FORTHCOMING IN ADMINSTRATIVE SCIENCE QUARTERLY

Waiting to Inhale: Reducing Stigma in the Medical Cannabis Industry

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Abstract

When an entire industry category is predicated on a product or activity that's very nature is stigmatized—that is, is subject to "core" stigma—the actors trying to establish the stigmatized industry struggle to gain the resources they need to survive and grow. In this study we take an inductive approach to understanding how actors in the core-stigmatized medical cannabis industry collectively attempted to increase audience support and reduce their industry category's stigma by creating a moral public image, even as they individually acted in ways that violated this image in order to acquire resources necessary for survival. We found that to navigate these tensions category members employed a phased process that that employs different relational spaces, and that category emergence is a central tool in the stigma reduction process. We also identified ways in which category emergence in core-stigmatized categories differs from the process for non-stigmatized categories.

"How selfish soever man may be supposed, there are evidently some principles in his nature, which interest in him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it, except the pleasure of seeing it" –Adam Smith, 1854

Imagine starting a business where the federal government has declared your product or service illegal; banks won't let you open a checking account; you cannot deduct your business expenses or pay your taxes through conventional means; you are forced to pay your employees in cash; your friends and neighbors look at you with suspicion; and many of your customers do not want to admit they use your product or service. These are the sorts of things that can happen (Hudson & Okhuysen, 2009; Kovaleski, 2014; Voss, 2015) when an entire industry category is predicated on a product or activity that is subject to "core" stigma (Hudson, 2008).

Core stigma is a "a vilifying label that contaminates a group of similar peers" (Vergne, 2012: 1028), and category-based core stigmas are harmful stereotypes about firms that share similar devalued or discredited attributes that overwhelm perceptions of any positive attributes that individual firms may possess (Devers, Dewett, Mishina & Belsito, 2009). Core stigmas are difficult to remove because they are tied to "core routines, core outputs, and/or core customers" (Hudson, 2008: 252) such as the violence involved in mixed martial arts (Helms & Patterson, 2014), the weapons sold by the arms industry (Vergne, 2012), and the homosexual men served by gay bath houses (Hudson & Okhuysen, 2009). Additionally, because core stigma relates to category members' central attributes and identities (Goffman, 1963), exiting the category is often not an option, as doing so would require firms abandon their reason for being. Furthermore, because the stigma is attached to the overall category, firms can take individual actions to cope with the stigma, but find it difficult to change the generalized perceptions of the entire category by themselves. How then, is a category's core stigma reduced?

Category stigma reduction[1] is a topic that has received limited attention in the organizational stigma literature (Adams, 2012). Instead, scholars have typically focused on how firms in stigmatized industries act independently to manage the effects of the stigma on their

[1] Although the eventual goal is to completely remove, or destigmatize, the category, assessing whether this has occurred can be complex, as we will discuss. Thus, to be conservative we use the terms "reduce" and "reduction" rather than "remove" or "destigmatize."

individual firms through practices such as shielding, straddling or coopting (e.g., Helms & Patterson, 2014; Hudson & Okhuysen, 2009; Voss, 2015). They shield to protect important stakeholders from the negative effects of the stigma (Hudson & Okhuysen, 2009), they straddle multiple categories to divert attention away from the stigmatized category (Vergne, 2012; Voss, 2015), and they coopt negative labels to strategically use their stigma to galvanize support from those with similar values (Helms & Patterson, 2014). However, this stream of research has not considered the category-level implications of organizations' independent actions, and whether their efforts to manage stigma at the organization level reduce, perpetuate or even worsen the overall category's stigma.

A few studies that have begun to explore how a category's core stigma can be reduced suggest that it calls for more coordinated efforts than have typically been considered. They found that collective actions such as professionalization, political activism and certification by reputable or high-status actors can reduce a category's stigma (Adams, 2012; Clair et al., 2016; Warren, 1980). Warren (1980: 67) also suggested that collectives can engage in a process of "aristocratization" where "deviant collectivities frame themselves as a chosen people" by engaging in some form of moral heroism that makes them superior to "normals;" for example by defining themselves as the "non-drinking alcoholic" or "clean dope fiend."

Most of these studies, with a few exceptions (e.g., Adams, 2012), focus on stigmas affecting groups of individuals instead of organizations. As such, they identify useful but isolated tactics for reducing stigma that may not be generalizable to organizational categories. Thus, they offer limited insights into the overall process of reducing category level stigma, the more macro effects of individual organizations' efforts to obtain the resources, and the contestation that shapes the process. They also do not focus on the relationships between the category's and individual firms' rhetoric and actions (Pfeffer, 1981). Consequently, we have a limited understanding of the process through which an industry category's core stigma can be reduced. This is important, because stigma can thwart growth, and failure to understand these category-level processes can lead to ineffectual efforts to reduce category stigma.

To understand the core stigma reduction process, we conducted an inductive study of the medical cannabis industry, whose central practices, products and providers are stigmatized. Given our limited understanding of the category-level stigma reduction process and our interest in theory building, we employed a qualitative, grounded theory (Charmaz, 2006; Strauss & Corbin, 2008) and process analysis (Langley, 1999) approach. We used archival, direct observation, and interview data to understand the sources of the industry's stigma and the process through which a variety of industry members, both collectively and individually, attempted to destigmatize it. We also considered firms' clandestine attempts to acquire resources while simultaneously striving to change the public's perceptions of their industry. We found that the process unfolded across different phases, and employed distinct "relational spaces" (Mair & Hehenberger, 2014). These involved a combination of collective "front stage" activities (Goffman, 1959) associated with *initiating a moral agenda*, engaging in *moral prototyping* and *morality infusion*; "backstage" activities that were necessary for the survival of individual organizations but conflicted with front-stage presentations; and the unintentionally observable "side-stage" negotiations that resulted from various factions' differing agendas and interests.

Our study makes two primary contributions. First, we add to the stigma literature by presenting a process model of category-level core stigma reduction that transpires in multiple phases and across distinct relational spaces. We do so by looking at efforts to remove as opposed to manage a deeply engrained stigma. We illustrate the coordinated but conflicted nature of this process, how resource considerations lead firms to continue privately engaging in stigmatized behaviors that are publicly denounced, and the separation required for this to occur.

Second, we identify how category emergence (Durand & Khaire, 2017) was employed as a tool to integrate the actions of industry actors and facilitate the stigma reduction process. Category emergence was necessary to change the association that audiences made between the stigmatized product and broader societal values. To do this, morality was used as a tool, thus appealing to that "nature of man [sic]"—as described in the opening quote by Adam Smith—that makes him interested in the fortunes of others. We also contribute to our understanding of

category emergence by highlighting how the process differs when the category's core product is stigmatized. Finally, we contribute to the literature on strategic entrepreneurship by illustrating how new industries can overcome the resistance they may face.

THEORETICAL BACKGROUND

Core stigma is a categorical phenomenon. Much of what we know about stigma comes from the seminal work of Goffman (1963), who focused on individuals tainted because characteristics such as their physical attributes, race, religion or national origin deviated from societal perceptions of what is considered "normal." Goffman conceptualized stigma as a social categorization process, positing that as we encounter strangers we immediately try to categorize them based on our perceptions of their attributes and social identities. "Culturally given categories are present even at a preconscious level and provide people with a means of making shorthand decisions that free them to attend to other matters" (Link & Phelan, 2001: 369).

As with stigmas based on individuals' characteristics, firms can be stigmatized simply because of their similarities to other devalued firms (Vergne, 2012). In other words, the categorical nature of stigma "links an organization to a negatively evaluated category of organizations collectively perceived by a specific stakeholder group as having values that are expressly counter to its own" (Devers, et al., 2009: 157). Audiences' negative perceptions of a category will often dominate any positive perceptions (Voss, 2015), and they are motivated to distance themselves from stigmatized industry categories to avoid having the stigma transfer to themselves (Vergne, 2012). Furthermore, audiences often disidentify from (Elsbach & Bhattacharya 2001), and impose sanctions on organizations in stigmatized categories (Sutton & Callahan 1987), making it difficult for them to hire employees, attract customers, secure financing (Deephouse & Suchman, 2008; Hudson, 2008; Vergne, 2012; Voss, 2015), and gain or maintain legitimacy (Piazza & Perretti, 2015). Ultimately, stigma can stifle markets (Anteby, 2010; Chan, 2009; Livne, 2014), making it important for these firms to confront the stigma. Below, we consider how firms and industry categories have contended with core stigma.

Organizational Responses to Stigma

Prior research on organizational stigma suggests organizations experience either "core" or "event" stigma (Hudson, 2008), where event stigma results from negative social evaluations based on "some anomalous or episodic negative event" (Hudson, 2008: 253), rather than the organization's core characteristics. Examples of characteristics that trigger event stigma include bankruptcies (Sutton & Callahan, 1987), tree-spikings by environmental activists (Elsbach & Sutton, 1992), homelessness at the Port Authority of New York and New Jersey (Dutton & Dukerich, 1991), and product recalls (Zavyalova, Pfarrer, Reger & Shapiro, 2012). Because event stigma is related to a specific infraction, organizations can remove it by decoupling the illegitimate actions of specific actors within the organization from its more legitimate core (Elsbach & Sutton, 1992). Through decoupling, an organization can "credibly claim that the offending part acted without the consent or knowledge of the rest of the organization," allowing the organization to "redraw its boundaries to exclude the offending part(s)" (Devers, et al., 2009: 158). In this way, firms can deflect attention away from (Zavyalova, et al., 2012), justify (Elsbach & Sutton, 1992), or accept partial responsibility for their actions (Dutton & Dukerich, 1991; Sutton & Callahan, 1987). However, decoupling has its limitations, as to be effective units within the organization must be loosely coupled (Elsbach & Sutton, 1992).

Stigma reduction is more difficult for core-stigmatized organizations. Core stigma is identity-based, and calls into question central characteristics of the organization (Hudson, 2008). Examples include gay bathhouses (Hudson & Okhuysen, 2009), arms dealers (Vergne, 2012), brothels (Wolfe & Blithe, 2015), and pornography producers (Voss, 2015). Since the stigmatized attributes are core to the firm's identity and purpose, they are tightly coupled, making decoupling largely unavailable for reducing stigma. Decoupling would require eliminating its key attributes, and the organization would cease to exist (Hudson & Okhuysen; 2009). As such, management research has primarily focused on how core-stigmatized organizations cope with their stigma.

To cope with core stigma, Hudson and Okhuysen (2009) illustrated how gay bathhouses employed shielding and concealing strategies—organizational survival efforts centered on safeguarding resource-providing audiences such as customers and suppliers from stigma transfer.

Bathhouses picked isolated locations, sourced suppliers from their personal networks, provided customers with discreet membership cards, and hid the true nature of what they did under the guise of "gym" activities. Similarly, Wolfe and Blithe (2015) found that brothels concealed themselves from disapproving audiences, while selectively revealing parts of themselves to attract customers.

Organizations have also coped with stigma by straddling stigmatized and non-stigmatized categories (Vergne, 2012), or even exiting the stigmatized category altogether when the organization has business interests in multiple categories (Piazza & Perretti, 2015). Category straddling can divert stakeholders' attention to the organizations' more legitimate practices. For example, adult entertainment companies *Playboy* and *Hustler* increased their social acceptance by diversifying into more mainstream activities; they opened nightclubs, published magazines on the topics of video games and photography, hired respected writers for their lifestyle magazines, and provided funding for scientific research on sexuality (Voss, 2015).

Co-optation, where organizations use the stigma in beneficial ways, seems to be one of the few theorized options for reducing core stigma. Helms and Patterson (2014) showed how mixed-martial arts (MMA) firms used stigmatizing labels to draw attention to themselves and build support among critical audiences. Once they built support, they altered their offensive activities to encourage support from additional audiences (Helms & Patterson, 2014). Similarly, Hampel and Tracey (2016) demonstrated the utility of cooptation in examining the history of the Thomas Cook travel agency, which disrupted the travel industry by offering services to the masses at a time when travel was primarily the province of the upper classes. Societal elites rejected this innovation, but were repudiated by the agency. Hampel and Tracey noted, "Cook's apparent aim was to portray his critics as selfish elitists who held society back by wanting to prevent others benefitting from the advantages of travel" (2016: 25). As the firm grew, it changed its approach to one of cooptation, enticing its stigmatizers into becoming supporters by offering services (such as international news) that appealed them.

In summary, much of the research on core-stigmatized organizations has considered how

they act in isolation to cope with the effects of stigma on their individual firms, and has given limited attention to the collective actions that are necessary for reducing their category's stigma. Below, we examine the scant literature on reducing category stigma.

Managing Stigma at the Category Level

Organizational categories are conceptual boundaries that allow audiences to cluster organizations by labeling them according to common attributes, and to aggregate specific attributes into more generic classification systems (Fligstein, 2001; Khaire & Wadhwani, 2010; Tsoukas & Chia, 2002). These categories can be based on attributes such as the markets in which organizations participate (Granqvist, Grodal & Wooley, 2013), industry membership (Piazza & Perretti, 2015) or product offerings (Lounsbury & Rao, 2004). Categories allow for judgments about the member organizations' value and worth (Vergne & Wry, 2014); if the member firms are devalued, the result is a stigmatized category.

Given that core stigma affects an entire organizational category, we need category-level theory that helps us understand how to address it. Organization-level approaches to stigma management are possible when firms remain sufficiently small that their immediate networks can provide needed resources (Hudson & Okhuysen, 2009). The literature's current focus on coping behaviors does not recognize the tensions between the actions individual firms take to meet their immediate resource needs, and the category's goal to create shared meaning systems and collective identities that will sustain its long-term viability (DiMaggio, 1988). This oversight is in part because when stigma research moved from the individual to the organizational level, scholars largely stopped treating core stigma as a category-level construct and focused only on its organization-level effects (Vergne, 2012). This is why Piazza and Perretti have called for greater attention to the role of "field-level processes of stigmatization" (2015: 739).

As we will discuss in our findings, part of the process for reducing a category's stigma can involve establishing a new category. The categories literature provides evidence for how actors can manipulate materials (e.g., physical artifacts, roles and practices), symbols and rhetoric to alter categorical boundaries and the cognitive associations that audiences have with

particular categorical attributes, and to establish new categories. Durand and Khaire (2017) identified two different ways that new categories are formed: category emergence and category creation. Category emergence is generally initiated by peripheral actors willing to upend the existing order to introduce new artifacts and roles that are not part of the current category system. These material shifts precede a change in the labels and rhetoric that delineate the criteria for category membership, and the legitimacy of these criteria have to be explicated and defended. Some examples include the emergence of the nouvelle cuisine (Rao, Monin & Durand, 2005) and minivan categories (Rosa, Porac, Runser-Spanjol, & Saxon, 1999).

