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Medical Cannabis: Modeling a Destigmatization Process for its Candidacy to Become a Pharmaceutical Brand

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Abstract:

Purpose: *This paper discusses an investigation of medical cannabis in an attempt to explore opportunities to liberate the product from its stigmatization and to identify possible routes for its candidacy to become a medical brand. It is believed that this is feasible with the contribution of social marketing. We present a conceptual model for medical cannabis destigmatization and justify the contribution of social marketing, as a bridge to attain a consensus within the opposing parties and clear the fog around the identity of medical cannabis.*
Design/methodology/approach: *A literature review produced a pool of pertinent data associated with medical cannabis and its destigmatization process through social marketing.*
Findings*: Data was grouped into two categories: (a) medical cannabis stigmatization and (b) social marketing as a tool to reduce stigma.*
Practical implications: *Following the literature review, we were able to construct a Tri-stage model for destigmatizing medical cannabis and strategizing its future as a medical brand.*
Originality/value: *The Tri-stage model will initiate discussions since it is the first to attempt the destigmatization of medical cannabis. We also emphasize and justify the contribution of social marketing acting as an ambassadorial agent to attain a consensus and to acquit medical cannabis, unfolding its real potential in medicine.*

Keywords: *Medical cannabis, stigmatization/destigmatization, social marketing.*

JEL codes: *I12, I18.*

Paper type: *Conceptual paper.*

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1. Introduction

For most of its history, the use of cannabis has been regarded as an antisocial activity (Belle-Isle *et al*., 2014). However, today cannabis is widely accepted and used among the general public in different contexts (Patel *et al*., 2017). Nevertheless, in many countries, cannabis use for medical purposes is impeded by existing stereotypes and stigma about the plant, associated with its use for recreational purposes (Belle-Isle *et al*., 2014).

Using a drug for medical reasons is viewed as less morally acceptable if other consumers use the same drug for recreation (Wilson, 2022). Instead of using cannabis to treat sickness, its largely illegal status and the criminal sanctions associated with it have prevented its wider use in medicine (Bottorff *et al*., 2013). The implications of this outlook are clear: as long as cannabis continues to be considered an illegal drug and is criminalized when used for recreational purposes, its medicinal applications and uses remain questionable and limited.

The current state of public perceptions regarding cannabis explains and confirms that the prevailing negative stereotypes hinder significant research efforts that would possibly reveal the potential medicinal properties of cannabis (Blackman and Bradley, 2017). In parallel, cannabis' use for medical purposes is limited largely due to the lack of conclusive research on its medicinal potency (Hall *et al*., 2019).

A vicious cycle is thus created because the limited research on cannabis' medicinal potency is linked to its stigma. Furthermore, since a widespread and enduring stigma surrounds cannabis use even for medical purposes, the result is a lack and limited use of research funds. Consequently, practitioners tend to shy away from prescribing cannabis for fear that doing so may put their patients in greater danger and, by extension, negatively affect their medical practice and personal reputation (Ko *et al*., 2016; Melnikov *et al*., 2021).

In fact, many physicians in the US have been reluctant to prescribe medical cannabis because of scarce high-quality evidence and concerns about their legal liability for any adverse effects (Hall *et al*., 2019). In addition, healthcare providers who do not partner with patients seeking information about medical cannabis may be replaced by dispensaries and websites with expertise in cannabis but without an understanding of patients' medical conditions (Brady *et al*., 2020).

Therefore, it is established that the medical potentiality of cannabis remains far from being exploited due to its stigmatized identity, its negative social status and disputes over its medicinal potency. This results in physicians' hesitation to prescribe cannabis-based treatments, limited access of patients to them, inconclusive research findings due to limited state funding, and the presence of many non-regulated over-the-counter (OTC) cannabis products which are marketed with non-evidence based claims that they provide medical assistance in a great variety of disorders frequently substituting

conventional treatments (Bramness *et al.*, 2018; Carrieri *et al.*, 2020; Temple *et al.*, 2019).

In order to better understand and reverse this stigmatization surrounding medical cannabis, we examined the literature surrounding its stigmatization and the instrumentalization of social marketing as a bridge to attain a consensus within the opposing parties.

