


Our “Cannabis” Vocabulary Is Eroding Public Health Safeguards

 **Matthew E. Rossheim, PhD, MPH**

ABOUT THE AUTHOR

The author is with the Department of Health Administration and Health Policy, Texas College of Osteopathic Medicine, University of North Texas Health Science Center, Fort Worth.

Imagine if cigarette companies had convinced Americans to describe tobacco laws as “recreational nicotine policy” or if bottles of vodka were labeled “nonmedical ethanol.” It sounds absurd, because it is. Yet, the same linguistic sleight of hand is happening now to support the rapid commercialization of intoxicating tetrahydrocannabinol (THC) products.

Misleading terms such as “recreational,” “medical,” “adult use,” “cannabis,” and “hemp” now dominate policy debates, media reporting, public opinion surveys, and even scientific discourse. Although often framed as neutral descriptors, these words act as powerful framing devices. They normalize use, lower perceived risks, and blur critical distinctions between reducing criminal penalties and expanding retail access. As states debate legislation, the president calls for rescheduling, and intoxicating hemp derivatives proliferate nationwide,¹ the vocabulary we use is shaping the policies we face. Words do not merely describe policy environments; they help construct them.

Using language to shape public opinion is hardly new. Tobacco companies promoted terms such as “environmental tobacco smoke” to make secondhand exposure sound less harmful.² E-cigarette

marketers popularized the term “vapor” to downplay the risks of aerosolized chemicals. This strategy works: using more accurate terminology increases risk perception, which is strongly associated with supporting tobacco-free policies.³

HOW INDUSTRY LANGUAGE MASKS RISK AND EXPANDS MARKETS

A prominent example in THC discourse is the term “recreational” marijuana, which evokes casual, low-risk activities. In stark contrast, today’s THC products carry substantial risks including addiction, psychosis, impairment, traffic crashes, injuries, and poisonings.⁴ The label recreational was not coined by clinicians or epidemiologists; it emerged from ballot initiatives and industry messaging designed to make commercial THC products sound like low-risk entertainment.

“Medical marijuana” sounds reassuring, but it is a political label, not a medical one. Clinical evidence does not support cannabis as an effective treatment for most conditions that qualify patients for state programs.⁵ The only cannabinoid medications approved by the Food and Drug Administration (FDA)

are those designed to treat HIV/AIDS-related anorexia, chemotherapy-induced nausea and vomiting, and certain pediatric seizure disorders. In state dispensaries, “medical” products routinely include smoked/vaped flower and high-potency concentrates (often 70%–95% THC), products fundamentally different from FDA-approved medications.

Research supports that state medical programs facilitate use unrelated to qualifying conditions; for example, from 2018 to 2021, Arizona’s medical market showed a 120-pound per-day sales spike on average during the week of 4/20.⁶ Medical programs also serve as the pathway to commercial markets. Support for legalization is much higher when THC products are described as “medical.”⁷ This appears related to perceptions that “medical” use is more moral and less addictive, harmful, and impairing.⁷ Because “nonmedical” is implicitly defined against “medical,” both terms reinforce the misconception that THC products carry inherent therapeutic value.

Many professionals avoid the word marijuana because of its racialized history and have adopted cannabis as a more neutral alternative. However, cannabis evokes the image of a natural plant, contrasting sharply with today’s THC market, which increasingly relies on synthesized cannabinoids.⁸ The botanical term obscures distinctions between plant material and manufactured intoxicants, potentially lowering risk perceptions.

Overly broad terminology creates confusion that industry actors exploit. Cannabis refers to a plant used to create products in many categories: textiles, cosmetics, nutritious foods, and nonintoxicating cannabidiol (CBD). None of these products are the focus of contemporary THC policy debates.

When states pass “cannabis laws,” they are not regulating soap or lotions; they are expanding commercial access to intoxicants. This market expansion raises equity concerns, consistent with patterns observed in alcohol and tobacco markets: the populations most exposed to harms—including youths, lower-income communities, and historically marginalized groups—are often the least resourced to absorb the resulting health and social consequences.⁹

Companies also exploit the word “hemp.” By calling their intoxicating THC products hemp, they attempt to evade marijuana laws while framing regulatory efforts as irrational attacks on harmless, nonintoxicating goods. In efforts to reduce associated harms, several states have recently enacted laws to regulate intoxicating hemp products. However, in doing so, many inadvertently created state-legalized THC markets for products that remain federally illicit. Public Law 119–37, enacted on November 12, 2025, further clarifies the federal illegality of these products by redefining hemp to explicitly exclude products containing synthesized cannabinoids or more than 0.3% intoxicating cannabinoids by weight or 0.4 milligrams per container. This policy direction was recommended in the National Academies of Sciences, Engineering, and Medicine 2024 report *Cannabis Policy Impacts Public Health and Health Equity*.⁴ The law includes a one-year implementation period and represents an important step toward protecting public health that industry groups are already mobilizing to overturn.