In contrast, category creation is primarily cognitive, where central or high-status actors take characteristics within an existing category and redefine them. Further, rather than the material changes preceding labeling, as in category emergence, the labeling precedes material changes, and the legitimacy of the category comes from the status of the actors making the change. For example, by creating a new category for “light cigarettes” (Hsu & Grodal, 2015: 28), manufacturers aimed to convince users that the product was safer than “full body” cigarettes, even though there were few material differences between the two. Category creators also tend to suppress attributes that are either devalued (Hsu & Grodal, 2015) or contradictory to their overall narratives (Carroll & Swaminathan, 2000). If the process is successful, the proponents of the new category create strategic advantages for themselves.

Actors start with a positive reference point in both category creation and category emergence, as the preexisting category they compare the new category to is legitimate. Thus, these processes do not account for the ways categories form around stigmatized attributes, or how organizations can create a positive category based on negative core attributes. Further, this literature provides limited insights into the process involved in reducing the stigma of contested categories, particularly when the stigmatized category is itself not well-established.

Adams (2012) considered organizational tactics for reducing category stigma. He conducted a comparative historical analysis of the plastic surgery and tattoo industries, and found that the plastic surgery industry established collective organizations to define the boundaries of

their field, and that destigmatization occurred when the major medical associations began recognizing their industry association. He also found that the tattoo industry attempted to remove its stigma by redefining the meanings of its practices and attempting to recast its core product as art. However, Adams concluded that the tattoo industry's "level of internal competition and lack of organization hampers the ability of the industry as a whole to effectively reframe the image of tattooing and refocus attention away from the more stigmatized elements of the industry" (Adams, 2012: 158). This finding hints at the tension between the goals of the collective and actions of individual organizations, but it leaves this tension unexplored. Thus, while Adams's (2012) study provides a useful starting point for exploring issues related to reducing category stigma, it leaves unanswered the nature of the relationship between category and organization-level actions as the process unfolds, and the actual process through which stigma reduction occurs. Also unexplored is the role of individual firm survival and resource needs in the process (neither industry was ever illegal), and the internal conflict inherent in stigma reduction.

Our goal is to build theory that explains the process of reducing an industry category's stigma. While "firms have greater capacity for action when standing together than when remaining apart" (Voss, 2015: 128), these actions can also create tensions as firms attend to their individual needs.

METHODS

Research Context

The cannabis plant (also known as marijuana or marihuana) has had a long and controversial history. Reports suggest that cannabis was grown in China at least since 4,000 B.C., and was used for ailments such as constipation, rheumatic pains, malaria and "female disorders" (Grinspoon, 2005). Cannabis was also used medicinally in the United States, and was available both with and without a prescription (Snyder, 1970). To understand the stigma reduction process, it is important to first understand how cannabis became stigmatized.

In 1930 President Hoover created the Federal Bureau of Narcotics (FBN) (subsequently renamed the Drug Enforcement Agency) and appointed Harry J. Anslinger to lead the agency.

Anslinger committed himself to eradicating narcotics, which for him included cannabis. He reconstructed the meaning of the word *marijuana,* suggesting that among ancient Aztecs it meant "captured prisoner" or "addict," contributing to the onset of cannabis's stigma. He also circulated fabricated stories of immigrants—under the influence of cannabis—engaging in violence, promiscuity and homosexuality. He used his influence to place newspaper stories that alluded to the users' demographics and the link between cannabis use and violence. This all led to the emergence of various stigmatizing labels, from "killer weed" to "killer of motivation" (Geluardi, 2010). Table 1 provides a timeline of the labels associated with cannabis; the events crucial in initiating the phases of our model are noted in gray.

[Insert Table 1 about here]

Legislation around cannabis also changed. First, the 1937 Marijuana Tax Act prohibitively taxed cannabis to try and make it publicly unavailable. Then, despite—or perhaps, because of—growing marijuana use in the 1960's, in 1970 the Controlled Substances Act classified cannabis as a Schedule I drug, defined as "substances, or chemicals…with no currently accepted medical use and a high potential for abuse. Schedule I drugs are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence" (Drug Enforcement Agency, n.d.). These legislative actions contributed to cannabis's stigma, and limited the prospects for using cannabis as medicine, since doctors cannot prescribe Schedule I drugs, and scientists have great difficulty accessing them for research studies.

Nevertheless, in the 1990s a new industry emerged in the United States around the medical use of cannabis. San Francisco, California legalized cannabis in 1991 and then the state of California legalized cannabis in 1996. After these events, medical cannabis dispensaries increasingly became a part of the California landscape. In that same decade, four other states legalized medical cannabis (Alaska, Oregon, Washington and Maine), and many more followed.

Two critical problems for the industry are access to banking and tax regulations. Because cannabis is federally illegal, banks that do business with cannabis-related businesses are subject to federal punishment. "It is illegal to aid and abet the manufacture, distribution, or dispensing of

marijuana. It is illegal to conspire to manufacture, distribute, or dispense marijuana" (Hill, 2015: 10). Thus, providing a checking account or loan to firms growing or selling cannabis, or accepting their deposits—even in states that have legalized cannabis—can result in federal sanctions under the Money Laundering Control Act. This banking climate created a number of difficulties. First, dispensaries' transactions needed to be predominantly cash-based, burdening them with managing and protecting their cash. In addition, traditionally mundane tasks such as paying employees, vendors and taxes assumed great significance. For example, it is not uncommon for entrepreneurs to pay their taxes in person with stacks of cash, and to use "decoys" when transporting large amounts of cash to confuse would-be robbers (Pierson, 2014). Furthermore, without bank lending, many entrepreneurs have had to rely on their personal funds or expensive short-term loans from individuals for working capital (Kovaleski, 2014).

Firms in the industry also experience major challenges in determining their tax liabilities. Under Section 280E of the federal tax code, "No deduction or credit shall be allowed for any amount paid or incurred during the taxable year in carrying on any trade or business if such trade or business consists of trafficking in controlled substances" (Legal Information Institute, 2015). This means that firms in this industry could have an effective tax rate of between 60 and 90 percent if they cannot deduct business expenses (McCoy, 2014).

Overall, the history of cannabis in the United States is a contentious one, where public perceptions have followed the pendulum swing from acceptability to marginalization and slowly back towards acceptability. The medical cannabis industry is an "extreme situation" (Eisenhardt, 1989: 537) of a core-stigmatized industry category seeking to reduce its stigma, making it an ideal setting to study the stigma reduction process.

Data Collection

We primarily focused our data collection on Colorado, Oregon and Washington since these states had operational medical cannabis dispensaries, and did not have the high level of variability in rules governing dispensaries that proved problematic in California. These three states led the way in efforts to destigmatize the industry, and influenced the legalization

processes in states that legalized later. The data for this study came from three main sources: (1) direct observations; (2) interview data; and (3) archival data. All of our data sources are summarized in Table 2. These data sources allowed us to triangulate the insights that we were generating about the industry. We collected data from 2013 to 2015, but the time period we focused on in our analysis ended in 2013 because recreational cannabis became available in Colorado on January 1st, 2014. At that point, medical cannabis was legal in 23 states and the District of Columbia. Nonetheless, cannabis is still illegal at the federal level, and is still classified as a Schedule I drug.

[Insert Table 2 about here]

Direct Observations: We conducted two types of direct observations: we attended industry conferences, and we were given dispensary tours. Industry conferences provided an opportunity to embed ourselves in the context and observe first-hand how the dispensary owners, entrepreneurs and other industry leaders talked about and tried to manage the industry's core stigma. In 2013 the first author attended an industry conference in Seattle, WA organized by *Marijuana Business Daily*, the leading trade publication for the cannabis industry. At the time, our primary research question was, what motivated individuals to start businesses in a stigmatized industry? However attending this conference revealed that a more pressing issue the industry saw itself facing was how to remove its core stigma. The conference was a "field-configuring event" (Lampel & Meyer, 2008: 1026) where industry actors convened to share beliefs and values, engage in collective sensemaking, and orient the field towards a shared vision and direction (Mair & Hehenberger, 2014) in their efforts to change perceptions about medical cannabis. As such, it was an ideal venue for observing real time efforts to reduce core stigma.

The first author attended another of these conferences in 2015 to see how the industry's approaches had evolved. The tone of the presentations was more "corporate," with many of the presentations focused on how to liaise with mainstream organizations, and with a significant increase in the number of trade show booths by mainstream firms. Another noteworthy difference was that whereas the conference two years prior had been held at a fairly remote horse

racing track (since mainstream hotels would not allow to industry to use their facilities), this conference was held in a luxury hotel in Chicago. Both of these observations were indicators of the industry's changing level of acceptance. Finally, the first author was invited to attend a third day-long conference where ancillary businesses (businesses providing support services, but that did not directly touch the plant) could pitch their businesses to wealthy individuals, Wall Street investment bankers, and other potential investors in an effort to gain investments.

In addition to conferences, we visited five dispensaries in Colorado and Washington. During these visits we had the opportunity to observe the dispensaries' front-office operations, and in some cases were also given behind-the-scenes access, such as tours of the cultivation and production areas, and of the consultation rooms where patients were served. There, we observed organizational practices and to ask probing questions about the reasons for those practices.

Interview Data: Prior to the first conference, the first author was unsuccessful in obtaining interviews with industry members, but conferences were useful for building rapport with industry actors, and for highlighting the great the desire of actors to destigmatize the industry. This helped us refine our research question and interview protocol. We used our initial contacts to assist us with purposeful sampling as we wanted to get the insights of prominent industry actors, but were aware that given the nature of the context, we needed to be introduced by trusted associates. Because of this, we also employed snowball sampling, asking informants at the end of our interviews if there were other industry members they could refer us to.

Between 2013 and 2014 we interviewed proprietors of dispensaries and other cannabis-related firms, such as growers and firms producing edible products. We also interviewed influential leaders in the cannabis industry, including activists and others invested in changing public perceptions of the industry. The level of influence enjoyed by many of these people is reflected in the repeated coverage they received from top news outlets in the United States. We asked research participants about past events, as well as those unfolding in real time. The recency and saliency of events greatly reduced the likelihood of recall bias (Huber & Power, 1985). We used a semi-structured interview protocol (see appendix), that provided us with the flexibility to

pursue topics related to our research interests as they emerged in conversation. Most of the interviews were recorded and transcribed verbatim; however, because of the sensitive nature of some of the issues, it was not always practical or appropriate to record the interviews. As such, we took extensive notes for nine interviews. Overall, we conducted 38 interviews that generally lasted from 45 to 90 minutes.

Archival Data. We collected archival data concurrently with field data. Most of the information we used to understand the history and first phase of the stigma the reduction process came from archival sources that gave us a general understanding of cannabis's history in the United States, particularly a congressional commission report that was generated to "separate fact from fiction, reality from myth, and to achieve a balanced judgement on the marihuana issue" (Shafer, 1972, vii). The commission was a multi-disciplinary effort of professionals in areas such as law, medicine, criminology, education, sociology and psychology, and examined the history of cannabis use for both medical and recreational purposes, its biological effects, and its social and legal implications. We used more recent books on the industry to confirm the historical information in the report and provide a more contemporary view.

In addition, we searched *ProQuest Congressional* for House and Senate reports, bill documents and hearings related to the major legislation affecting the sale and use of cannabis. The hearings were especially useful for understanding the debates around these issues. We also used *Access World News* to search the *Denver Post*, *The Oregonian* and the *Seattle Times* for articles related to the cannabis industry. We picked these newspapers as they have the highest readership in Colorado, Oregon and Washington, respectively. Sometimes a theme emerged in one of these newspapers, and we would then search more specialized news outlets for further details. This search resulted in about 900 articles that we downloaded and coded. In addition, we had access to two in-depth industry reports that provided extensive analysis of the current state of the industry and projections for its future (Abernathy, 2013; Kreit & Geci, 2011). Finally, we used a number of books and televised documentaries.

Data Analysis

Given the limited knowledge about category-level core stigma removal, we employed a qualitative, inductive research approach to both generate theory and supplement existing theory (Edmondson & McManus, 2007). We followed a grounded theory methodology (Strauss & Corbin, 2008) coupled with process analysis (Langley, 1999) in the design and analysis of this study. We began by using the archival data to develop a chronology of key events in the stigmatization of cannabis, as well as key events in the subsequent development of the medical cannabis industry. We paid close attention to "critical junctures" (Sewell, 1996: 843) that were transformative to the industry. These chronologies allowed us to tentatively bracket the time period of the study into three overlapping phases (Langley, 1999) that served as a framework for our analysis, and that ultimately became the phases of the model. Within these bracketed time periods we employed grounded theory, using both archival and interview data to understand how industry actors moved transitioned within and across phases and stages.

Early on, we observed that industry actors' efforts could be categorized into collective and individual organizational actions, and we focused on understanding these distinctions within the bracketed periods. In this context, we define "collective efforts" as actions and rhetoric that were geared towards the group goal of removing the stigma in order to grow the overall industry. Thus we treated actors as representing "the collective" when they prioritized the industry's goal to destigmatize, and used language and took actions towards that end. Collective actions were primarily taking place on the front-stage, and often unfolded in interviews and through group interactions in public forums such as conferences. Conversely, individualized organizational actions primarily focused on protecting the competitiveness and survival of the focal firm, and could conflict with the collective's goals. These were also observable to a more limited extent at conferences, through interviews, and within the archival data.

With the timeline and tentatively bracketed time periods in place, we used open coding of our interview data to gain an in-depth understanding of the phenomenon from the perspectives of those who are deeply embedded in it (Charmaz, 2006; Locke, 2001). This helped us develop first-order codes and provisional categories from the raw data. We labeled and categorized direct

"in-vivo" quotes from informants to "extract or abstract the most relevant themes" (Kreiner, Hollensbe, & Sheep, 2006: 1036), iterating between the raw data, the insights that were emerging from that data and the theoretical literature to refine our initial codes. These codes and categories also informed subsequent data collection and coding. For example, initial coding highlighted the importance of efforts to change the labels associated with cannabis. With this insight, we paid close attention to the use of labels in subsequent data collection, and revisited the archival data to code for labels that were used to stigmatize cannabis over the course of several decades. In addition, we observed that individualized organizational actions were sometimes at odds with the goal of destigmatizing the industry. In subsequent interviews we paid attention for cues to such actions, and carefully probed to try to understand the nature of and motivations for these actions. We provided informants with the option to respond to these questions by describing what "others" were doing, or with hypotheticals, so that depending on the actions they were not incriminating themselves.

