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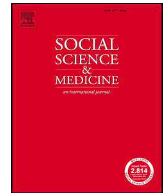

Rhetorical and regulatory boundary-work: The case of medical cannabis policy-making in Israel

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ABSTRACT

Recent studies have explored how professionals draw boundaries to reach workable solutions in conflictual and contested areas. Yet they neglected to explore the relationships and dynamics between how boundaries are demarcated in rhetoric and in policy. This article examines these relationships empirically through the case of medical cannabis (MC) policy-making in Israel. Drawing on interviews with key stakeholders in the MC policy field, formal policy documents, and observations of MC conferences, this article sheds light on the dynamics between rhetorical boundary-work and what we term *regulatory boundary-work*, namely setting rules and regulations to demarcate boundaries in actual practice. Results show how certain definitions of and rationales for a discursive separation between "medical" and "recreational" cannabis and between cannabis "medicalization" and "legalization" prevailed and were translated into formal policy, as well as how stakeholders' reactions to this boundary-work produced policy changes and the shifting of boundaries. Both rhetorical and regulatory boundary-works emerge as ongoing contested processes of negotiation, which are linked in a pattern of reciprocal influence. These processes are dominated by certain actors who have greater power to determine how and why specific boundaries should be drawn instead of others.

1. Introduction

The term "boundary-work" was coined by Thomas Gieryn (1983) to capture how scientists demarcate discursive or ideological boundaries between science and non-science to maintain an image of expertise, authority and credibility, thereby eliciting financial and political backing. However, the boundary-work concept has since been used to explain a variety of processes and phenomena within and without science (Lamont and Molnar, 2002; Pachucki et al., 2007). Indeed, boundary demarcation is now recognized as a pervasive strategy people use for diverse purposes.

Several studies have shown how professionals draw boundaries to reach workable solutions in contested or conflictual areas (Brosnan et al., 2013; Duke, 2016; Ehrich et al., 2006; Hallowell et al., 2009; Wainwright et al., 2006). For example, Wainwright et al. (2006) showed how stem cell scientists presented themselves as ethical by drawing lines around which sources of embryos they agreed to work with, as well as by deferring to regulatory frameworks. Others found that professionals deflect responsibility onto regulatory frameworks and an abstract notion of "society" in contentious and highly regulated fields (Brosnan et al., 2013; Kerr et al., 1997). Thus "displacement of responsibility" has been recognized as a boundary-work repertoire, i.e., a recurrent pattern of how boundary-work is employed (Frith et al., 2011). Still, regulation does not always map neatly onto individuals' use of boundary-work as some individuals may draw less or more permissive boundaries in their own work/lives than those of the relevant regulatory framework (Brosnan et al., 2013). Nonetheless, the actual relationships and dynamics between boundary demarcation in rhetoric and in policy remain largely underexplored.

This article examines these dynamics empirically through the case of medical cannabis (MC) policy-making in Israel. Using cannabis for medical purposes is a highly contentious issue, replete with scientific uncertainties and ethical ambiguities; the formation of related policies is an ongoing process unfolding before our eyes in many states and

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countries around the world (Abuhasira et al., 2018; Philipsen et al., 2014; Zarhin et al., 2017). In most places where MC programs have been established recreational use of cannabis remains illicit, so policymakers must decide whether and how to draw boundaries between what are often termed "medical" and "recreational" cannabis. This is not an easy task as these boundaries are blurred (Bostwick, 2012). Thus, MC serves as a good case study to explore how stakeholders demarcate boundaries in both rhetoric and policy in contested and conflictual areas.

Reviewing existing MC programs reveals that some programs draw clear and firm boundaries between legitimate and illegitimate uses of cannabis; others do so less adamantly. For example, MC programs in California and Canada have been criticized for making MC so easy to obtain that they produced *de facto* legalization of all types of cannabis usage (Fischer et al., 2015; Hall, 2015). Williams et al. (2016) have found that programs with a stronger medical orientation have fewer enrollees than nonmedical programs, and argued that states with medicalized programs are less likely than older nonmedical programs to legalize recreational use.

Yet whereas some studies have discussed the relationship between medical and recreational cannabis use (Cerdá et al., 2012; Chu, 2014; Johnson et al., 2017; Pacula et al., 2015; Sznitman, 2017), to our knowledge no study has examined how stakeholders address their boundaries in MC policy formation. We draw on the Israeli case of MC policy-making to explore the following questions: (1) how and why do stakeholders demarcate boundaries between medical and recreational cannabis? (2) Is this boundary-work translated into policy, and if so, how? (3) How do stakeholders react to the ways boundaries are drawn and maintained in formal policy and actual practice?