Our study led us to a Tri-stage model of how the medicinal use of cannabis could be destigmatized and accepted by the general public. This research aims to provide a tool for medical cannabis destigmatization to the benefit of patients in need and their relatives who struggle with non-effective treatments (e.g., patients with severe epilepsy), their physicians and other healthcare professionals who lack alternative solutions, medical cannabis manufacturers and marketeers, the state which could save significant healthcare costs by providing the most cost-effective treatment to its citizens and the society in general by opening its acceptance boundaries to areas that used to be marginalized.

2. Research Methodology

In this paper, a literature review was used to gather information about the current status in the research area of the medical cannabis' stigmatization effect and the potential contribution of social marketing as an ambassadorial agent to attain a consensus and to acquit medical cannabis, unfolding its real potential in medicine.

Attempting to combine keywords from the three pillars of this study (medical cannabis, stigma, social marketing) produced no results in Scopus database which covers a diverse range of publications in Medicine, Sociology and Marketing. Thus, a non-systematic approach was adopted (Kraus *et al.*, 2022) by the selection of papers related to any combination of two of these three pillars.

A single search algorithm was created for each pillar (Table 1). We limited our search to peer-reviewed journal articles, books, book chapters, conference proceedings and editorials written in English. The search was not restricted by date; the aim was to include those articles which are within the scope of this paper and were published by January 2023. After a first screening, we considered all potentially relevant articles.

We manually read the titles and abstracts of all articles identified through this process and removed unrelated and duplicate articles. For these articles, the relevance and eligibility of which was not clear within the title or abstract, we conducted full-text screening. Some articles deviated from the topic and some others were repetitively reproducing the same information. Next, we reviewed the reference lists of the articles selected so far to identify additional papers that may have been disregarded by the search engine.

The refinement process resulted in articles that met the scope of this paper and therefore were included in the literature review. Two researchers screened each paper separately. No previous similar attempt to synthesize this particular literature in a non-systematic or systematic manner was found.

Table 1. *Search algorithm used and results*

Pillar	Algorithm	Results
#1 Medical cannabis	"medical cannabis" OR "medical marijuana" OR "medical cannabinoids" OR "pharmaceutical cannabis" OR "pharma-grade cannabis"	4,746
#2 Stigma	"*stigma*" OR "social stigma" OR "discrimination" OR "labeling" OR "social marginalization" OR "social norms" OR "stereotypes"	1,029,219
#3 Social Marketing	"social marketing" OR "social marketing intervention*" OR "social marketing program*" OR "social marketing policy"	8,588
#1 AND #2 AND #3		0
#1 AND #2		186
#2 AND #3		531
#1 AND #3		4

Source: *Own study.*

3. Medical Cannabis Stigmatization

Stigmatization is a process where differences in human behavior or characteristics get labeled, and then labeled individuals are associated with negative stereotypes (Fortney *et al.*, 2004).

Link and Phelan (2001) described stigma as a social process where different characteristics are distinguished and labeled, labeled people are associated to negative stereotypes, ‘‘us’’ and ‘‘them’’ distinctions are created to separate from the rest labeled people, who in turn experience status loss and discrimination.

In theory, public stigma has been conceptualized as having cognitive and behavioral core features that incorporate stereotypes (cognitive knowledge structures), prejudice (cognitive and emotional consequences of stereotypes), and discrimination (behavioral consequences of prejudice) (Corrigan and Watson, 2002).

Social norms around medical cannabis use still remain unfavorable for many users, despite the fact that regulated medical cannabis has been legal for more than twenty years in some countries e.g. Canada (Bottorff *et al*. 2013; Reid, 2020).

Although not with the same physiological and psychological signs and withdrawal symptoms associated with benzodiazepines and opiates, medical cannabis remains more stigmatized than these other classes of drugs (Roberts, 2020).

The widespread impression is that cannabis is a dangerous drug, not worth using by anyone living in any morally upright society (Vasconcelos *et al.,* 2019). The stigma associated with medical cannabis use may influence patients' access to cannabis, information seeking about cannabis and decisions to delay onset of medical cannabis treatment (Dahlke *et al*., 2022; Hulaihel *et al.,* 2022). Reid (2022) reported that cannabis patients face persistent cannabis-related stigmas and discrimination, even in a post-prohibition US state like Michigan and these stigmas create tension for patients in their personal relationships, work environments and sense of self.