We iterated between our emerging codes and theory, and we used axial coding (Strauss & Corbin, 2008) to try to understand the relationships across the codes, and to aggregate them into more theoretical and abstract second-order themes (Pratt, Rockmann & Kauffman, 2006; Sonenshein, Nault and Obodaru, 2017). For example, we recognized that industry actors' language related to patients' rights, along with their use of patient testimonials in their marketing, were linked under the more abstract theme of connecting to alternative values. Finally, we aggregated related second-order themes into higher-level theoretical dimensions, comparing their relationships to each other as they unfolded within and across the phases and stages that were emerging from the data. These comparisons allowed us to identify the dynamic process—represented in our model—that connects the theoretical dimensions. Figure 1 summarizes our data structure, and Table 3 presents additional examples of data related to the theoretical categories.

[Insert Figure 1 and Table 3 about here]

Establishing Trustworthiness

We established trustworthiness through several means. First, we triangulated on issues and claims across diverse data sets. For example, we were able to get various perspectives on certain issues by interviewing the actors while also consulting the media data. In addition, we established the findings' credibility through our "prolonged engagement at the site" (Guba, 1981: 84). The first author gained significant entry into the industry and built a good rapport with industry insiders, which led them to open up and provide sensitive information (Krefting, 1991). Industry insiders also offered to connect her with their networks and to host her during visits to the field. We also used peer debriefing (Guba, 1981; Lincoln & Guba, 1985), where we discussed our findings with and obtained feedback from another researcher who is skilled in qualitative methodologies but was not invested in the project. Finally, after the first author completed the open coding and we had developed the emerging categories, we used a professor with expertise in business and entrepreneurship who was not otherwise involved in the project as a secondary coder to confirm the categories (Butterfield, Treviño, & Ball, 1996; Corley & Gioia, 2004). We provided him with 40 samples of the data on index cards, with each sample representing a coded unit of text that could be a sentence or a paragraph. We gave the coder the codes and their definitions, with instructions to match the data to the codes (Butterfield, et al., 1996). Overall agreement was .83—an acceptable value (Cohen, 1960).

FINDINGS

In presenting our findings we differentiate between category-level (i.e., collective) actions and responses and individual organizations' actions and responses. At the industry level, we define collective actions as the framing activities and actions that align with the overall missions and goals of the industry (Benford & Snow, 2000). In the medical cannabis industry, this involved the actions of activists, industry group advocates, medical cannabis entrepreneurs (e.g., growers and edibles manufacturers) and/or dispensary owners who are speaking and acting on behalf of the industry in some capacity—such as in newspaper interviews or public presentations—and that align with the industry's goal to destigmatize. We use the terms "collective" and "category" to refer to actions and narratives at this level. In presenting direct

quotations, when the same actor represented the collective (e.g., as a conference presenter) and participated in an interview, we used a single identifier for the actor and differentiated the context in which the data were provided (e.g., E#2_Conference vs. E#2_Interview. We use the signifiers D to identify dispensary owners, E for other kinds of medical cannabis entrepreneurs, and AI for activists and industry group representatives). The personal interviews were an opportunity to differentiate between collective actions and organizational actions that contradicted the collective goals and were not meant to be publicly visible.

Figure 2 summarizes our findings and presents our process model. A key finding of our study is that the stigma reduction process was a contentious, multi-phased effort that involved "front stage" collective actions that convey the industry's moral agenda and practices, "backstage" organizational coping activities by medical cannabis entrepreneurs and dispensary owners that conflicted with the message presented on the front stage, and collective "side- stage" negotiations. Goffman (1959) characterized social life as a performance that unfolds across various "stages." These stages provide access to information—to "a given pattern of access to the behavior of other people" (Meyrowitz, 1986: 37). Goffman (1959) argued that when actors know their actions are visible to others, they engage in front-stage behaviors that fulfill moral expectations. Co-occurring with front-stage behaviors are backstage activities that can contradict front-stage performances, and are thus meant to be hidden from audiences. According to Meyrowitz (1986: 39), "when we find ourselves in a given setting we often unconsciously ask, "Who can see me, who can hear me?" "Who can I see, who can I hear?" The answers to these questions help us to decide how to behave. Finally, the side-stage provides partial views of the backstage as well as the front stage, thus containing elements of both, but "lacking their extremes" (Meyrowitz, 1986: 47). That is, the "curtain" unintentionally shifts, and the audience gets glimpses of the messiness involved in producing the show, and the clashes among actors over how the front stage should be enacted. Because this stage is partially within public view (such as in the media), actors try to hide whatever they can, but also try to justify and reconcile their backstage and front stage actions (Meyrowitz, 1986).

We use this framework to understand the complexities of a process where actors must collaborate to achieve collective goals while at the same time individually taking actions to garner critical resources and survive. Figure 2 illustrates that stigma reduction unfolded through three, partially overlapping phases: *Initiating a Moral Agenda, Moral Prototyping,* and *Morality Infusion*. Each phase was triggered by an event or collection of events that started externally and moved internally as the process evolved. The first phase took place primarily on the front stage, whereas the latter phases unfolded across all three stages, (front- and backstage activities and side-stage negotiations). For clarity of exposition we describe these phases in a linear fashion, although in actuality they partially overlapped.

[Insert Figure 2 about here]

Initiating a Moral Agenda

The stigma reduction process started with a collective effort to initiate a moral agenda that departed from previous, failed efforts. Beginning in the early seventies, activists such as the National Organization to Reform Marijuana Laws (NORML) spent about twenty years unsuccessfully pushing for full legalization of all uses of cannabis based on a moral agenda that focused on individual rights and the social harm caused by incarceration for minor drug offences. The new moral agenda that eventually took hold was more narrowly linked to patients' rights; it was initiated by activists in the gay rights movement who were directly affected by the AIDS epidemic, and who began advocating for cannabis to treat terminally-ill AIDs patients. To initiate the moral agenda, actors *coopted the "medical marijuana" label* and narrative—a narrative that, as discussed above, had been suppressed through most of the twentieth century.

The first piece of the puzzle fell into place in 1978, when the Supreme Court upheld the right of Robert Randall, a 28-year old Washington DC teacher, to use cannabis to treat his glaucoma. The Court's decision directed the US government to supply him with federally-grown cannabis for medicinal purposes, injecting some legitimacy into the cannabis-as-medicine narrative. This decision was also the first record we could find of the term "medical marijuana"—the label later coopted by the AIDS activists.

The second event that led to initiating the moral agenda was the AIDS crisis. In the early 1990s AIDS activists, and in particular an individual named Dennis Peron, crusaded for AIDS patients' rights to use cannabis for medicinal purposes. The activists were in effect, *linking their efforts to alternative values*, and the medical marijuana label and accompanying moral agenda gained credibility as activists linked them to AIDS patients' suffering. To them this advocacy was urgent; activists like Peron were personally affected by the AIDS epidemic (his partner, Jonathan, was afflicted with the disease), and there were no effective means of treating AIDS suffers' symptoms (Werner, 2001). They believed that cannabis alleviated AIDS's symptoms by reducing nausea, increasing appetite and preventing wasting. Peron recounted his belief in marijuana's medical benefits:

> "Jonathan was taking many prescribed drugs, and there were severe side effects, from nausea to loss of appetite. Marijuana was the only drug that eased his pain and restored his appetite and gave him some moments of dignity in that last year" (Gardner, 1996).

Peron sold cannabis to AIDs patients and introduced the language that became the foundation of the medical cannabis industry when he pleaded "morally not guilty" after being arrested for selling cannabis. He stated, "The fact is, we did sell marijuana in San Francisco to sick and dying people for 3 1/2 years. We were morally compelled to do this" (DelVecchio, 1996).

Framing cannabis as medicine that alleviated suffering resonated with voters, particularly in San Francisco, which was at the forefront of confronting the AIDS epidemic. The city had allocated millions of dollars for AIDS programs at a time when the Federal government's financial commitment was less than $9,000 for the entire country (Werner, 2001). San Francisco ultimately legalized medical cannabis through passage of Proposition P in 1991; in 1996, California did the same. In response to this success, Peron stated, "I think this is a moral victory. This is about who we are as a people and where we're going as a nation" (Epstein, 1996).

Gaining any sort of victory for cannabis legalization temporarily united groups with somewhat different agendas, thereby limiting backstage conflicts during this phase. The legislative efforts were successful because many cannabis activists, including NORML, AIDS activists, and patients with a variety of other maladies whose symptoms could be alleviated by

cannabis, put aside their differences to collaborate (Gardner, 1996). *Patient testimonials* became a vital part of initiating a moral agenda centered on healing. They were also useful for differentiating between using cannabis for medical and recreational purposes.

Patient testimonials were central to the process of identifying medical cannabis with healing, enhancing its identity as medicine, and reducing cannabis's stigma. These testimonials allowed the collective to draw on the language and legitimacy of an existing field, and on the broadly accepted value of patients' rights. Patients and their families appealed to legislators, and those in the general public who were skeptical about cannabis's efficacy as medicine. For example, during California's 1996 Proposition 215 campaign to legalize medical cannabis, the medical cannabis collective used television advertisements featuring a 67-year old nurse who talked about her husband's experience with cannabis while undergoing chemotherapy:

> "The nausea from his chemotherapy was so awful it broke my heart. So I broke the law and got him marijuana. It worked. He could eat. He had an extra year of life. Proposition 215 will allow patients like J.J. to use of marijuana without becoming criminals. Vote yes on 215. God forbid someone you love may need it" (Goldberg, 1996).

Stories such as this one were designed to challenge pre-existing stereotypes about who smoked cannabis, and to appeal to the societal values of compassion and the belief that individuals should have reasonable access to treatments that reduce their suffering. Overall, this new moral agenda set the stage for *moral prototyping*, where industry actors collaborated to create morally differentiable category prototypes, but also engaged in more backstage and side-stage activities that conflicted with the actions taking place on the front stage.

Moral Prototyping

Passage of Proposition P in 1991 and of Proposition 215 in 1996 initiated the moral prototyping phase of the process because they legalized medical cannabis and created the possibility to develop a new industry category that required a prototype. Prior to establishing the moral agenda, the cannabis trade was seen as one undifferentiated category—the black market. After the moral agenda was initiated and legislation legalizing medical marijuana was passed, this undifferentiated category began to experience *category emergence* (Durand & Khaire, 2017);

the language, symbols and values associated with healing and the alleviation of suffering supplanted the values long associated with marijuana and its use as an intoxicant. Moral prototyping thus required industry actors to create a medical cannabis category prototype that incorporated positive elements from the healthcare category, while simultaneously dis-identifying from the black market and another emerging category, recreational cannabis.

The medical cannabis category provided its proponents with a mechanism for disassociating from stigmatizing labels such as “dope”, “pushers”, “stoners” and “burn-outs” given to the cannabis plant and its users, and to transfer them—along with the associated stigma—onto other categories. They acknowledged, and even agreed with the devaluing labels, but contended they were descriptors of *other* categories—particularly the black market. Through rhetorical work, the medical cannabis collective identified alternative, positive labels that they could associate with their category, and strived to make their use commonplace. Simultaneously, individual dispensary owners and medical cannabis entrepreneurs—who supported the collective’s efforts—participated in illicit backstage actions to access critical resources. Below, we consider the collective identification and dis-identification of front-stage moral prototyping, and their co-existence with backstage prototype violations and side-stage negotiations.

Identifying the category with healing. Identification creates a “cognitive and emotional link” between a category and a set of “central, distinctive, and enduring organizational characteristics” (Zavyalova, Pfarrer, Reger & Hubbard, 2016: 257) that helps others relate to the category and see it as reflective of their own values. Key to developing a moral prototype was developing language, symbols and practices consistent with healing and patients’ rights. Rhetorically, the collective coopted positively-valued labels from the medical field, which was “a professional practice governed by a moral framework” (Miller & Brody, 2001: 582), to replace the old, stigmatizing labels. This dynamic was highly visible at industry conferences, where participants actively negotiated the medical cannabis category’s lexicon and explicitly highlighted preferred labels. For example, one prominent speaker at the first conference appealed to member organizations, “We don’t say medical marijuana anymore, we just say cannabis. It’s a

new world" [E#2_Conference]. Thus, "pot" was now "medicine," "potheads" were now "patients" and those using cannabis were not "toking" or "getting high," they were "medicating." Indeed, the first author was frequently asked by others at the conference if she "medicated." The owner of a marijuana-infused products company succinctly captured these efforts when he stated:

> "Put out the best *medicine* to the best *dispensary* owners. That's your end goal, making sure that you are servicing the largest *patient* base because they [the dispensaries] are considered the best in what they do." [E#8_Conference] (Italicized for emphasis).

Patient Testimonials. Just as patient testimonials were important to initiating the moral agenda, they continued to be employed in the moral prototyping phase, and were instrumental for identifying the category with healing. For example, an edibles manufacturer presenting at a conference rationalized the practice this way: "How can a parent of a child, a loved one who is diagnosed with cancer or AIDS or a mass or fibromyalgia, who uses marijuana successfully, not change a politician's mind after seeing that?" [AI#2_Conference]. He went on to say,

> "You make it personal, tell your story, your family story "… I lost my stepfather to cancer, my step-mama to cancer," we all know somebody has that story. But stay real, use real data." [AI#2_Conference]

As this quote highlights, patient testimonials put a human face on the category and introduced an emotional component into the discourse. Emotions are essential to moral judgments, making patient testimonials an essential tool for moral prototyping (Haidt, 2001).

Disidentifying with recreational use and the black market. Disidentification is the inverse of identification. It involves identifying in opposition to something else; that is, by stating "who I am not" rather than "who I am" (Elsbach & Bhattacharya, 2001). As the collective was actively constructing and identifying with the medical cannabis category, they were simultaneously disidentifying from the black market and recreational cannabis categories. Both the black market and recreational categories harbored the long-standing stigma associated with using cannabis just to get "high," and the collective was careful to demonstrate that medical cannabis did not fit that prototype. It is worth noting that their disidentification from the

recreational category was subtler than from the black market. Below, we consider both efforts.

The recreational use of cannabis has encountered considerable opposition over time. Indeed, the stigma around cannabis emerged against a backdrop of a general disapproval of recreational intoxication:

> "The early campaigns against marijuana use can be viewed as an extension of the temperance and moral reform movements which swept the country during the 1920's. They were generally spearheaded by persons who opposed the use of opiates, alcohol and tobacco on the grounds that all such substances were physically, mentally and morally debilitating" (Shafer, 1972: 424).

