avoid potential embarrassment and stigma with their personal physician.

> Once I did a little research and found out what I needed to know, I bypassed my own doctor and went to one of those places that specialize in that type of stuff. They advertise in the weeklies, so it was easy.

One of the few patients who received a recommendation from a physician conceded that it was not until her second or third round of chemotherapy treatments that she finally discussed the issue with her physician, and the impetus of her discussion was a nurse who initially broached the subject with her, asking whether she had ever thought about using marijuana to assist with the chemotherapy and cancer-related medical issues that had emerged (including sickness and lack of appetite). This patient stated:

> I feel fortunate that my nurse—who was like my guardian angel—brought it up to me as an option, and I'm pretty sure that she brought it up to the doctor too, and then we [the doctor and I] talked about it and I thought, “What the hell, why not?”

Some respondents noted that initially they didn't consider medical marijuana a legitimate treatment option. Although every respondent had previously used marijuana for recreational purposes—sometimes decades earlier, and other times at small social gatherings directly before obtaining their “patient” status—many expressed an initial uncertainty concerning the practical medical uses for marijuana. Moreover, almost all respondents commented that they

thought Proposition 215 was a loophole for recreational users "to score some weed." Because California law allows physician discretion in recommending medical marijuana, most respondents acknowledged that a severe health malady was not required in order to obtain a medical marijuana "card," and that it would probably be easy to lie to a physician in order to acquire a recommendation. Several patients commented on their initial negative view of medical marijuana, often reflecting on their recreational use:

> At the beginning I would say, "Okay, this medical marijuana might be a little bit kind of shady, people just using medical marijuana in the guise of using medical marijuana just to get high, in the guise of feeling sick." So, oh, I have diabetes or high blood pressure, and any kind of disease that the doctors are willing to sign off on, just to get me some marijuana, some weed, and I was thinking it was going to be some shady doctor that's willing to just write you a prescription if you paid the right amount of money, that was kind of the fly-by-night operation kind of thing, something very shady and underhanded.

The observation as described above, and the perceived stigma attached to such a belief system, was enough for some to initially forego using marijuana for medical use. Several respondents waited for months or years before deciding that medical marijuana could potentially benefit their health. For these people, it usually took further research or a trusted friend or medical practitioner to convince them that medicinal marijuana could be beneficial. For others, the timing had to be right due to the potential stigma one faced, particularly in the workplace:

> I worked for many years for my employer, and I was more concerned about them finding out about this; that's why I didn't start treatment sooner. I was concerned about the stigma. My job requires total concentration and focus and I wouldn't want people to think that my marijuana use would interfere with that, or my ability to do that.

Whom to Tell?

Because being a medical marijuana patient could be considered an "invisible stigma," users feared the repercussions of others knowing their "patient" status, but were quick to point out that their fear usually emerged as something precautionary, depending on who might discover their user status. Thus, once they became official "medical marijuana patients," users had to decide which members of their social networks they would tell about their treatment and use. Some patients chose not to tell anyone except a spouse or partner. Others decided it was best not to disclose their use to parents or co-workers. Older patients tended to conceal their user status to almost everybody around them (except for their spouses), and younger patients were more apt to have a network of friends for whom they felt like they could confide in. Younger patients deemed their peer group as more accepting of marijuana use in general than did older patients. Regardless of age, decisions about disclosure appear to have been based on how the patients expected others to perceive them and their marijuana use.

> I won't broadcast it. I've had close friends who would make derogatory remarks about people who smoked and they didn't know I smoked...So, I really don't tell

> people unless it comes up. I don't say, “I’m a pothead” [laughing]. No way. [Why don't you say anything?] Because the people tend to have these negative ideas about marijuana; they seem to have an idea in their head of what a marijuana user is like; what their life is like. I've accomplished a lot in my life; smoking is a big part of it. So, people would be surprised. I guess it's just such a personal thing with me so I guess I don't share it with people because I don't want people to think negatively of me.

Because concealing their marijuana use and treatment was a regular part of their lives, managing their “patient” identities was normalized for the medical marijuana users. Although those closest to the patients already knew of their use, patients said that they could easily conceal their use when they chose not to disclose it to others. Some users likened it to taking “regular” prescription medications:

> I see it the same way as taking any other kind of prescription. I don't tell people, and people don't tell me. I bet there's a whole bunch of people that I know who take something like Prozac but don't announce it. And I don't announce it that I smoke marijuana to feel better. It's pretty simple that way.

While patients indicated that concealing their marijuana use was easily accomplished because they could smoke or ingest the marijuana in privacy, a handful of users noted that on occasion the topic of marijuana would come up in conversation with those who had no idea of their use. This frequently led to situations in which the patients generally remained quiet when others made marijuana-related comments.