Similarly, Sinclair *et al.* (2022) found that community and cultural factors such as the history of cannabis as an illicit drug and the resulting stigma, even when prescribed by a medical doctor, still existed and was of concern to Australian women with primary dysmenorrhea.

Indeed, medical cannabis patients experience a high prevalence of perceived stigma from many corners of society including their healthcare providers (Troup *et al*., 2022). In a recent survey of 276 approved medical cannabis users (Leos-Toro *et al*., 2018), approximately one-third of respondents reported that their physician had refused to provide a medical document and the vast majority of respondents reported hiding their medical cannabis use, most commonly to avoid judgement.

Satterlund *et al.* (2015), after having interviewed eighteen medical cannabis patients, reported that most patients circumvented their own physicians in obtaining a recommendation to use medical cannabis and also used blue-sky strategies in order to justify their medical cannabis use to family, friends and colleagues to stave off potential stigmas.

4. Social Marketing as a Tool to Reduce Stigma

Social marketing was first defined by Kotler and Zaltman (1971, p. 5) as "the design, implementation and control of programmes calculated to influence the acceptability of social ideas". Much later, Dann (2010, p. 151) defined social marketing as "the adaptation and adoption of commercial marketing activities, institutions and processes as a means to induce behavioural change in a targeted audience on a temporary or permanent basis to achieve a social goal".

More recently, Zainuddin and Russell-Bennett (2017, p. 351) took a step further in stating that "social marketing involves the use of marketing theories and concepts, in addition to other approaches to influence individuals, communities, structures and societies to bring about positive social change". Social marketing uses marketing principles and techniques to change the behaviour of individuals in favor of the greater good of the society (Kubacki *et al.,* 2018; Gordon *et al.,* 2018; Twum *et al.,* 2021), rather than influencing commercial gains (Ryan *et al.,* 2022).

Behavioural change can be hindered by one or more of individual factors, such as beliefs, motivation, knowledge, attitudes, psychological and biological characteristics, as well as cognition and natural and/or acquired skills (Kellou *et al.*, 2014).

Social marketing is often used in the public and non-profit sector to push for behavioural change (Truong, 2017). The importance of behavioural change for effective and efficient interventions in the long term is a challenge for public policy (Crawshaw, 2013). The aim of social marketing interventions is generally to ensure that the target audience adopts the promoted behaviour (Lee and Kotler, 2011).

Social marketing targets changes in policy or social norms by (i) identifying marketing principles that can be used to achieve prosocial goals and (ii) providing a useful theoretical framework for the design of interventions and services that help develop prosocial behaviours (Gordon, 2011). A social marketing strategy therefore consists of the creation and administration of a marketing plan to effectively attract, motivate and retain an audience to engage in a targeted prosocial behaviour (Barbier *et al*., 2021).

Social marketing is frequently used for tackling health problems (Domegan *et al.*, 2017), and has been used for over 40 years to encourage voluntarily changes in health behaviour (Kim *et al.*, 2019). Health-related social marketing is an important tool for improving population health by influencing lifestyles (Carins *et al*., 2014; Truong, 2014), as well as in decreasing health care costs (Rothschild, 1999), an important and growing area of expenditure in the public policy arena. Social marketing helps make healthcare products and services attractive and affordable for both providers and consumers (Berg and Mitchell, 2013).

In practice, social marketing represents one potential approach to guide the development of health promotion interventions (Chin *et al.*, 2018; Da Silva *et al.*, 2016; Firestone *et al.*, 2017). Social marketing offers strategies that may be used to address the broader determinants of health and to develop efficient interventions in the area of public health (Donovan *et al.*, 2010). Segmentation is one of the strategies used to identify the profiles of healthcare consumers (Chong *et al.*, 2019).

Tailoring a service or intervention to segments of the target population is another important strategy. A recent study has shown that tailored communication is more effective than non-tailored communication in increasing health screening behaviours in the primary prevention setting (Bai *et al*., 2020). The marketing mix, traditionally known as the 4Ps - Product, Price, Place and Promotion - can also be useful.

This strategy has been used, for example, in the field of public health as an approach to the categorization of existing nutrition policies, the assessment of their perceived effectiveness and the setting of guidelines for future policy (Lloyd-Williams *et al.*, 2014).