Using cannabis as an intoxicant was claimed to induce violent behavior, sap the users' motivation, and serve as a gateway to using more dangerous drugs. These perceptions have persisted for almost a century. For example, after Colorado passed a bill to allow for medical cannabis in 2009, state senators Chris Romer and Tom Massey wrote a commentary where their opening statement was, "Marijuana. Most people see it as a recreational drug and are skeptical of its tangible, medical benefits for patients with chronic pain" (Romer & Massey, 2009). They went on to talk about the importance of keeping cannabis out of recreational users' hands.

On the front-stage, the collective emphasized that they were proponents of providing cannabis to patients in need, and when pressed, would make clear distinctions between the medical and recreational uses of cannabis. However, their hesitation to explicitly denounce recreational use was evident throughout our data. Both dispensary owners and entrepreneurs acknowledged that not all of their clients were using cannabis strictly for medicinal purposes; later we will show that recreational users were important to individual firms' backstage activities.

One of the few examples that we could find of medical cannabis dispensaries vehemently opposing recreational use was in Washington State, when regulators proposed fully legalizing cannabis and eliminating the distinction between medical and recreational use. This would have resulted in levying higher taxes on medical cannabis and threatened the image and business models that medical cannabis dispensaries had built over time. Resistance to this plan was not universal, though, as activist and industry groups seeking full legalization generally embraced

the change. This battle is an example of the side-stage[2] activities that occurred when various coalitions with differing interests came into conflict with one another.

Conversely, the medical cannabis category was more publicly opposed to the black market category, and positioned medical cannabis as a mechanism for its eradication. They argued that medical cannabis dispensaries could recapture revenues previously lost to the black market and redistribute them to the local communities. Furthermore, building on the "patients' rights" narrative, they argued that dispensaries could protect patients by providing them with safe access to quality-controlled medicine—patients would no longer have to resort to the black market. For example, in contesting a policy that would make it difficult for dispensaries to operate, a Colorado attorney specializing in medical cannabis wrote in the *Denver Post*,

> "We also hear government officials with no formal medical training demonizing and second-guessing private confidential decisions of trained physicians who advise patients. Government should not interfere with private medical decisions. Many of these proposals would drive vulnerable patients away from the well-lit, safe, secure, private, confidential medical marijuana dispensary and put them and their wheelchairs back in the dangerous black market" (Corry, 2009).

Furthermore, the medical cannabis collective worked to transfer many of cannabis's discrediting labels to the black market category. For example, a prominent dispensary owner stated: "In terms of what I would call the 'thug influence', the influence of the thug dispensary has been potentially the largest single challenge that the cannabis reform movement has faced in recent years" (D#3_ Interview). The dispensary owner used "thug influence" to refer to dispensaries that existed on the fringes of what the industry considered acceptable, particularly with regards to their linkages to the black market.

The cannabis-related stigma of the twentieth century also had a significant racial component, as marijuana use was associated with immigrants from Mexico and the West Indies (Geluardi, 2010), and with jazz musicians, many of whom were African-American. Drawing on racial stereotypes, stigmatizers generated fear by publishing frequent and often false articles about cannabis-intoxicated Mexicans committing atrocious crimes (Geluardi, 2010). The

[2] We further define and discuss "side-stage" actions below.

collective drew on some of these same racial inferences to disassociate from the black market, often making references to "Mexican drug cartels" when discussing the black market. For example, a Colorado-licensed cannabis grower stated in an interview that, "I do believe the people of Colorado are better off buying marijuana from the likes of me than they are buying it from the Mexican drug cartels" (Carroll, 2010).

Overall, to distance medical cannabis from stigmatizing labels and stereotypes, on the front stage the collective positioned the medical cannabis category as the antithesis of the black market category, and as the solution to the "black market problem." In short, the medical cannabis category constructed the black market category as the "other."

***Backstage survival violations*.** At the same time the medical cannabis collective was identifying with the medical field and disidentifying with the black market and recreational categories on the front stage, on the backstage individual dispensaries were engaged in some of the very activities being publicly castigated. Relational spaces are "temporally bound settings for interaction and negotiation of social order" (Mair & Hehenberger, 2014: 1176) that can bring together individuals who do not normally interact. The backstage was a relational space where they could access necessary resources that were unavailable through other means, allowing them to survive until the resources became more broadly available. For example, many dispensaries had difficulty accessing cannabis to sell and capital to finance their growth. To access capital and/or product, some dispensary owners engaged in *covert liaising*, where they worked with the black market on the backstage. There is evidence that some dispensaries sold excess cannabis to the black market as a source of additional revenue. In Oregon for example, *The Oregonian* analyzed law enforcement data and found that about 40% of the cannabis trafficked out of the state was linked to the medical marijuana program (Crombie, 2012). They found that the price of cannabis sold out of state could be more than five times higher than in-state legal sales. A dispensary owner discussed this dynamic as follows:

> "I think certainly a lot of people did start in a black market and now they have found a way to transition into the new legal market, and that is perfectly appropriate to me. You still do see some areas where things aren't well-regulated, and you might find some

> people sort of playing both sides of the equation there, and sure I wouldn't recommend that. I think it's not worth the risk but it does happen. They're growing cannabis but then when push comes to shove, they don't like the compensation that they get from those patients or from a legal dispensary, they'll sell that product in the black market or give it to somebody who is a broker who is going to get 200 pounds from various people and ship to the east (coast)" (D#7_Interview).

This quote illustrates that some dispensary owners returned to the black market for capital, a transaction facilitated by their prior experience. One grower said, "That's one thing you have in me, is you have a person that grew up through the whole thing. I have been a participant the whole way. I began cultivating in the late 70s and that continued. At this point, of course, I am confessing to felonies" (E#11_Interview).

Dispensary owners also sometimes needed to go to the black market for product. A dispensary owner 'hypothetically' explained how that worked in a market organized as a collective, where patients could grow their own cannabis and contribute it to the collective. He saw this as opportunity for dispensaries to source cannabis from the black market, because they used a don't-ask-don't-tell approach when determining the actual source of the product:

> "As long as you are a patient with the doctor's note and you come to my dispensary and you join the collective. Basically is just to sign the membership form and agree to be a member of the collective, then cannabis that you have in your duffle bag and whatever is technically considered legal and you can contribute it to the collective" (D#7_Interview).

Thus, entrepreneurs and dispensary owners engaged in backstage activities that departed from the moral prototype that was being constructed on the front stage, but allowed them to fortify their resource position, presumably until crucial resources were more widely available.

Side-stage negotiations

Situated between the front-stage collective actions and the backstage organizational actions were side-stage debates that resulted from goal incongruence and disagreements over how to normalize the industry. These activities were side-stage because while the messiness of the disagreements was not within full public view, the public could see evidence that they were occurring. Side-stage prototype negotiations became apparent even as the medical cannabis industry attempted to define the category in part by disidentifying from the black market and recreational categories. A dispensary owner expressed this by stating: "When you get down to

the details of actually regulating how cannabis is going to be made legal, there can be some real divergent interests. There's some divergence there even within the industry in terms of what kind of model people want to see" (D#3_Interview).

The debate in Washington State over eliminating the distinction between medical and recreational cannabis mentioned earlier is one example of side-stage negotiations. The infighting among members of the medical cannabis category resulted in very visible public confrontations. As some factions put their support behind Initiative 502—a measure to legalize recreational cannabis and punish users for driving under the influence—others opposed the initiative, while still others fought over who should be the loudest voice of dissent. An excerpt from *The Seattle Times* described one such confrontation:

> "Philip Dawdy, well known among the state's marijuana activists, had invited reporters to the offices of Seattle lawyer Kurt Boehl for the kickoff of the new trade group, called Safe Access Alliance. The purpose was to discuss opposition among medical-marijuana patients to Initiative 502, which would legalize and tax up to an ounce of pot for recreational use in Washington. Two members of another group, the No on I-502 campaign, crashed the news conference and accused Safe Access Alliance of co-opting their message — and their donations." (Johnson, 2012).

Dawdy was immediately fired, because his boss did not agree that Safe Access Alliance was or should oppose I-502. According to The Seattle Times, "The spectacle underscored how severely fractured the marijuana-activist community has become in Washington state, with various groups running competing initiatives and taking opposing positions on whether the state should be in the dispensary-licensing business" (Johnson, 2012).

Another example occurred when a bill was introduced in Colorado that would outlaw medical cannabis dispensaries. Many members of the collective vehemently opposed the bill, with over 200 publicly rallying in opposition. According to the *Denver Post*, "Conspicuously absent from the rally, though, were a number of prominent medical-marijuana groups, which on Thursday announced they have formed a new coalition to push for 'the middle ground in the debate'" (Ingold & Fender, 2010). This new coalition's executive director was later quoted as stating he found lawmakers surprisingly willing to listen to the cannabis community's proposals,

in contrast to other cannabis lobbying groups that were “still talking with lawmakers about fighting back a proposal that would effectively outlaw retail marijuana dispensaries and instead introducing a bill the cannabis community could support” (Ingold, 2010b).

Morality Infusion

Moral prototyping established and set the stage for solidifying the medical cannabis category through morality infusion. The morality infusion phase began around 2010, once a working moral prototype had been established and the new industry had begun to develop trade associations and lobbying groups who could help disseminate the new prototype to others outside the industry. They wanted their prototype to become the dominant way others view the category. While language was still important, and actors continued to build on the rhetoric that they had developed during moral prototyping, a critical component of the morality infusion phase was to introduce the material changes that would help project a *squeaky-clean image* on the front stage that they could actively disseminate. One conference presenter noted, “Business owners need to be squeaky clean in order to survive in a world of increasing scrutiny from regulators, neighbors and the media” [D#10_Conference]. A squeaky-clean image meant that all aspects of their businesses should be beyond reproach. It also meant demonstrating that they were good people concerned with the wellbeing of their patients and local communities.

We refer to these material and symbolic actions as *showcasing* and *diluting*. Showcasing was meant to demonstrate that they were operating normal businesses, while diluting helped make their cannabis-related activities less threatening to newcomers and outsiders. Below, we unpack these morality infusion activities.

Material changes to project a squeaky-clean front-stage image. *Showcasing* was an important part of the collective’s efforts to create a squeaky-clean image by altering the category’s material attributes. They used the look and presentation of the dispensaries—from their structural designs and layouts to their hiring practices and self-presentation—to make themselves appear professional and non-threatening, and to communicate the specific values that the collective wished to espouse: that they were responsible and caring business owners

providing a valuable healthcare service to their community. Figure 3 provides examples of showcasing. Showcasing started with picking the right locations, preferably places that were not in depressed parts of town. The building's signage should be simple, clean and non-threatening. Once patients walked through the door, they should enter an open, professional space analogous to a doctors' office, and the sales floor should be well-lit and inviting. A dispensary owner emphasized the importance of design:

> "At [my dispensary] we've tried to design everything that we do in order to discredit the stigma associated with cannabis. From the time that people walk into our facility, they see a different approach. It's absolutely sparking clean. It's decorated and we're very professional but in a very welcoming way so that anybody can walk in and feel comfortable" [D#10_Interview].

Product presentation was also critical, as the firms needed to differentiate their products from the black market's products, and to tie them more closely to medicine. As Figure 3 illustrates, that included presenting cannabis buds in clear jars and selling them in child-proof containers that resemble those used for prescription drugs.

[Insert Figure 3 about here]

Showcasing also extended to the symbols the dispensaries and product developers used in marketing and product packaging. Many employed medical symbols, such as the cross and the Rx symbol. Figure 4 provides some examples. The consensus seemed to be that dispensaries should avoid "stereotypical" cannabis culture. People in advertisements should not be scantily dressed or look like "stoners." Furthermore, industry spokespersons should be antithetical to stereotypical cannabis users. A dispensary owner expressed his views on marketing this way:

> "Start with a logo and have to be very professional and simple. You want to avoid the stereotypical cannabis user stigma. That has been holding us back for the last 75 years. Hopefully one day we will actually be able to be aggressive with the marketing like the alcohol companies. Right now it is just going to bring a lot of trouble. Make sure you are professional, very simple. Don't put any kind of cannabis leaf in there. Try to avoid names like Danny Fat Sax or something like that." [D#7_Conference].

[Insert Figure 4 about here]

Another element of showcasing is providing detailed information on the composition of each cannabis strain to support their claims that certain components of cannabis are beneficial for

particular conditions. A traditional problem with black market cannabis is that its potency and chemical composition can vary dramatically, and it can contain pesticides or other potentially hazardous chemicals. As such, cannabis dispensaries initiated product testing for chemical composition, pesticides and potency to align their products with science and signal product safety. It also allowed the dispensaries to provide information and treatment recommendations to customers, supporting their claims that cannabis is medicine. As one dispensary owner stated:

> "We professionalized the industry in ways nobody had previously—we laboratory tested all of our medicine. So before [my dispensary], patients didn't really know that the cannabis they were getting was safe. They didn't know whether it had contaminants and they didn't know really what was in it. And that to me was unacceptable. If I was going to call it medicine I had to know it was safe." [D#3_Interview]

Overall, with showcasing organizational actors aimed to have squeaky-clean enterprises that would withstand the intense scrutiny that came with being in a stigmatized business, and infused morality by providing physical manifestations of their rhetorical claims.

To project a squeaky-clean image, dispensary owners and entrepreneurs also engaged in *diluting*. Diluting involved de-emphasizing cannabis and its potentially negative elements so that it is less threatening to external audiences. One way this was accomplished was by more deeply embedding cannabis within their overall health and wellness offerings. That is, many dispensaries identified themselves not so much as sellers of cannabis, but as providers of "medical care" or "wellness services" of which cannabis was one component. A dispensary owner described his presentation of cannabis this way:

> "We've also done things like we surround cannabis with other holistic healing techniques so any of our patients who come in can utilize our holistic healing clinic, which offers chiropractic, acupuncture, reiki and about 7 or 8 other holistic therapies completely free of charge. We have free classes for our patients so they can learn how to do yoga or learn how to grow their own cannabis" [D#3_Interview].

Deemphasizing cannabis while highlighting wellness services like yoga and reiki rendered dispensaries more approachable, as it is easier for a resistant individual to enter a wellness center that *happens* to sell cannabis than to enter a dispensary that *only* sells cannabis. A dispensary owner eloquently stated, "I think it gives the community a little bit of comfort that,

yeah, these businesses are selling cannabis, but they're also providing other healing and wellness services and other remedies to assist in these patient's treatment plan" [D#10_Interview].