> There were a few times when I would be at work or maybe out with work friends for a drink after work and it would come up. Of course, they didn't know I was using marijuana as part of my treatment and someone would make a joke about smoking reefer or they would call someone else a pothead for smoking marijuana and I just thought, “If they only knew.” I thought it was kind of funny, actually.

Stigma and Purchasing Medication

The stigma of marijuana use, for some, also affected where they went to purchase their medical marijuana. Those who were most concerned about stigma tended to select discreet dispensaries where they “could get in and out quickly.” Several patients favored establishments that were “so nondescript that nobody would ever know that the place was a dispensary.” Other patients remarked that they would drive long distances to an accessible dispensary and purchase larger amounts so as not to have to make the trip regularly, because of the fear of others somehow finding out.

> There are places [dispensaries] that are closer to where I live, but I think it's better, at least for me, to go to [dispensary name], which is in [city]. [Why is it better?] Well, it has an incredible selection and the prices are good. I also don't have to worry about running into anyone I know. Plus, they're right off the freeway, and that makes it pretty easy for me when I make the trip.

Justification for Use

In the cases in which patients opened up about their medical marijuana use to others, the patients pointed out marijuana's benefits, thereby justifying their use and neutralizing potential stigma. Nearly every respondent—regardless of whether they experienced a medical condition which might be considered severe or not—strongly espoused marijuana's positive medicinal benefits in statements such as “marijuana gets me out the bed in the morning so I can function” or “before [marijuana use], I was constantly in pain and even bedridden.” Moreover, it was not simply the specific ailment in which marijuana provided relief to the patients. Some patients spoke of enjoying a fuller life because of what marijuana provided them.

> If you look at my life history, and you look at how I've spent my time, I am more engaged now, I am more productive now, I work more now, I’m more active in the community now than I ever have been in my life.

Justifications used to legitimize marijuana's medicinal value included the fact that marijuana was “natural,” in contrast to pills which were deemed synthetic and therefore “unnatural.” Most patients reasoned that even long term use of medical cannabis seemed safe, especially compared to the alternative. They maintained that in contrast to taking pills, long term cannabis use could be maintained with relatively minimal health-related risks. Pills, and the pharmaceutical companies that supplied the pills, were viewed with a certain amount of contempt and cynicism:

> So, I mean, they say, it's [marijuana] addictive, well, what's Prozac? I mean, if you take it every day, aren't you addicted to it? If you can't make it through the day without a medicine, aren't you addicted?

Comparing the “evils” of “big pharma” with what was seen as the seemingly benign and beneficial use of marijuana allowed users to minimize the stigma attached to their medical marijuana “patient” status, and also allowed users to appear normal as compared to others who would take other medicines in dealing with their conditions. This rhetoric also allowed those who revealed their patient status to mitigate the perceived stigma of their medical marijuana use.

Labeling and Stigma

Respondents asserted that considerable misinformation related to marijuana and its many uses reinforces the stigma of marijuana use and medical marijuana patients. Respondents took the stance that even if people were using medical marijuana for recreational purposes, it was better than using other drugs like methamphetamine and cocaine, or even licit drugs like alcohol and tobacco.

> It's sad, it really is. Most people seem to be misinformed, and this includes the lawmakers. They see it as black and white. Marijuana is bad. Drugs are bad. Yet, they have no problem drinking their scotch, smoking cigars. They have no idea how incredibly beneficial cannabis can be. Like I said, it's sad.

Respondents reported mixed feelings about the use of marijuana as both a treatment and a recreational activity, and part of these mixed feelings were tied to perceptions of stigma

related to its recreational uses. Some patients felt that marijuana served as their medication and *only* their medication. As one patient stated, “This is my medicine and I use it to help me. Nothing else, and no more than I need to.” Other patients confided that they engaged in recreational marijuana use, from “time-to-time.” Still others felt that they could use marijuana as both a medicine and for “leisure” and “to chill sometimes.” Patients in this latter category made the argument that even using marijuana as a recreational drug was “probably therapeutic... and probably helping with my stress” and therefore even their recreational use could be identified as “healthy.” Nonetheless, all of the patients were concerned that their marijuana use—whether medicinally or recreationally—would garner them the label as a “stoner” or “pothead” and therefore they tended to conceal their use.

DISCUSSION

Findings demonstrate that the stigma of using medical marijuana may contribute to the undertreatment of those who might benefit from marijuana. This finding concurs with studies showing that perceptions of stigma negatively impact medical treatment (Sirey et al. 2001; Livingston et al. 2011; van Boekel 2013), as well as the utilization of mental health (Link et al. 1997) and substance abuse services (Luoma et al. 2014). Potential patients may postpone or completely forego treatment for mental illness due to perceived stigma (Boton 2003; Corrigan 2004; Mak et al. 2007). Other studies of alcohol abuse treatment (Keyes et al. 2010) and drug abuse treatment (Cunningham et al 1993; Myers, Fakier & Louw 2009) have shown similar effects of stigma on treatment-seeking.