Social marketing is found to be effective in public health (Carins *et al.*, 2014, Gordon *et al.,* 2018). A recent systematic review found that social marketing strategies were effective at increasing physical activity participation and levels among older people (Goethals *et al.,* 2020). Social marketing has been effective in the reduction of HIV-related stigma and in the prevention of AIDS, with reports of changes in knowledge, attitudes and behaviour related to HIV (Grieb *et al.,* 2022).

Through the analysis of empirical data, Ayikwa and de Jager (2016) have demonstrated the importance of social marketing in changing people's sexual behaviour and in combating the misconceptions that lead to discrimination and stigmatization of those living with HIV. Hull *et al.* (2017) suggested that social marketing campaigns may be a promising strategy to reduce homophobia in black communities in the United States.

In an evaluation of the impact of a social marketing campaign on the institutionalized stigma of mental illness, Kemper and Kennedy (2021) reported an overall increase in the use of mental health services. Similarly, Sampogna et al. (2017) identified social marketing campaigns as key to effectively reducing mental health stigma.

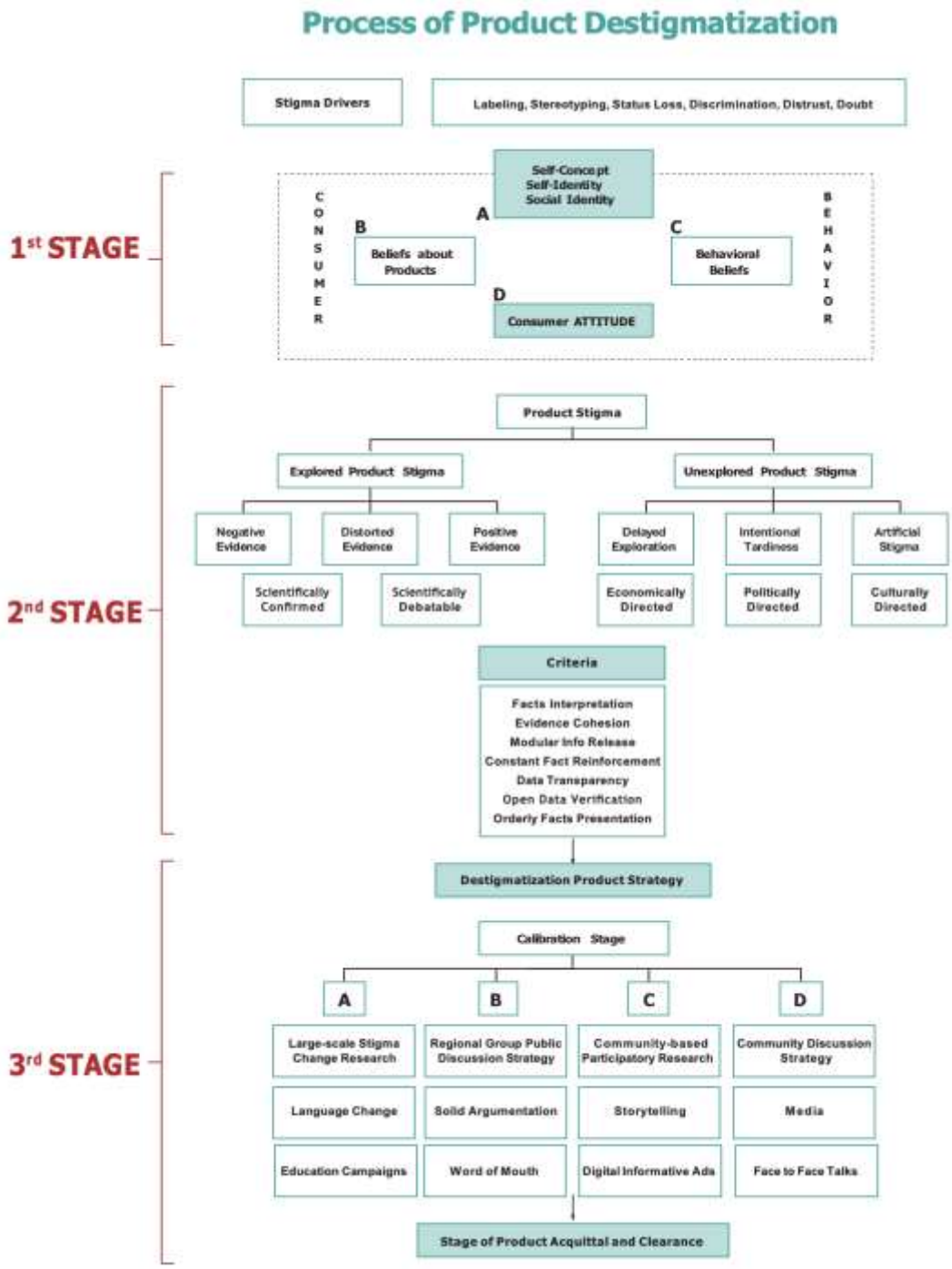
5. The Destigmatization Process: The Tri-Stage Model for Medical Cannabis