Innovation was also instrumental for dilution. Cannabis is traditionally smoked, and smoking can have adverse health effects. This is problematic for an industry that wants to associate itself with health and wellness. In addition, cannabis also has a distinct smell that is often associated with its countercultural use. Accordingly, product manufacturers introduced concentrates that can be used in vaping devices that conceal the smell, and growers have developed cannabis strains such as "Mother of Berries" that smells of blueberries. Entrepreneurs and dispensary owners have also been innovating with alternative delivery systems such as infused edible products, and using traditional delivery systems such as capsules, tinctures (liquid applications that are taken sublingually) and topical salves that are non-psychoactive. They have also developed cannabis strains that possess different levels of the chemical components believed to affect different kinds of illnesses, and in some cases eliminated its intoxicating effects. One organizational actor tied these innovations to public perceptions by stating,

> "We're attempting to just cultivate a message of normalcy. This is not a new thing. This is not a scary thing. This is a plant that humans historically have had in their lives. We are just simply introducing it in a new way. It also helps that the products that we make are not psychoactive and they are not going to get you high. That kind of changes that perception too" [D#5_Interview].

Backstage Survival Violations. Even as they attempted to create a squeaky-clean image on the front stage, dispensary owners still violated this image on the backstage when interacting with customers, since not all "patients" were using cannabis strictly for medical reasons. It was not uncommon for individuals to obtain the patient documentation needed to access cannabis for recreational use. Dispensaries were aware of this, and were willing to serve these customers. To accommodate these two sets of customers, the entrepreneurs and dispensary owners used the rhetorical strategy of *code-switching*. Code-switching is a term employed in linguistics to describe "the use of more than one language in the course of a single communicative episode" (Heller, 1988: 1). It also describes the way minority groups such as African-Americans alter their communication styles to effectively navigate different cultural settings (Degans, 2013). While

individuals generally did not code-switch within the same conversation, they changed their language across conversations with different audiences. For example, as a part of our fieldwork, a dispensary owner invited the first author to tour his dispensary. During the tour, the guide took her to the "accessories" or "glassware" room. She questioned the use of these names and the guide explained:

> "Well I guess it just depends on the audience. I think younger people are more likely to know what a head shop is versus older people. You can't always know by looking at someone if they have a medical condition or not. But I can sort of gauge when someone walks into the door if they are here to use it as *medicine* or to just get their *weed* and be on their way. So, those kinds of people I would usually call it a "*head shop*" and for older people I would call it an *accessories shop* usually." [D#32_Interview]

This quotation illustrates the different terminologies that the dispensaries used with different audiences that allowed them to transition between the front and back stages. Dispensary owners assumed that individuals who appeared to be more in tune with popular culture and whose experiences with cannabis seemed more aligned with recreational use would be more comfortable with the colloquial labels. Code-switching allowed organizational actors to presumably create a comfortable space for recreational users in order to retain valuable customers who did not identify with the medically-oriented labels. Conversely, dispensaries needed to use medically-aligned labels with customers who approached the industry more tentatively, as well as with governments, the local community and the medical establishment.

Dispensaries also used the backstage to circumvent the roadblocks created by cannabis's federal illegality through sometimes engaging in activities that did not align with their front stage portrayals of professionalism. We referred to this practice as *resource supplementing*. For example, they had difficulty accessing everyday banking services such as checking accounts, forcing them to pay their taxes by showing up at the tax office with duffel bags of cash (Huddleston, 2014) and relying on cash for transactions with customers and employees. A conference presenter described this challenge:

> "Cash is still king. This can be extremely problematic from an operations standpoint. Tracking an inventory can be a nightmare. How do you pay your taxes, vendors and suppliers? Dispensaries face the risk of crime, such as robberies, break-ins, a lot of internal theft. If you have got a bank account, you want to keep your cash separate from

> your cannabis, because if your cash smells like weed the banks will not accept it" (E#23_Conference).

To deal with some of these issues, entrepreneurs accessed resources in unconventional ways that they preferred to keep out of the public view. A conference presenter explained:

> "We know that merchants have been forced to open accounts under their personal name. Others have opened a management account or an accounting firm or found a loophole where they can manage the business processes of the actual cannabis dispensing collective. Other merchants have opened a holding company, of course with no reference to cannabis; they may use an innocuous name like Acme Corp or ABC Company etc. In many cases the owners are forced to misrepresent the nature of the businesses. This is what we have been seeing. We have very few choices at this point" (E#22_ Conference).

He went on to discuss the pros and cons of dispensary owners and other entrepreneurs using offshore accounts in order to access credit and debit cards. Another way dispensary owners contended with their banking challenges was to give patients the option of using regular prepaid gift cards, reloadable cards designed specifically for the industry, or cashless ATMs that are:

> "Terminal pin-based solutions that allow the merchant to accept all pin-based transactions without any added scrutiny. There is a nominal monthly fee and a small transaction fee for the service. When a patient is ready for the transaction the debit card is swiped through the cashless ATM terminal and we enter the transaction amount. They enter the pin, there is a service charge and within 24 to 48 hours funds are deposited directly into your account" (E#23_Conference).

While some of these approaches were innovative, they were not necessarily approaches that the industry wanted to publicize, since they were roundabout ways of transferring funds into bank accounts that were not supposed to be used for cannabis-related transactions, and that could expose them to federal sanctions.

Side-stage negotiations. While the collective attempted to appear beyond reproach on the front stage, they were not always able to achieve these goals, and sometimes their debates would appear in the public sphere. One example was Coloradans for Medical Marijuana Regulation (CMMR), a medical cannabis advocacy group in which a number of dispensary owners were directly involved. Even as the group was having legislative successes it was simultaneously in public disarray as the organizations' leaders traded accusations. Matt Brown, one of its leaders, "presented a packet of information to DA personnel, spurred by his discovery that thousands of dollars in donations to CMMR never made it into the group's main bank

account. Instead, he learned, the money had been placed in a newly created CMMR account to which he had no access" (Roberts, 2010). At the same time, Brown was accused by another CMMR member of violating the organization's bylaws by loaning himself money to purchase a new BMW. There were also allegations of missing donations. However, CMMR leaders tried to keep these dramas away from their supporters, because they were concerned about the potential impact on their legislative efforts (Roberts, 2010). All of these activities were in direct violation of the squeaky-clean image that the industry was working to present, and as they unfolded publicly audiences were getting an opportunity to see what was happening behind the scenes.

Other examples of these collective side-stage disagreements are seen in debates over how states that were new to medical cannabis should structure their programs. For example, the non-profit model was preferred by some, as it clearly separates the medical cannabis category from the "drug dealer" narrative, and prioritizes serving patients over profit-making. However, this point was debated. A prominent dispensary owner argued "the nonprofit label is just a smokescreen. Just as the United Way offers top salaries to its executives, he says, "I can call myself a nonprofit and still pay myself $3 million a year" (Shapiro, 2010).

There were also debates about cannabis dispensaries' marketing approaches. While the industry chastised the use sexually suggestive marketing on the front-stage, a minority within the industry believed that they should be able to advertise however they saw fit, and publicly expressed their right to do so. As one entrepreneur who regularly used semi-nude models in his advertising stated to the press, "How dare these people, who think they represent the cannabis culture, single out the edge of this culture—because we are the cannabis culture" (Hecht, 2011).

In general, the collective resisted engaging in public debates that could undermine their overall goals, and the public only knew about these debates as new groups with divergent platforms formed, or as certain factions publicly challenged the emerging norms. These side-stage activities were valuable though, as they were an opportunity for the collective to emphasize important norms.

Disseminate locally. A crucial part of morality infusion was disseminating the squeaky-

clean image to external audiences who could act to reduce the industry's stigma. The collective divided their efforts, with dispensary owners and entrepreneurs focusing on local dissemination, while industry and advocacy groups focused on broader dissemination.

To locally disseminate the squeaky-clean image, dispensary owners and entrepreneurs believed they needed to be hyper-local and deeply embed themselves in their local communities. The advice at one industry conference was:

> "You need to participate in the community, you do not want to operate in the shadows. Go to the neighborhood council, the city council, put a face to what a dispensary owner is because they have no idea. This is where all their illusions come from. You want to know all your neighbors. If they have a problem, they can call you. Give them your phone number. It's much better to have them call you rather than law enforcement. Be proud of what you do" [D#12_Conf].

The dispensary owners showed that they attended church, were members of parent-teacher associations and had professional backgrounds, and this local embedding built strong interpersonal and interorganizational ties that could serve the industry in a number of ways. One dispensary owner expressed these beliefs by stating, "We are basically prophets, all of us are prophets, and I don't mean profit. We want to profit but we also want to bring this message of love, goodness, in everything we do in our personal lives and professional lives. It has to be seamless" [D#31_Conference]. This "prophesizing" involved highly visible acts of philanthropy:

> "Another great company that has actually, from out here in Denver, started a nonprofit group called the [X]. That's been around since 2009, actually. It's a group of cannabis entrepreneurs, their patients, employees or owners that go around and help communities with community-oriented events such as feeding the homeless and picking up trash from marijuana events and cleaning up after the 420 rally. We don't want to leave a bad image of us" [D#25_Interview].

As important as being involved in community projects was, the dispensary owners needed to have data that demonstrated their involvement: "and measure it. [X Dispensary] does a great job of measuring impact. They count everything and make these cool info graphics that we can share. When we say we belong here, we can also say, 'look what we've done'" [D#6_Conference].

Dispensary owners' attention to local dissemination helped infuse morality into the

industry by making dispensaries more familiar to their audiences, ultimately increasing empathy for them and thereby reducing fear of the "other." Local dissemination also contributed to morality infusion by giving category members a platform to communicate their values to diverse audiences. One dispensary owner stated, "What we really want to do is similar to the gay and lesbian movement. It's a coming-out party where people learn that cannabis consumers and business people are normal people. They are just like us, like me and you" [D#10_Interview]. By dispensary owners showing that they were normal, they hoped that these perceptions of normalcy would also transfer to their businesses and industry.

Furthermore, local dissemination had practical implications for the emerging category, particularly for individual firms' survival. Dispensary owners could get valuable information that helped them cope with a dynamic environment. "I just know the right people and I play the right politics. Often times I have changed the company direction just basically based off of the rumor and it happened to be extremely accurate" (D#10_Interview). In addition, local ties could be invaluable in times of crisis:

> "Connect with your community. Make sure you are going out and talking to those in the community who are established influencers. Because if something goes wrong, and you've done a really great job of cleaning up the block your business is on, making sure you are providing strong security, and your block is definitely better for you being there, then they are going to stand with you when the shit hits the fan" [AI#2_Conference].

Another dispensary owner stated,

> "I can't be less concerned with it (the federal government). I don't see how they can stop this snowball. It's already rolling too fast. They came out with that memo[3] because they understand they're losing control. People understand the drug war is a miserably failed endeavor. I don't think that you can ever stop what we've done. With the track record that we have, and the people that we have supporting us, if they came to shut us down, there would be riots in the streets" [D#18_Interview].

Disseminate broadly. While the dispensary owners and entrepreneurs focused on local dissemination, the collective also recognized that legislative changes at the federal level would be necessary in order to achieve destigmatization. Through industry groups, the collective

[3] "That memo" refers to the Cole memo, issued by the justice department, which said that banks would not be prosecuted by the current justice department for providing banking services to dispensaries and cannabis entrepreneurs.

became involved in legislative and regulatory processes at the state level in order to broadly disseminate a squeaky-clean image and crack down on the thug elements in the industry that threatened their efforts. Industry trade associations and lobbying groups presented many of its showcasing practices to legislators to demonstrate their willingness to take the necessary steps to make these practices the industry norm, and were willing to cooperate in passing or implementing regulations that made these practices mandatory. They believed that once the practices became instantiated in regulations it would weed out (no pun intended) those firms that did not conform to industry expectations. The director of one of the industry groups stated:

> "We do a lot of political and community organizing on behalf of the industry. It's really amazing to see all the supporting groups like NCIA (National Cannabis Industry Association) here. When the NCIA has the resources to have local and state level chapters, and you as business owners can pool your resources and have advocates on your behalf, it will work in the state house to build coalitions in support of your issues and your businesses. That's the real way to build power and create the change" [E#8_Conference].

Furthermore, the industry established procedures for paying its fair share of state taxes, and for paying federal taxes, despite its actions being federally illegal—actions that the collective hoped would foster a more favorable regulatory environment, as well as reassure external audiences that industry actors went further than mere compliance—they exceeded expectations, and these efforts would reduce the industry's stigma (Warren, 1980).

Success of the Stigma Reduction Process

Given that the industry's goal is full destigmatization, the question thus becomes, how successful have their efforts been? This is a complex question; it can be difficult to quantify stigma, and hence the extent to which it is removed; to determine among what audiences it needs to occur in order to declare the medical cannabis industry has been "destigmatized;" and whether it is even a reasonable or meaningful measuring stick. Warren (1980) defined destigmatization as achieving "normalcy," and Clair and colleagues (2016) and Adams (2012) noted that different degrees of destigmatization can be achieved. Destigmatization can also be achieved along some dimensions but not others (Clair et al., 2016; Warren, 1980), and as with other forms of social

evaluations, “not all audiences are equally important, which provides the organization with a strategic choice as to which audiences it should attend to” (Bitektine, 2011: 154). This means that destigmatization can also be achieved with some audiences and not others. This industry is not yet fully destigmatized, so in assessing the amount of stigma reduction in our context, we argue that the relevant audiences for the medical cannabis industry are state and federal governments; the general public, including the media; and the medical community.

State and federal governments. All cannabis sales and usage are still illegal at the federal level, and cannabis is still classified as a Schedule I narcotic, a decision that was reaffirmed by the Drug Enforcement Agency in August of 2016 (Saint Louis, 2016). Further, only a handful of small, state-chartered banks are willing to offer financial services (Popper, 2016). At the same time, the federal government has not been enforcing federal marijuana laws in states with legalized cannabis, and it has taken some steps to allay concerns about federal enforcement of the Money Laundering Act against banks providing services to the industry. Arguably, the industry will be fully destigmatized when cannabis is federally legal and the industry can access the same resources as other industries.