The majority of respondents did not immediately seek marijuana treatment due to the stigma associated with marijuana use, and several patients waited months or years before deciding that marijuana could be a beneficial treatment. Moreover, all of those interviewed commented that they avoided discussing marijuana as treatment with their personal physician unless, in rare cases, their physician or healthcare provider initiated discussion of marijuana as a treatment option.

The stigmatization of medical marijuana patients may thus have negative short and long term health effects, and in cases such as this one may be seen as two-fold: Firstly, patients who perceive stigma may experience chronic stress, which frequently manifests itself in withdrawal and isolation (Link et al. 1997; Stuber, Meyer & Link 2008), and this in turn may lead to a host of health maladies related to the stress (Ahern et al. 2007). Secondly, stigmatization may dissuade potential patients from seeking treatment in which medical marijuana may provide relief; or similarly, those who may most benefit from medical marijuana treatment may seek out an outside physician rather than their own personal physician, who, it can be argued, has a better understanding of their patient's needs. In this way, underutilization of healthcare services by potential medical marijuana patients is analogous to the underutilization of healthcare services and treatment by people with some mental health conditions due to the stigma associated with these conditions (Corrigan 2004; Livingston & Boyd 2010; Mak et al. 2007). Additionally, just as illicit substance users tend to hide their drug use in a health care setting (Kurtz et al. 2005), our research found that respondents were reluctant to discuss medical marijuana treatment with their personal physicians.

A number of the study participants used the term stigma themselves, unprompted by the interviewer. Unlike other scientific words that have markedly different lay meanings (e.g., “theory,” “error,” or “significance;” Somerville & Hassol 2011), the word stigma as used by the study participants appears to be the same as the social science term first fully conceptualized by Goffman (1963). Among the study limitations are a relatively small number of participants, a higher proportion of college-educated respondents than might be found in the general population of marijuana users, and al lack of ethnic diversity. Moreover, we interviewed only patients and did not conduct parallel interviews with physicians. However, our analysis of the interview transcripts suggests that these patients’ perceptions of stigma were based on their assessment of how marijuana is viewed within their social contexts, through the cumulative effect of everyday commentary on marijuana use by people around them, together with their own personal histories as “recreational” marijuana users. For instance, younger users tended to disclose their patient status to a wider group of people than older users, who were more apt to conceal their patient status to all except for their most inner circle.

Considering the moral ambiguities expressed regarding different kinds of marijuana consumption, it may be said that medical marijuana patients consider that there are two marijuanas: one is “cannabis,” a medicine and thus a licit substance, and the other is “pot” or “weed,” a drug and thus an illicit substance. Analogously, there are two kinds of consumers: one is a patient, a legitimate identity, one is a drug user, an illegitimate identity. These two substances and these two identities slide over each other in uncomfortable ways. For example, all of those interviewed professed to being at one time “drug users,” which may make it even harder for them to disambiguate the two identities than someone who was naïve to the substance altogether. Furthermore, marijuana use is generally criminalized on the one hand, yet increasingly normalized on the other (Hathaway, Comeau & Erickson 2011; Lloyd 2013). This contradiction has further ambiguated the social status of marijuana and marijuana consumers. Further complicating matters, state recognition of marijuana as a recreational drug may undo the gains of the hard-fought battles for recognition of marijuana as a medicinal substance, undermining the legitimacy of “cannabis” and marijuana “patients,” and reducing all consumers to “drug users” again. These uncertainties may have the effect of reducing the likelihood that individuals will seek, and that healthcare providers will recommend, marijuana as a medical treatment.

The growing number of ballot initiatives across the United States proposing expanded access to marijuana for both medicinal and recreational use may both reflect and to some extent drive a shift in societal norms regarding marijuana and marijuana users, just as changes in policies regarding tobacco use both reflected and impacted societal norms about cigarettes and cigarette smokers (Satterlund, Lee & Moore 2012). Increasingly restrictive tobacco policies have come hand in hand with increasing stigmatization of tobacco use and users (Stuber, Galea & Link 2008), while increasingly liberal marijuana policies appear to reflect the stigma associated with marijuana and its consumers. Conducting additional research on medical as well as cultural, psychological, and other positive and negative repercussions of marijuana use is essential in order for citizens and lawmakers to make reasoned decisions regarding additional legal institutionalization of marijuana for either medical or recreational use.

Finally, attitudes of physicians and other health professionals toward medical marijuana could be further investigated, analyzing whether the attitudes impede collaboration and communication between physician and patient. For instance, negative attitudes of physicians and other health professionals may have a detrimental impact on patients, including their treatment outcomes. This study underscores the need for further research as well as updating the training and education of physicians and healthcare providers in order to expand the knowledge and skill base as it relates to medical marijuana treatment.

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