Labeling, typifying and assigning status to a thing may lead to its stigmatization (Link and Phelan, 2001). Whatever is labeled is set apart and associated with undesirable characteristics, subject to devaluation, exclusion and rejection. Labeled products are directly stigmatized, set apart and associated with undesirable characteristics, leading to status loss and discrimination, since labeling contributes to stereotype formation (Link and Phelan, 2001).

Awarding labels to an entity ignites the separation effect of one entity from another (Devine *et al*., 1999), while negatively labeled entities are framed as fundamentally different from those who are label-free. If the entity is a product or service, a negative label identifies it as a threat to consumers and the market itself.

Based on the above considerations, a conceptual model for medical cannabis destigmatization has been developed. Our model explores and attempts to identify the logic of the product stigmatization process and a strategic destigmatization procedure in order to lift the stigma if the produced findings support and fulfill the purpose evaluating the nature, identity, status, use and existence of the product. The destigmatization model designates certain processes and introduces specific strategies that should be enforced in order to lift the stigmas from a product. Our model is operationalized in three stages - the pre-stigmatization stage, the stigmatization stage and the meta-stigmatization stage - strategically intending to lift the stigma and to liberate the product from the problematic status (Figure 1).

Figure 1. *The Destigmatization Process: The Tri-Stage Model for Medical Cannabis*



Source: *Own study.*

1st Stage: The Role of Attitude in Stigmatization:

The stigmatization process considers the "self", the self-identity concept and the social identity concept. This triptych formulates the *attitude* towards the product and subsequently consumer behavior at large. Attitude has been identified as the most important framework in social psychology (Allport, 1935). Attitudes are integrated evaluations of objects along a positive to negative continuum (Petty *et al*., 1997). They have been used to predict judgments (Krosnick and Petty, 1995) and tend to guide people's behavior (Armitage and Christian, 2003).

Our model designates that the impact of attitude on behaviors related to stigmatized products may be moderated by a number of factors such as attitudinal certainty, experience and the influence of important social referent groups. The contribution of social norms, behavioral beliefs and attitude control influence behavior and behavioral intent in many domains (Link and Phelan, 2001).

Consumer attitudes (positive or negative) concerning a stigmatized product can be influenced by cognitive considerations relative to it along with beliefs about the product itself, evidenced by the way consumers label, characterize and bestow a specific status to it.

2nd Stage: The Nature of Stigmatization:

In situations where a stigmatized product is at stake, the model examines whether the stigmatized entity is explored or unexplored. In an explored stigma situation, the model examines whether the stigma is negatively evidenced, evidence-distorted or positively evidenced.

A stigma is negatively evidenced where there is not sufficient data to support the accusations and delay impedes its acquittal decision. A stigma is evidence-distorted when there is the fabrication of deliberated argumentations, backed by unscientific and unconfirmed data. A stigma is positively evidenced in the presence of valid and confirmed scientific data regarding its harmful effect and influence. Upon completion of evidence orientation, the model then investigates whether the evidence offered is scientifically confirmed or still debatable.

In the case of an unexplored yet still stigmatized situation, the model investigates whether the stigma is intentionally delayed to be investigated due to case complications, unjustly and prematurely awarded or if the stigma is artificially created and is intentionally maintained to serve a purpose overtly or covertly. The model then investigates whether the unexplored stigma is economically influenced, politically directed, culturally rooted or interest group-specific directed.