However, industry actors have made considerable strides at the state level towards their goal of removing cannabis’s stigma. One indication that they are succeeding is the trend in state medical cannabis legalizations. The earliest states to legalize medical cannabis did so using ballot measures that only required a majority vote. Bypassing the legislative process was critical for the early successes, since politicians were unlikely to legalize medical cannabis legislatively. However, the trend in recent years has been to legalize medical cannabis through legislative action, meaning legalization received a majority vote in the state house and senate, and had the support of, or at least was not actively opposed by, the governor. In the case of Minnesota, for example, the medical cannabis bill had bipartisan support, and was signed into law by Governor Mark Dayton in 2014 (Bailey, 2014). In addition to having state political support, 74 percent of Minnesotans supported medical cannabis (Public Policy Polling, 2014). This suggests that politicians have sufficient confidence in their constituents’ support of medical cannabis to

introduce these bills. Overall, as of 2018 thirty-three states and the District of Columbia have legalized medical cannabis, and ten states plus the District of Columbia have also legalized the recreational use of cannabis (Governing, n.d.).

General public. The general public's support for medical cannabis has increased. In 2014, a CBS poll showed that 86 percent of Americans supported medical cannabis (Dutton, De Pinto, Salvanto & Backus, 2014), up from 73 percent in a 2010 Pew Survey (Pew, 2010) and 58 percent in a 1997 ABC News poll (Pew, 2013), far outpacing support for recreational marijuana (Pew, 2013). In 2017, a Quinnipiac University poll showed that support for medical cannabis was at 94% (Quinnipiac, 2017). In addition, the media has been increasingly supportive of medical cannabis. Exemplifying this was CNN's chief medical correspondent Sanjay Gupta. In 2013, Gupta's documentary *Weed* chronicled his change in beliefs regarding the medical effectiveness of cannabis (Gupta, 2013a). That same year, Gupta wrote an article entitled *"Why I Changed My Mind on Weed,"* where he publicly apologized for previously voicing negative opinions about cannabis without due diligence. He stated:

> "I am here to apologize. I apologize because I didn't look hard enough, until now. I didn't look far enough. I didn't review papers from smaller labs in other countries doing some remarkable research, and I was too dismissive of the loud chorus of legitimate patients whose symptoms improved on cannabis…I now know that when it comes to marijuana …it doesn't have a high potential for abuse, and there are very legitimate medical applications." –Sanjay Gupta (2013b)

In 2014, Gupta wrote another article where he once again expressed his belief that cannabis has medical benefits, and that failing to consider it as a treatment option was irresponsible (Gupta, 2014), and he went on to produce two additional segments of *Weed*.

Overall, mainstream media outlets have helped normalize cannabis. For example, CNBC produced the documentary *Marijuana Inc., Inside America's Pot Industry* in 2009 to focus on the inner workings of the industry. Discovery Channel produced the reality television show *Weed Wars* in 2011 that chronicled the challenges of prominent dispensary owner Steve Deangelo as he tried to manage his dispensary, Harborside Health Center, and in 2013 aired *Weed Country*, where they featured the patients, growers and dispensary owners in the medical cannabis

industry. National Public Radio profiled high-end restaurants incorporating cannabis into haute cuisine (Ulaby, 2018), noting, “Chefs and entrepreneurs making cannabis-infused foie gras and ‘stoner souffles’ have been featured on not one but two series devoted to gourmet ganja: the Netflix competition program, *Cooking On High*, and the Viceland show *Bong Appetit*.” Bong Appetit’s cookbook is forthcoming.

The most significant mainstream media endorsement may have come from the *New York Times* Editorial Board, which published the six-part series "High Time: Editorial Series on Marijuana Legalization,” that called for an end to marijuana prohibition. Andrew Rosenthal, one of the editors, explained, “The *Times* editorial board has for years supported the legalization of medical marijuana. And we have opposed federal crackdowns on people who grow or sell marijuana for medical purposes in states where that’s legal” (Rosenthal, 2014).

Finally the first US-headquartered (but Canadian-located) cannabis company, Tilray, went public on the NASDAQ stock exchange in 2018 (Wieczner, 2019). Its IPO was one of the most successful of the year; its stock was up 315% at the end of 2018, its market capitalization was $9 billion, and it has entered into agreements with Anheuser-Busch InBev and Sandoz pharmaceuticals to market cannabis-infused products outside the US.

Medical community. Finally, support for medical cannabis has increased within the medical community. In 2014, the Epilepsy Foundation issued a statement calling for “the rights of patients and families living with seizures and epilepsy to access physician directed care, including medical marijuana” (Gattone & Lammert, 2014). A WebMD survey found that 67 percent of physicians believed that cannabis should be a medical option for patients (Rappold, 2014), and NORML listed approximately 60 health organizations that have endorsed patient access to and/or research on medical marijuana (NORML, 2017).

One example of a strong advocate for medical cannabis is Dr. Peter Grinspoon, who teaches medicine at Harvard Medical School, regularly blogs for Harvard Medical Publishing on the health benefits of cannabis, and who sees medical cannabis as a partial solution to the opioid crisis in the United States,. He stated, “It is quite effective for the chronic pain that plagues

millions of Americans, especially as they age. Part of its allure is that it is clearly safer than opiates (it is impossible to overdose on and far less addictive)" (Grinspoon, 2018).

Overall, the medical cannabis industry has not yet been fully destigmatized across all audiences, but as more firms gain access to financial markets and partner with major corporations, it is likely that destigmatization is near. While the industry has been least successful at the federal level, federal statutory changes typically lag public sentiment, and it may take intervention by the courts—for example, as recently occurred with gay marriage—to bring federal laws in line with public opinion, state legislatures and the medical establishment. However Brendan Kennedy, CEO and co-founder of Tilray, predicts cannabis legalization will be a campaign issue in 2020, and that federal legalization in the US could occur as soon as 2021 (Wieczner, 2019).

DISCUSSION

In this study we inducted a process model that explains how a core-stigmatized industry can reduce its stigma. As with individuals bearing the scars and tribal markings of stigmatized groups (Goffman, 1963), firms in core-stigmatized industries are often shunned, forcing them to exist in the shadows. But stigmatized industries sometimes have growth aspirations they cannot achieve within the shadows, and thus face a crucial dilemma—the light required to grow also exposes the industry's morally objectionable traits to greater scrutiny. These industries must thus figure out how to reduce their core stigmas while their constituent members take the actions necessary to survive the transition. Our study exploring this process makes several contributions to research on organizational stigma, categories research, and strategic entrepreneurship.

Below we outline our findings' major implications for theory and practice. The first implication is that separation is a critical aspect of reducing stigma, and that it takes three forms: (1) separation in phases across time; (2) separation across different relational spaces (Maire & Hehenberger, 2014); and (3) separation across new categorical boundaries (Durand & Khaire, 2017). The second implication is that category emergence in stigmatized industries differs in some respects from category emergence in non-stigmatized industries; and the third implication

is that the process we inducted can also be employed more generally by start-ups in new industries that face resistance.

Separation into Phases, Spaces and New Categories

While stigma is a categorical phenomenon where audiences group and devalue organizations with similar attributes (Vergne, 2012), much of the existing literature on core stigma has centered on tactics that individual organizations use to manage the stigma. Our findings build on recent research emphasizing that core stigma resides at the category level (Piazza & Perretti, 2015; Vergne, 2012), and suggest that while prior research on managing (Hudson & Okhuysen, 2009; Vergne, 2012; Helms & Patterson, 2014) or reducing (Adams, 2012; Clair et al., 2016; Hampel & Tracey, 2016; Warren, 1980) core stigma has identified a number of the tactics employed, it has neglected to consider how the process unfolds in identifiable phases and that it occurs in distinct front-, back- and side-stage relational spaces (Mair & Hehenberger, 2014). Further, most process models focus primarily on the connections that link different parts of the process in a particular order. While connections and the order of events are important in the model we inducted, as Figure 2 illustrates, we found that separation is also important. Specifically, separating activities into different relational spaces provides the ability to manage competing interests and accomplish conflicting tasks as firms balance stigma reduction with survival. Separation also involves forming new category boundaries.

Phases of reducing stigma. Our findings suggested that categorical stigma reduction unfolds in three distinct, but overlapping phases: initiating a moral agenda, moral prototyping and morality infusion. Whereas prior, tactics-focused research has not considered the ordering of activities, our model shows that the ordering of activities is important; certain actions must be separated in time, and will be unsuccessful until they are connected to others that have already taken place. For example creating a moral prototype and category emergence cannot occur until a clear and acceptable moral agenda has been established, and morality infusion will be unsuccessful if the actions associated with creating a moral prototype have not occurred first.

Another insight from our findings is that key events trigger each phase in the process, and as Figure 2 illustrates, the nature of these triggering events changes across phases. Although the motivation is there from the beginning, initiating the process requires that the environment is also receptive. Exogenous events that serendipitously come together can provide both the means and opportunity to initiate the new moral agenda. Once the moral agenda is established, the collective has the influence necessary to establish a moral prototype, but exogenous events and conditions outside the collective's control are still required to proceed. However, as the new category becomes established, the events precipitating morality infusion are largely driven by members of the stigmatized category.

For example, as Table 1 illustrates, in our context groups such as NORML tried to initiate a social justice-based moral agenda for over twenty years, but it was not until the confluence of the language used in a 1978 Supreme Court decision and the AIDS crisis a decade later that a viable moral agenda was created and there was sufficient energy to press it forward. Similarly, it took the passage of Proposition P in 1991 legalizing medical cannabis in San Francisco, and Proposition 215 in 1996 legalizing medical cannabis at the state level in California, to initiate the moral prototyping phase. These ballot initiatives required the efforts of medical cannabis activists, but they also benefited to a great extent from these communities' sensitivity to the AIDS epidemic and the patients' rights-based moral agenda, making the timing right for these initiatives to be proposed and passed, and passage was ultimately outside their control. It was another twenty years until morality infusion started to take place, as the language, symbols, values and practices needed for the new industry category to emerge took hold, and as more states legalized medical cannabis. At this point the industry had professionalized—establishing an industry infrastructure, and lobbying and trade organizations—and the collective began focusing its efforts on disseminating the industry's moral image and prototype local and broadly. While we expect the shifting locus of triggering events from external to internal across the phases is likely to generalize to other contexts, future research should confirm this finding.

Relational spaces and survival. It is not just the timing of when activities and events occur that is critical, but also where and when different competing interests are addressed and managed. Whereas initiating a moral agenda takes place primarily on the front stage, our findings suggest that moral prototyping and morality infusion unfold across all three stages simultaneously. Establishing and collectively agreeing on what exactly the category prototype will be was a contested process involving messy negotiations that took place partially in public, and thus were partially visible on the side stage. Prior research on stigma reduction (e.g., Adams, 2012) has focused only on front stage activities, and has not considered the conflict that competing interests and agendas can inject into the process, or how they are managed.

In their study of how two different institutional logics can come to coexist, Mair and Hehenberger (2014) argued that the front and back stages represent different relational spaces, where different types of meetings occur to allow parties with different perspectives to resolve conflicts. Our findings suggest that these different relational spaces also play an important role in how category stigma is reduced or eliminated. In particular, our model highlights the important role of backstage activities for organizational survival during the stigma reduction process, and the separation among the different relational spaces this required.

Not all core activities crucial for organizational survival are consistent with the values and practices being propounded on the front stage, and existing research on managing stigma has primarily focused on hiding these stigmatized attributes from public view (Hudson & Okhuysen, 2009; Vergne, 2012). We found that reducing category core stigma required creating a separate, backstage, relational space that not only separated survival activities from the prototype they were creating and disseminating on the front stage, but also for cognitively managing the value incongruence the two sets of practices engendered (Maire & Hehenberger, 2014). While some may view this as hypocritical, since they were using the black market to access resources, the industry members saw it in more pragmatic terms; destigmatizing their industry would do them little good if they were not around to enjoy the fruits of their efforts. Whether and to what extent

the backstage continues to be necessary, and whether the activities change once the industry has become largely or wholly destigmatized, is an interesting avenue for future research.

Forming new categories. Our findings also showed that in addition to connection and separation across time and space, a third form of connection and separation was accomplished through category formation. Reducing a category's core stigma does not just involve linking an existing category to another category with a different set of values, or through certification by reputable actors. Rather, it can involve more complex processes of category emergence (Durand & Khaire, 2017), where a new category (medical cannabis) forms out of an existing category (the black market) through bottom-up processes of boundary creation (i.e., by rank and file industry participants, rather than elites or some governing authority), and the proponents of the new category push the stigmatized values and labels onto the existing category while tying the new category to different, more accepted values, symbols and labels. It does this through processes of identifying, or connecting, with a new set of values, language and symbols, and disidentifying, or separating, from the old category and its associated values, language and symbols. In doing so, it perpetuates the stigma, even as it separates itself from it. Once the new category prototype begins to coalesce and its values, language and symbols are shared among its members, it can then be disseminated to external audiences through morality infusion.

Category Emergence in Stigmatized Categories

Our study also contributes to the literature on categories and categorization, more generally. There has been an increased interest in the role and influence of category membership on a variety of organizational outcomes (e.g., Delmestri & Greenwood; 2016; Hsu, 2006; Paolella & Durand, 2016; Rao, et al., 2005; Rosa, et al., 1999; Zuckerman, 1999), and on how values and identity influence responses to new categories (e.g., Carroll & Swaminathan, 2000; Hsu, Koçak, & Kovács, 2018). Less attention has been paid, however, to how categories can morph and change (Durand & Khaire, 2017). In distinguishing how new categories come about through the processes of category emergence and category creation, Durand and Khaire (2017: 97) noted, "In category emergence, the cues and elements solicited to recombine, build, and

narrate the story around the novelty belong to alien repertoires and vocabularies; as a result, the emergent category is more likely to be fought against, rejected, demoted, and vilified by incumbent actors that defend and benefit from existing orders and economic models."

However, this presumes that the artifacts and practices at the center of the existing category are perceived as moral. We find that when new categories emerge from stigmatized categories the opposite occurs: it is the existing category that is "fought against, rejected, demoted and vilified" as the newly-emerging category works to establish and distinguish itself, and push all of the existing stigma associated with the product at the core of both categories onto the pre-existing category. Thus, "removing" stigma does not necessarily mean that the stigma "disappears;" rather, it can involve scraping the stigma off of one category and concentrating it on another. We show that a variety of actors worked collectively to create a new moral category prototype they can identify with, while simultaneously creating and disidentifying from a negative category prototype. They did so by drawing on generally sanctioned cultural values and infusing these values into their practices, narratives, overall identities, and, ultimately, their image (Gioia, Hamilton & Patvardhan, 2014). Unlike the new values incorporated in the emergence of unstigmatized categories, these values must be strong enough to supplant the prevailing values at the root of the stigma, and at the same time decouple a stigmatized industry's core artifacts or activities from one set of values and attach them to a new set of values. Our theoretical model highlights the interplay between the language, materials, symbolic actions and processes of identification and disidentification necessary to make these changes.