1.1. The Israeli context

Israel has run a MC program since the late 1990s, where the Ministry of Health (MoH) is responsible for MC regulation, including granting licenses to patients, growers, and suppliers. Since then, demand for MC has increased steeply, leading to a rise in the number of license applications (approximately 300 a day according to a MoH representative, Welfare committee, January 9, 2017) and licensed patients (approximately 28,000 in March 2017 according to a MoH representative, Medicalization of Cannabis conference, 2017). This expansion pressured policymakers to upgrade MC regulation and monitoring in Israel.

The legal status of cannabis in Israel is contradictory. Israeli law follows the UN Single Convention on Narcotic Drugs (UN, 1961) and classifies cannabis as an illicit drug with no medicinal value. However, the government has issued three resolutions acknowledging its medicinal effects. Hence, cannabis remains a liminal substance: a legitimate medicinal alternative and an illegitimate dangerous drug. Responsibility for setting the boundaries between the two was assigned to the MoH, which established the Israeli Medical Cannabis Agency (IMCA). This agency has exclusive authority to authorize licenses for cultivating, producing, dispensing, and researching, as well as using, cannabis. Most physicians cannot authorize patients' licenses, but rather recommend that the IMCA issue these licenses to specific patients. Next we draw on a variety of sources showing how and why the IMCA, and other MC policy stakeholders, engage in boundary-work in both rhetoric and practice.

2. Data and methods

2.1. Data collection

Data collection began after the research received ethical approval from the Research Ethics Committee at the University of Haifa (#357/15). Between December 2016 and September 2017, the first author (D.Z.) and a trained interviewer conducted interviews with 21 individuals: physicians (n = 8), patient activists (n = 6), past and present government officials in the MC field (n = 3), a Member of Knesset (n = 1), a central figure in the Israeli Pharmacist Association (n = 1), and two individuals at the Israeli Anti-Drug Authority (n = 2). Of these, 18 interviewees were identified as key stakeholders because of their participation in Knesset committees on MC policies. Three more physicians were interviewed because they had previous experience with recommending MC for patients or directly granting MC licenses to patients.

Fourteen interviewees were interviewed face-to-face at workplaces or coffee shops; seven chose to be interviewed by phone. Interviews lasted 40–120 min and each provided rich and detailed data. Prior to interviews participants were informed of the overarching research goal (to understand the MC policy process in Israel) as well as the voluntary nature of the interview. Participants signed informed consent forms (face-to-face interviews) or gave oral consent (phone interviews) before interviews. Interviewees were guaranteed confidentiality and anonymity. As the number of persons actively involved in the MC field in Israel is comparatively small, painstaking measures had to be taken to protect their privacy. We removed all identifiers such as socio-demographic characteristics or details of any affiliation with organizations or institutions. We avoided using pseudonyms, which were judged ineffective in disguising participants' identities (Morse and Coulehan, 2015, 151), and instead referred to participants by their social location in the field of MC (such as patient activists, MoH representatives, and physicians).

Furthermore, we analyzed protocols of Knesset Committees dealing with MC regulation. The Knesset is the nation's legislative authority and has played a major role in shaping the discourse around MC and its policies. Individuals and groups with a stake in an upcoming topic on the agenda can participate in Knesset committees. The public can access protocols, allowing researchers to explore the diverse stakeholders' voices and perspectives. We searched the Knesset website (http://main.knesset.gov.il/Activity/committees/Pages/AllCommitteeProtocols.aspx), entering the words "cannabis," "marijuana" and "hashish" in the topics of committee discussions from 1980 to November 2016. Of the 26 results, 21 focused on MC. Document analysis began in December 2016. Note that these data reflect the political and public discourse around MC, but are limited in their excluding stakeholders who did not participate in these committees.

Our data also include all documents available on the IMCA website (http://www.health.gov.il/UnitsOffice/HD/cannabis/Pages/default.aspx). These data include government resolutions on MC, and other formal policy documents such as Form 106 which lists diagnoses approved by the MoH as MC indications and the most comprehensive MC document produced by Israeli policymakers to date entitled "Cannabis for medicinal use: An information booklet and medical guidelines" (also known as "The Green Book"). Lastly, the first author attended three international MC conferences that took place in Israel, as well as a lecture by the MoH at the National Institute for Health Policy. The data compiled included materials in both Hebrew and English.

2.2. Data analysis

Data from all of these sources were uploaded to ATLAS.ti (a qualitative data analyses program) and were analyzed following the principles of constructivist grounded theory method, including systematic conceptualization, constant comparisons, coding and memo-writing (Charmaz, 2006; Morse et al., 2009). Coding was inductive and exploratory, aiming to generate theory. In the initial coding stage all data enjoyed equal consideration and all theoretical possibilities were explored. Here a variety of codes emerged, describing how stakeholders defined and distinguished "medical" from "recreational" cannabis, as well as "medicalization" and "legalization" (all emerged as *in vivo* codes, meaning they were taken directly from respondents' accounts (Charmaz, 2006, 92)). The later stages of coding (focused and

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