The model is designed to facilitate the destigmatization decision-making process considering a series of indicative criteria for any product that could provide a thorough investigation for any complex business or social issue. The model rests on facts interpretation to be simple to interpret and easy to understand, ensuring that it

considers consumer, managerial and social constructs in its aim to destigmatize the product (Leeflang *et al*., 2000).

The model pursues evidence cohesion based on its attempt to examine and clarify disputed areas and issues of disagreement in a sequential and logical order (Leeflang *et al*., 2000). It also provides modular info release only when explanations about the grey areas of the stigma dispute are final and confirmed based on research findings (Ehrenberg *et al*., 2000). Gradual release of modular information facilitates better understanding and assimilation of verified data and findings by the recipient parties.

The modular release and logical sequence of confirmed and clear findings/facts accelerate consensus in disputed cases and areas. Orderly facts presentation by the model promotes understanding about the process to destigmatize the entity via the use of valuable and confirmed scientific information. The model preserves constant fact reinforcement since a good model should adequately describe the variables and relationships of the contexts which operate in, considering flexibility and adaptation in order to be effective (Laurent, 2000). The model should secure data transparency.

Appropriate data must be used to fit in the business and social realities. The model should be responsive and adaptable in using and facilitating data management (Albers, 2000) validly and transparently. Also, it should be capable of being updated with new and additional data when available, since data affect the model's parameters and structure (Landry *et al*., 1996).

Finally, open data verification requires the model to show the relationship between its individual elements and affiliated data subject to confirmation and verification. A model initiating and promoting openness to data interpretation, verification and control tends to gain trust and credibility and encourage synergistic thinking since its dimensions and strategies should converge to produce a collaborative effect towards problem-solving stigmatization.

3rd Stage: The Destigmatization Strategy:

Strategic calibration is essential in the destigmatization process to identify the best set of strategies for converting opinions and perceptions of the negativists and acquitting the product. Subcomponents of the first stage should be fully identified, explored and aligned to allow procession to the second stage of the model. Issues related to the second stage must be clarified and based on the criteria model structure; advancement to the third stage will require the application of strategies to lift the stigma.

A plethora of strategies will revolve around Large-scale Stigma Change Research, Community-based Participatory Research, Regional Group Public Discussion, Community Discussion, Language Change, Solid Argumentation, Storytelling, Media, Education Campaigns, Word of Mouth, Digital Informative Ads and Face to Face Talks.

5.1 Large-Scale Stigma Change Research and Community - Based Participatory Research

Large-scale research can provide opportunities for the initiation of participatory learning in order to diminish the gap between ignorance causing unfair stigmatization and the availability of scientific information favorable to medical cannabis (Michalak *et al.*, 2016; Hull *et al.*, 2014). Widespread information will loosen the negative attitude of opponents and will allow medical cannabis to offer its own defense.

Conferences on research findings, team discussions focused on attitudes and beliefs about medical cannabis, voluntary cross-orientation and consultative catechesis will support participatory learning.

5.2 Regional Group Public Discussion and Community Discussion

The model suggests conducting frequent community expert engagements and gatherings to discuss priorities and to develop orientation and consultation programs for examining stigma's complex synthesis and fragmentation (Knifton *et al.*, 2010; Knifton 2012).

The participation of individuals who have experienced stigma and discrimination due to their perspective and association with medical cannabis will contribute to the surfacing of primary sources, new data and real-life experiences related to stigma's context.

The incorporation of the feedback from community advisory groups, experts, patient review boards and planning councils/groups will ignite the beginning of a less hostile approach concerning medical cannabis.

5.3 Language Change

The model advises the adaptation of an appropriate and respectful communication language regarding the medical cannabis stigma. The use of accurate and humanizing language along with the correct terminology and suitable structured and unstructured phrases to refer to the stigma blocks the chasm between opposing parties from growing and shapes at least a degree of tolerance for understanding stigma (Williamson *et al.*, 2020; Volkow *et al.*, 2021).

The formation of communication-oriented sessions focused on medical cannabis can designate lexical patterns to avoid confrontation, offer linguistic rules for adaptation, establish inclusive language principles and indicate respectful language sharing resources to stay abreast of evolving terms (in particular to specific groups being affiliated with the stigma and the process for its resolution).