Our study also highlights the importance of different relational spaces in this process. Research on category emergence based on non-stigmatized products and practices has not given a great deal of attention to how individual actors survive as the new category emerges. With stigmatized categories, firms cannot simply dip their toes in the water and adopt the new category a little bit, such as adding a new type of dish to an established menu (Rao, Monin & Durand, 2003), or be a late adopter who switches categories once the new one is established (Simons & Roberts, 2008)—they must go all in to the new category. Our findings suggest that

with stigmatized categories, backstage prototype violations that facilitate organizational survival as the category emerges are also necessary.

Finally, Durand and Khaire (2017) argued that with category emergence in non-stigmatized industries, material changes precede changes in narratives and labeling. In other words, actors introduce innovations that are inadequately captured by the category's current classification system, and the innovators then devise a new classification system and category that is more representative. We find that the underlying processes for stigmatized category emergence unfold differently. In our context, the narrative that marijuana could be medicine had existed for more than 100 years, although it had been suppressed by the more dominant, stigmatized narrative for most of the twentieth century. Thus, the basic narrative itself was not new, even if how it was developed into a powerful moral agenda was.

Further, the product itself had not changed at all, even as the marijuana as medicine narrative reemerged and was re-configured into a new moral agenda. Indeed, it was only in the morality infusion phase, after the moral agenda was established and the new moral prototype was created, that material changes in the product—via selective breeding for particular attributes—and innovations in how the product was consumed (i.e., vaping, tinctures, topicals and edibles[4]) were introduced. While Durand and Khaire (2017) acknowledged that the processes they described were ideal types, our findings suggest that there may be substantive differences in how stigmatized and non-stigmatized categories emerge. More specifically, it seems that when a category is emerging from a stigmatized core, material changes are still critical, but they can only serve their intended purpose if the category's initiators first skillfully use language and symbols to establish new categorical boundaries based on morally acceptable premises, and begin to change the cognitive associations between the category's core artifact and the societal values associated with it. Future research on industry categories should continue to explore how firms survive the category's birth, particularly in stigmatized contexts.

[4] Pot brownies not withstanding

Practical Implications for Strategic Entrepreneurship

Finally, our study has practical implications for strategic entrepreneurship, or the combination of opportunity seeking with advantage seeking (Hitt, Ireland, Camp & Sexton, 2001; Ketchen, Ireland & Snow, 2007). Scholarship in this area considers entrepreneurial firms' strategic actions, but has generally not considered the negative social evaluations that entrepreneurial firms may deal with in new industries that carry some stigma (e.g., that require "dirty work" [Ashforth, Kreiner, Clark & Fugate, 2007]), rely on bricolage to make do with the substandard resources at hand (Baker & Nelson, 2005), that employ controversial or untested technologies (e.g., stem cell technology [Weitzer, 2012]), or that engage in practices challenging existing norms (e.g., Uber, Airbnb and Napster). Our study highlights how entrepreneurs can use morality to create new meanings for key audiences, particularly when these audiences draw on their values to object to the industry category's existence. Entrepreneurship involves exploring opportunities in unchartered territories that can be disconcerting to and resisted by some (Baker & Nelson, 2005; Garud, Hardy, & Maguire, 2007); by exploring how new industries deal with antagonistic stakeholders—typical in stigmatized industries—this study informs our understanding of how to overcome audience resistance to new industry categories.

Limitations and Future Research

Like any study, ours has limitations that create opportunities for future research. It is a qualitative inductive study; thus, there is the possibility that our findings may not generalize to other settings. Our study also focused on three states (Washington, Colorado and Oregon) that were early movers, and were located in the Mountain West and Northwest. It is likely there are regional differences in industry approaches to remove stigma. Comparing early and later legalizing states could yield interesting insights.

Future research should also explore whether the process we identified is observed in other core-stigmatized industries, such as abortion providers' efforts to be seen as meeting women's healthcare and reproductive needs; garbage collectors' repositioning as providing waste management services, including recycling; positioning prostitution as a feminist issue (Weitzer,

2012); or pornography firms' desires to become mainstream (Voss, 2015). While we expect the process we have outlined will be more effective in dealing with morally- and socially-grounded stigmas than physical stigmas (Ashforth et al., 2007), future research should consider the extent to which the process generalizes across a variety of contexts and types of category core stigma. Future research should also consider whether our findings generalize to groups that are seeking to change audience perceptions around other related social evaluations such as legitimacy, that are "aggregated and objectified at the collective level" (Bitektine & Haack, 2015: 50).

Another potential limitation is that we studied the more prominent leaders of the industry, who were focused on changing and defining the industry. Further, because of the closed nature of the community, we began collecting data using snowball sampling. Thus, we may have been referred into networks of like-minded individuals and failed to capture the differing perspectives of other groups. For example, it is possible that there were other firms on the fringes of the industry that were not as concerned about changing the status quo, or had different perceptions about removing stigma. We also did not systematically interview the stakeholder audiences who were being affected, although we had substantial media accounts, voting data and poll results that were useful in tracking changes in their perceptions. Future research may consider how those firms affected, and were affected by, the overall process.

A related limitation is that while we discuss collective behaviors and perceptions, because our focus was on understanding the overall process of reducing category stigma, we did not conduct an in-depth analysis of the dynamics within the organizations and among the different individual players representing the collective. Our data revealed clear goal consensus with respect to stigma removal and differentiating medical cannabis from the black market; however, as our discussion of the side stage showed, there was disagreement on other issues. Future research focused on collective actions should explore these interorganizational dynamics in greater detail.

Our study also suggests additional avenues for future research. Since we conducted a contemporaneous rather than a purely historical study, the industry was not yet fully

destigmatized in the eyes of all of its different audiences. As we discussed, determining when a category's stigma has been completely removed is not straightforward. However, future research that follows contemporaneous stigma removal efforts to their conclusion could offer valuable additional insights, particular as they relate to the use of the various stages.

A final avenue for future research is that cannabis entrepreneurs are likely experiencing changes to their personal identities as their firms and industries undergo their transformations (Powell & Baker, 2014). Future research should examine the nature of these changes, and how they affect various outcomes (such as decision-making, innovation, etc.) for both the individual and firm.

Conclusion

Our study contributes to research on category core stigma by proposing a process model of category stigma reduction. Research on stigma has generally focused on its micro manifestations, and on efforts to cope with organization-level stigma. However, category-level core stigma reduction is a phased effort that takes place across different relational spaces. A moral agenda based on broadly acceptable values jumpstarts the process, and the industry must carry forward the mission by creating a new moral prototype that reflects these values, and with which the industry category can identify. At the same time, category members must publicly dis-identify with the current, stigmatized prototypes. They must also infuse the new moral prototype among their stakeholder audiences through their language and practices, creating emotional connections that lead to cognitive acceptance. This process is messy, as individual organizations often need to continue engaging in stigmatized behaviors in order to survive, even as they publicly disidentify from them. Scholars should continue to consider how the medical cannabis industry and its activities changes over time in response to a dynamic external environment.

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Table 1 – A brief timeline of cannabis in the United States

Time Period	Events	Description/Example Quote	Labels used for cannabis
1800s to early 1900s	Cannabis used medicinally and supported by the medical community in the US	Medical use of cannabis documented in the 1860 *Report of the Ohio State Medical Committee on Cannabis Indica (McMeems, 1860)*	"medicine"
1930	President Hoover created the Federal Bureau of Narcotics (FBN). Harry Anslinger picked to lead the agency.	Federal efforts to devalue and stigmatize cannabis begins	"killer weed"
1930s	Mexican and West Indian immigrants entering the US who used cannabis. At the same time, the FBN aims to reduce narcotic use. Cannabis gets improperly categorized as a narcotic.	"Although as appalling in its effects on the human mind and body as narcotics, the consumption of marijuana appears to be proceeding, virtually unchecked in Colorado and other Western States with a large Spanish-American population. The poisonous weed which maddens the sense and emaciates the body of the user, is being sold more or less openly in pool halls and beer gardens and, according to some authorities, it is being peddled to school children. …Most crimes of violence in this section, especially in the country districts, are laid to users of the drug." (The NYT, 1934, Sept 16).	
1936	*Reefer Madness*	A film about the dangers of cannabis use	
1937	Marihuana Tax Act	Cannabis taxed to essentially prohibit its use	
1950s-1960s	Cannabis use increase among students at prestigious US colleges and universities	"Many succumb to the drug as a hand means of withdrawing from the inevitable stresses and legitimate demands of society. The evasion of problems and escape from reality seem to be among the desired effects of the use of marijuana" (Judge J. Tauro, 1967 cited in Himmelstein (1983), From Killer Weed to Drop-Out Drug).	"gateway drug", "killer of motivation"
1970	Controlled Substances Act	Cannabis classified as a Schedule I drug, defined as having (1) a high potential of abuse, (2) no currently accepted medical use in treatment in the US, and (3) a lack of accepted safety for use of the drug or other substance under medical supervision (USDOJ, 2012).	
1978	Supreme Court ruled that Robert Randall could grow marijuana to treat his glaucoma	First recorded use of the term "medical marijuana"	"stoner", "pot head", "pushers", "peddlers", "dealers"
1980s	San Francisco the epicenter of the AIDS epidemic and leads US in confronting AIDS	Initiate Moral Agenda	
1991	San Francisco passed Proposition P	Moral Prototyping begins- Legalized medical cannabis in San Francisco	
1992	San Francisco Cannabis Buyers' Club opens	Moral Prototyping begins - One of the first legal dispensaries that served the needs of AIDS patients	
1996	California passed Prop 215	Entrepreneurial activity increasing in medical cannabis	
1998-1999	Maine, Oregon & Washington legalized medical cannabis		
2010	Industry associations and innovations	Morality Infusion begins	
Jan. 2014	Recreational marijuana		"Medical Cannabis"

Gray shading denotes critical junctures the emerging medical cannabis industry and its ability to change perceptions of cannabis. Blue shading represents increases in the use of the "medical cannabis" label. Not meant to denote linear and consistent process .

Table 2 - Data Sources

Source	Use
Archival	
House of Representative : * 1922 - Importation and Exportation of Narcotic Drugs * 1937 - Taxation of Marihuana * 1956 - Narcotic Control Act * 1968 - Clarification of Dr. Goddard Views on Marihuana *1969 - Commission on Marihuana * 2014 - Mixed Signals: The Administration's Policy on Marijuana *Congress Hearing*: * 1952 - Boggs Act * 1957 - Juvenile Delinquency * 1966 - The Narcotic Rehabilitation Act * 1967 - Problems Relating to the Control of Marijuana *1969 - Comprehensive Narcotic Addiction and Drug Abuse Care and Control Act *1970 - Crime in America-Views on Marihuana *1980 - Therapeutic Uses of Marijuana and Schedule 1 Drugs *National Commission on Marihuana and Drug Abuse:* *1972 - Marihuana: A Signal of Misunderstanding *1973 - Drug Use in America: Problem in Perspective *Other reports:* * 1850 - Report of the Ohio State Medical Committee on Cannabis Indica *1991 - Medical Use of Marijuana: Policy and Regulatory Issues (CRS Report for Congress)	Used to establish a timeline of events that are related to cannabis. Used for developing an understanding of the sources of stigma, the emerging industry's efforts to remove its stigma, and the challenges it faced in doing so.
Newspaper Archives - 1990-2013 - The Oregonian, The Denver Post, The Seattle Times. National newspapers.	Useful for observing front and side-stage activities. Also provided valuable reports of backstage activities.
Industry Reports - 2013 & 2014 - The State of Legal Marijuana Markets (Change Strategy & ArcView Group)	Useful for understanding the medical cannabis industry, its growth over time, and industry goals.
Books - Cannabiz: The Explosive Rise of the Medical Marijuana Industry, by J. Geluardi, "Marijuana", by E. Goode, "Marijuana: Weeding Out the Hype!: Myths, Facts & Illicit Drugs. What You Should Know" by Center for Substance Abuse Prevention, "Smoke Signals: A Social History of Marijuana - Medical, Recreational and Scientific" by Martin A. Lee	Useful for gaining an understanding of the broader context related to cannabis, how it became stigmatized, and efforts to remove the stigma.
Documentaries - "Weed"—Parts I, II & III by Sanjay Gupta and "Inside: Medical Marijuana".	Useful for gaining an understanding past and current perceptions of cannabis.
Interview Data	
38 interviews of proprietors of dispensaries and other cannabis-related firms, growers, activists, and industry representatives.	Most conducted between 2011 and 2013. Lasted from 45 to 90 minutes. Useful for identifying efforts by industry actors to change perceptions of cannabis. Useful for exposing front, back and side-stage actions.
Direct Observations	
3 Conferences. PowerPoints of 51 presentations. Video recordings and transcripts of presentations. Transcripts of Q&A sessions. Flyers and informational brochures. Extensive notes.	First conference in Seattle, WA, third conference in Chicago, IL. Both lasted 2 days and were organized by Marijuana Business Daily, the leading trade publication for the cannabis industry. Presentations by individuals acknowledged as industry leaders—

	including business owners; activists; industry association leaders; lawyers, accountants, and various suppliers. Useful for observing front and side stage actions, and hints of backstage actions. Second ancillary business pitch conference useful for observing framing of industry values.
Site visits to 5 medical cannabis dispensaries	Useful for understanding organizational practices on the front-stage and for subtle inconsistencies between their language and practices.