5.4 Solid Argumentation

Advocacy strategies tend to reduce some types of stigma. There are two specific types of advocacy strategies (national summits and protests) (Thomas *et al*., 2016). The organization of national summits enables advocates, consumers and experts to develop frameworks for tackling stigma after changing discourses, developing comprehensive strategies to change attitudes, redefining issue framing and lobbying for change. Protest strategies involve establishing groups that can respond to inaccurate representations of stigmatized cases.

A protest strategy is reactive and involves group formation which challenges inaccurate and hostile representations of stigmatized individuals and cases (Corrigan and Watson, 2002). This form of advocate strategy has been directed at the media (e.g., to stop inaccurate representations and reports) or towards the general public (e.g., to stop believing negative views about stigmas in general and becoming more righteous and less biased). Protests have been instrumental in getting these negative or stigmatizing images withdrawn as has been the case for medical cannabis in some jurisdictions.

5.5 Storytelling

The storytelling strategy will complement and support the indicative other affiliated communication strategies to decompose the complex context of the stigma and to offer easy-to-understand arguments about unexplored aspects of the stigma (Zhuang and Guidry, 2022). Traditional and digital storytelling are essential strategies to catch the attention of people who hold strong beliefs about an issue, specifically towards stigmatized entities such as medical cannabis. Seeing such stories encourage audiences to reconsider their attitudes towards stigmatized issues and products and to reassess their previous opposition (Nycyk and Mack, 2019).

5.6 Media and Digital Campaigns

The model proposes mass media campaigns that have the potential to change attitudes and behaviors relating to stigma (Thomas *et al*., 2016). Anti-stigma social advertising campaigns are one part of the social marketing mix and have been used throughout the world to reduce the stigma associated with a range of health and social issues such as mental health (Collins *et al.*, 2019; Lavack, 2007).

5.7 Education Campaigns

These can be designed for any scale, from local to national, which may explain the status of education interventions as the best-evaluated stigma change tactics (Griffiths *et al*., 2014). Education strategies are promising in reducing the stigma associated with and within particular population subgroups, in combination with contact strategies (Corrigan and Gelb, 2006).

Research findings suggest education in conjunction with contact strategies produce significant positive results that are more likely sustained at follow-up (Chan *et al*., 2009). The contribution of education alone on stigma reduction is noticeable in certain stigmatized areas, especially in public health (Economou *et al.*, 2014; Corrigan *et al*., 2012). This also relates to the long-term effectiveness of single, one-point-in-time interventions in 'transforming' young people's attitudes towards issues (Ramirez-Valles *et al*., 2013).

5.8 Word of Mouth

A word of mouth (WOM) communication is more persuasive than any other printed format of communication. Not only does WOM influence the context of consumption (prevalent in health products and services) but it enormously impacts healthcare providers, medical recipients and corporate decision-making processes (Freeman and Evan, 1990). Electronic word of mouth (eWOM) has also grown exponentially (Goyette *et al*., 2010) and used in specific industries such as in the healthcare sector (Heather *et al*., 2014) with convincing results.

The use of electronic platforms by interested parties enables them to write anonymous comments, opinions and reviews using their experiences (in contrast to traditional WOM reviews), thereby having a potentially larger and more dynamic audience because they are published online (Drevs and Hinz, 2014).

5.9 Face to Face Talks

The model recommends the use of direct contact strategies. Contact strategies relate to immediate contact at individual level or via social marketing initiatives with specific audience segments to examine short-term attitude changes (Thomas *et al*., 2016) regarding medical cannabis and its resistance towards destigmatization. Contacts may be direct (face to face) or indirect through the involvement of a media campaign or video, sharing stories (Brown *et al*., 2010; Chan *et al*., 2009) and experiences concerning stigma effects.

Direct contact strategies are generally used with very specific audience segments to explore intentions and attitudes (Corrigan, 2011). Many studies in public health show that direct contact has at least a short-term impact on reducing stereotyping and negative attitudes (Nguyen *et al*., 2012; Patten *et al*., 2012).

6. Practical Implications

Our Tri-Stage model explores and attempts to identify the logic of medical cannabis stigmatization, to develop the strategic route of its destigmatization process and to establish the clearance of medical cannabis from its stigma. It can give medical cannabis a fair chance to become a medical alternative for those who need it.