Table 3 – Supporting Data for First Order Codes

Initiating Moral Agenda
Peron's real mission with the San Francisco Cannabis Buyers Club was to get arrested. Once charged, he planned to launch a defense based on marijuana's medical necessity. He wanted to prove in court that nothing else made AIDS patients more comfortable. [Pollick, 2014, Herald-Tribune]. **First Order (FO) – medical marijuana, patient rights**
"Smoking marijuana makes the pain go away. Nothing else really worked." Chavez, 40, of Santa Ana gets his pot through the Cannabis Buyers Club in Los Angeles, part of an underground medical network catering strictly to pain sufferers. Its members are passionate believers in pot's medicinal value and are crusading to make their crime legal in California. [Sforza, 1996, Orange County Register]. **FO – medical marijuana, patient rights, patient testimonials**
"I'm serving so many people now we've become an auxiliary branch of the Health Department. We've got 25,000 people in San Francisco with HIV, and they're all going to be here someday." [Dennis Peron quoted in Goldberg, 1996, NYT]. **FO – medical marijuana**
The stories of sick people have propelled the cause of medical marijuana. Proposition 215 was framed by its supporters as a question of patients' rights, and their most effective television ads told the stories of cancer patients for whom smoking marijuana brought dramatic relief. [Pollan, 1997, NYT]. **FO – patient rights, patient testimonials**
Hundreds of new patients shuffled last week through the glass doors of the converted downtown warehouse on Market Street to register their ailments – from end-stage AIDS to dubious anxieties. "Aren't these the most gentle people?" Peron said. "What could possibly be wrong with this? They want to arrest these people? I just keep asking, why, what for, what crime?" [Booth, 1997, Washington Post]. **FO – medical marijuana**
Moral Prototyping
Ultimately what we are doing here is fulfilling the promise of regulated marijuana businesses, of taking marijuana out of the black market, creating jobs, providing people safe access, and expanding healthcare options for folks [AI#2_Conference]. **FO – new category solution for old**
There were a lot of growers that, especially back in 2009, 2010 had been growing marijuana which had been very illegal for so long. They unfortunately just had a lot of black market connections and activities and they were criminals. They were also good marijuana growers, but they were criminals. [D#6_Interview]. **FO – negative labels for black market**
There are lots of people in the world who like the idea of being able to visit a place and use cannabis and not feel like a criminal. Whether that's someone who is dealing with some sort of medical issue coming from another State, to try out marijuana medially before they try and talk a doctor into it, or whether it's the suburban group of moms who decide to come to Colorado for a weekend and go to the cannabis yoga spa retreat [AI#2_Interview] **FO – medical category**
We have to prove this argument, we have to prove that cannabis is a valid, compassionate choice that should be safely available to patients [E#5_conference] **FO – patient testimonials**
Morality Infusion
Always making sure you're doing correct business and never slighting anyone and making sure all your revenues were filed [D#10_Interview] **FO – showcasing**
We presented cannabis not as an intoxicant but presented in the context of wellness. So when you look at our advertising, when you look at our promotional and our advertising materials, when you take a look at our website, we're not talking to people about getting high or getting wasted. We are really genuinely interested in helping people with their wellness issues. [D#3_Interview]. **FO – diluting**
There will be a juice bar regularly [at the dispensary]. There will be both medical cannabis infused products, one side a juice bar and then in another area there are just your standard yogurt based smoothies and that sort of thing. Though we could host anything, we are medical facility too [Interview#11]. **FO – diluting**
The trade shows and events- the scantily clad outfits- I personally don't think that a good representation of our industry. I think we want to encourage people to see our industry as responsible, as doing good for the community, like everybody else in the room as your businesses grow, give back to the community. [E#14_Conference] **FO – showcasing, ties to local community**
We are doing a lot of work around ensuring that we are building a responsible and accountable industry where the leaders are participating in their communities. A lot of our members do a significant amount of community service, participating in local philanthropic activities. [E#2_Interview] **FO – showcasing, ties to local community**
We really just feel like if you show people that you can run a responsible cannabis business and help contribute to society and don't create a lot of problem, it just goes a long way and really just handling all the propaganda and all the fear that the federal government has pushed on us for the last 75 years [D#7_ Interview] **FO – showcasing**

Morality Infusion, cont.
When I am done, our image is going to be of strong community supporters, great involvement, engaged with the community. [D#7_Interview]. **FO – ties to local community**
We went to through a number of master growers early on and finally we set up with a guy who had a degree in horticulture from a university in Nebraska. He had never grown cannabis before but he was a good guy and understood plant science. [E#30_conference] **FO – showcasing**
Making sure that you are represented by people who understand the complexities of cannabis business, who understand the complexities of the people and culture in which they are lobbying, the individuals in which they are lobbying, and really understanding how you work collaboratively with your peers and colleagues. [D#5_Conference] **FO – using industry groups to lobby**
Side-stage Prototype Negotiation
Brian Vicente, executive director of the group Sensible Colorado, said his group is still talking with lawmakers about fighting back a proposal that would effectively outlaw retail marijuana dispensaries and instead introducing a bill the cannabis community could support. Matt Brown - executive director of Coloradans for Medical Marijuana Regulation, which has hired a team of lobbyists to represent it at the Capitol this session - said he has found lawmakers surprisingly willing to listen to proposals from the cannabis community. The change in tone for at least some advocates is pronounced when compared with a few months ago. [Ingold, 2010, Denver Post]. **FO – inter-group fissures**
I think that from a consumer point of view, consumers would want cannabis testing to be part of any regulatory model. I‘ve heard people within the industry who are resisting doing that who don’t think it’s a good idea because they don’t (a) think it’s necessary and (b) don’t want to pay the cost that's involved. I don't share that view. There’s another example where you can see a divergence of interest there. [D#3_Interview] **FO – disagreements on structure**
CMMR also has earned critics, including some from within the multi-faceted cannabis community who consider the group representative of big-money interests that they fear will corrupt the medical-marijuana system. William Chengelis, a marijuana activist with Mile High NORML, said his organization has been at "loggerheads" with CMMR over CMMR's lobbying campaign.[Ingold, 2010, Denver Post]. **FO – inter-group fissures**
But when you get down to the details of actually regulating how cannabis is going to be made legal, there can be some real divergent interests. So for example in the state of Washington, there was a lot of pressure during the regulatory process from people who wanted to make sure that there was a lot of access for local members of the community and for people who were not already super well capitalized. [D#3_Interview] **FO – disagreements on structure**
Backstage Survival Violations
I mean we have some patients who have things like seizure disorders. Things like that which you wouldn’t know from looking at them. There are the people who use it as medicine and there are the recreational users who are kind of under the guise of the medical users, and then there is like the in-between. There are people who are kind of both [D#32_Interview]. **FO – selling to rec users**
We get the older people who are sort of from the reefer madness era and they don’t know anything about it, they are still very hesitant to try it, and it is very taboo. So those people we are a little more cautious with the way we phrase things I guess. We don’t want to make them feel like you know in a drug den or whatever it is. Other people will just come in and say, “Oh, what is the best thing that you have?” Or something like that, which automatically think that they have shopped around and they are just looking for something to get them high [D#32_Interview]. **FO – selling to rec users**
Some people call it marijuana. I call it the drug cultivar because I want to be very clear that marijuana is a derogatory term. I don’t really ever use it. [Later in that same conversation, interviewee stated, "I have three patients including myself, until I can have 72 ounces of usable marijuana, so that I can have enough of the sugar leafs."] [Interview #5] **FO – changing labels**
“taking demand that’s already there and readjust where they [customers] go to get their medicine…pot” [Conf#9]. **FO – changing labels**
Cashless ATMs is a popular option at this point of time; everybody’s selling it. The reason is because you are using an ATM network and this is considered a cash transaction rather than using Visa or Mastercard networks. [Conf#22]. **FO – cashless ATMs**
Colorado Attorney General John Suthers said the ring is another example of diversion from the medical-marijuana industry that was highlighted in a report earlier this month by drug investigators. It is becoming clear that, as predicted in 2010 legislative hearings, Colorado is becoming a significant exporter of marijuana to the rest of the country, Suthers said in a statement. [Ingold, 2012, Denver Post]. **FO – sourcing from black market**
I was involved in the black market all the way up till six months ago when I finally said, “There is a conflict here. I can no longer be involved in the black market. I have to do everything above the table.” [D#5_Interview] **FO – sourcing from black market**

Figure 1 – Coding Structure

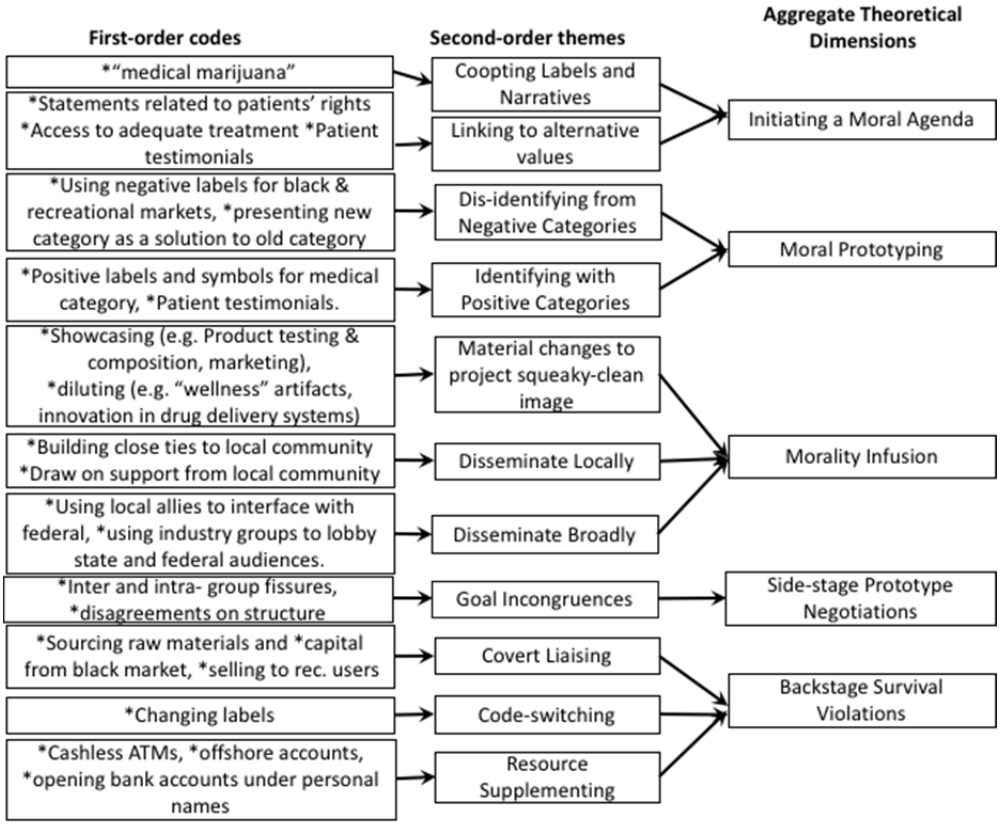


Figure 2- A Process Model of Category Stigma Reduction

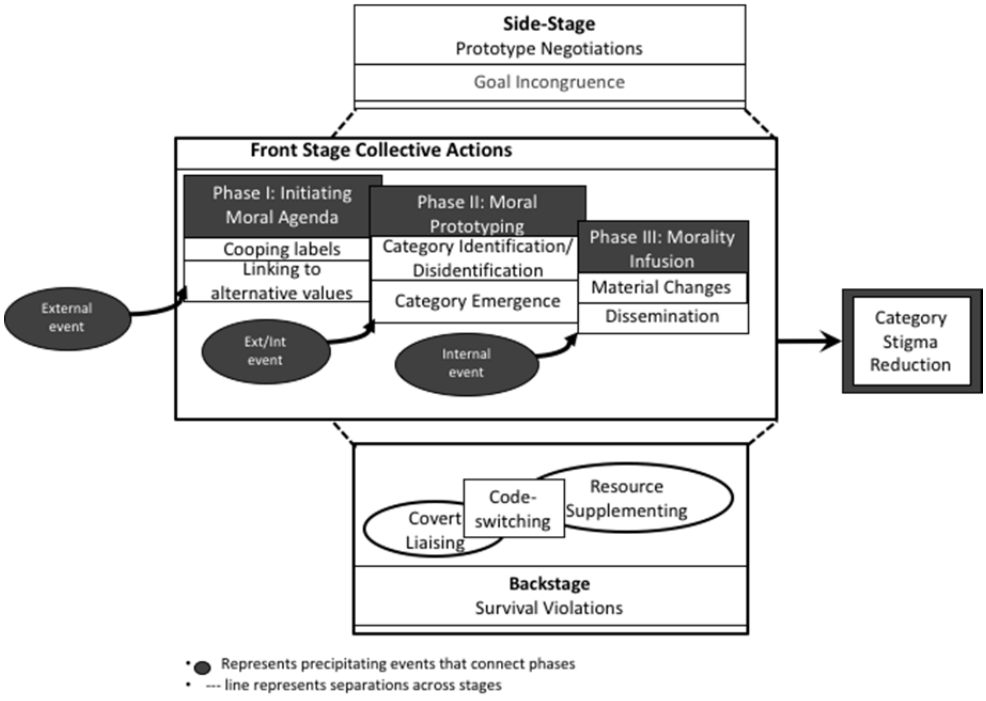
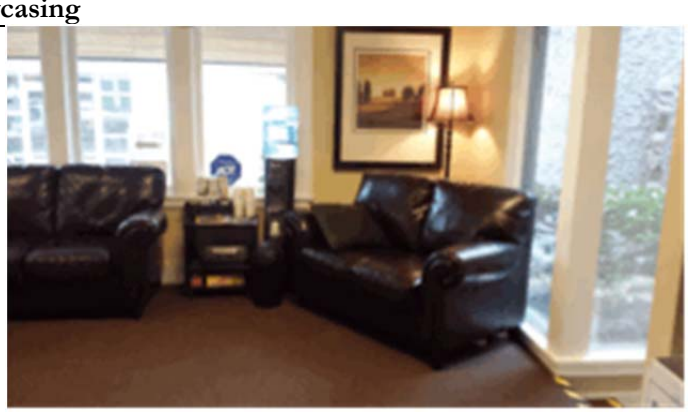


Figure 3 – Examples of Organizational Showcasing

Dispensary storefront



Dispensary reception area

Medical cannabis child-proof packaging

Medical cannabis on display in glass jars

Figure 4 – Examples of dispensary logos

Green cross often used in dispensary logos

Appendix

Interview Protocol – Medical Cannabis

OPENING. Can you tell me about your background and your motivations for getting into the medical cannabis industry? Tell me about your company/agency (how long in business, # of employees, etc)?

1. (Entrepreneurs/professionals) in emerging industries always face some challenges. Are any challenges that you think are specific to being an entrepreneur/professional in the medical cannabis industry? What do you think are the challenges for the industry as a whole?

2. How are you addressing those challenges? How are others addressing those challenges?

3. What is the role of advocacy in the cannabis industry? How has it changed over time? (How have advocacy and entrepreneurship affected each other?) How has your stance on advocacy affected how you conduct your business?

4. What is your sense of how outsiders view what you do?

5. When we say "outsiders"…could you please elaborate? Who are the outsiders that matter to your business? How are you trying to change their perceptions?

6. How do you view yourself? Do you consider yourself to be an activist? What is the role of activists in this industry?

7. Where do you see yourself in the future of this industry?

8. How do you see the evolution of these perceptions over the years? Have there been any shifts in those perceptions?

9. How would you like others to view you? Your business/agency? Your industry?

10. What are you doing to influence the creation of this image?

11. This must be a big challenge at the industry-level. Could you please tell me about how the industry is dealing with this?

12. Is there anything else I should know about the challenges that entrepreneurs/professionals in your industry?