Finally, the model can prepare medical cannabis for entering the phase of product/brand identity and for developing its value proposition.

The destigmatization of medical cannabis use is anticipated to inure to the benefit of a number of stakeholders who will take advantage from the lifting of one of the main barriers restricting its spread. More funding will be directed to a non-stigmatized therapeutic alternative such as medical cannabis possibly revealing its efficacy and safety in a number of diseases benefiting patients in need and their relatives who struggle with non-effective treatments.

Physicians and other healthcare professionals will become enabled to prescribe and administer pharma-grade cannabis products relying on evidence-based research. Medical cannabis manufacturers and marketeers will see their product portfolio developed and expanded. States could save significant healthcare costs by providing the most cost-effective treatment to their citizens and, in parallel, they will collect taxes from a market which is currently in the grey zone.

The destigmatization of medical cannabis will benefit society as a whole by opening its acceptance boundaries to areas that used to be marginalized, by promoting inclusivity and lifting stereotypes.

7. Limitations and Future Research

The determinant factors of someone's given behaviour is a combination of their intentions, skills and the environment (Fishbein and Cappella, 2006). Intentions are also influenced by attitudes, norms and beliefs about efficacy. The Tri-Stage model of this study took into account these key theoretical components of behavioural change, acknowledging that any behavioural expression is not just the action itself, but the result of a combination of influences.

Of course, our Tri-Stage model for medical cannabis is a newly developed conceptual model that requires verification for its level of applicability, appropriateness and beneficial use. Therefore, further and broader testing should be carried out to finalize the model structure.

The potential of social marketing research has yet to be fully realized. More evidence is needed to better understand how social marketing strategies can be interconnected to further advance the promotion of health in general, and of the medicinal use of cannabis, in particular. Another question that needs to be addresses is how this better understanding can further support the development and implementation of effective community-based interventions.

The model deployed in this paper proposes social marketing tools to destigmatize the medicinal use of cannabis. This behavioural change may facilitate the ultimate goal of social marketing, but does not provide sufficient evidence to assert that social

marketing interventions actually achieve their intended objective. Rather, this can be described as a factor mediating in the process of behavioural change or be categorized as an intermediate outcome (Andreasen, 2002).

Future research on evidence of changes in behaviour or improvements in health status of individuals using medical cannabis could address these concerns and provide a more reliable assessment of the effectiveness and impact of social marketing interventions (Raphael, 2000).

8. Conclusions

Cannabis faces many challenges to its becoming first a medical product and then a medical brand. This is almost exclusively based upon the stigma surrounding cannabis as an illicit substance used mostly for recreational purposes and the public's perception of its users (Wilson, 2022).

Cannabis' legal status as a prohibited substance in many jurisdictions is a major source for and contributor to its current stigma. Such prohibition results in no state-sponsored research funding concerning cannabis' medicinal properties. Funding is usually channeled toward research that is considered legal and socially acceptable; accordingly, research into the medicinal value of cannabis has been hampered by its illegal status and the rampant social stigma that is associated therewith.

Awareness is needed among members of the general public, along with the targeted audiences, regarding cannabis' actual and potential medicinal benefits. Cannabis has a viable chance to attain acceptance as a medical product and has promising potential to become a medical brand.

This is mainly because cannabis has already proven to possess medicinal properties that are beneficial in treating certain diseases (Lim *et al.*, 2021). With such diseases becoming major health problems across the world, any treatment that has the potential to alleviate the suffering caused by them is certainly to be welcomed.

The debate about medical cannabis use involves three major elements: the medical element, the business element and the social element. In this paper, central focus is attributed to the social element which should be seen through social marketing. Social marketing can become the vehicle to inform market segments about the medicinal properties of cannabis, bridge the difference of opinion between the adversaries of the dispute concerning its role in the medical field and clear the stigma which encircles the potential usefulness of medical cannabis.

Based on the literature review, a logical approach was employed to develop a model to destigmatize medical cannabis. This model provides a conceptual framework that can be applied through the mechanisms of social marketing. The model depicts stage

by stage process, which designates sequential synergies and effects produced within each stage.

The Tri-stage model could clear the fog around medical cannabis and enlighten opposing audiences. Destigmatization of medical cannabis for societal benefit calls for firm action by political leaders so that cannabis is cleared as a medical alternative for those in need.

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