“Adult use” is another industry-driven framing term that conveys a false sense of strong youth protections. The THC industry often cites alcohol and tobacco as models of effective regulation. Yet, alcohol and tobacco remain the

substances most commonly used by underage youths.¹⁰ Evidence demonstrates that expanded retail availability increases access for everyone—including youths—regardless of age gating.¹¹

Terms such as “cannabis reform” and “liberalization” suggest that expanding access is inherently progressive; critics are cast as prohibitionists, polarizing debates. This rhetoric blurs two distinct policy domains: decriminalization, which advances social justice by reducing penalties for possessing small quantities, and commercialization, which expands retail markets, use, and associated harms. Misleading language collapses them into a false dichotomy—criminalize or commercialize—and public health and equity suffer in both scenarios.¹²

Rescheduling illustrates similar dynamics. Scheduling is intended to reflect abuse potential, pharmacological effects, and demonstrated safety and efficacy. That evidence has not changed in ways that would justify rescheduling. Yet on December 18, 2025, the president issued an executive order directing agencies to expedite rescheduling to Schedule III, framing it as a way to expand research—an emphasis reflected in the order’s title.

However, the primary barriers to clinical research are FDA drug approval requirements, which rescheduling does not change. Schedule III substances—such as dronabinol (Marinol)—must be FDA approved, prescribed by a licensed clinician, and dispensed through a pharmacy registered by the Drug Enforcement Administration. Rescheduling will not make today’s marijuana markets federally legal or meaningfully expedite research.

The real impetus for rescheduling is tax deductions. Rescheduling makes THC products more profitable to sell

and makes them appear more medically legitimate than evidence supports. The disconnection between scientific criteria and commercial motivations underscores how THC policy narratives are increasingly shaped by industry framing rather than scientific evidence.

Language is not merely symbolic; it shapes how the public perceives risk and how policymakers set regulatory priorities. As intoxicating THC products proliferate—and with Public Law 119–37 clarifying the federal illegality of many such products—states should reconsider how their terminology, definitions, and policies align with public health goals.

RECLAIMING PUBLIC HEALTH VOCABULARY

Borrowing from tobacco control, states that prohibit the commercial and medical sale of THC products could be described as having “100% THC-free policies” or “comprehensive THC prevention policies.” By contrast, states authorizing commercial THC markets constitute weak prevention environments characterized by widespread retail availability, expansive advertising, and an industry empowered to lobby for increasingly permissive regulations.

Importantly, THC must be defined broadly enough to encompass cannabinoids with similar effects. As companies reengineer products to exploit definitional gaps,^{1,8} statutory language and policy discourse must evolve to prevent so-called loopholes from expanding commercial access.

Industry actors have strategically framed expanded intoxicant markets as modern, recreational, medical, and adult only. Public health must reclaim the vocabulary, not to oppose decriminalization but to ensure

clarity regarding the implications of commercialization.

We cannot effectively shape policy using terminology that obscures risk, minimizes complexity, and echoes industry messaging. If public health does not define the vocabulary, industry will. And once the language is lost, policy battles become far more difficult to win. **AJPH**

CORRESPONDENCE

Correspondence should be sent to Matthew E. Rossheim, PhD, MPH, Texas College of Osteopathic Medicine, University of North Texas Health Science Center, 3500 Camp Bowie Blvd, Fort Worth, TX 76107 (e-mail: matthew.rossheim@unthsc.edu). Reprints can be ordered at <https://www.ajph.org> by clicking the "Reprints" link.

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ORCID ID:

Matthew E. Rossheim  <https://orcid.org/0000-0003-4388-5251>

CONFLICTS OF INTEREST

The author manages an independent consulting firm and receives compensation for presentations and consultations, including expert work in litigation against the alcohol, cannabis, tobacco, and kratom industries. Neither the author nor his consulting firm accepts funding from these industries.

REFERENCES

- Rossheim ME, LoParco CR, Tillett KK, et al. Intoxicating cannabis products in vape shops: United States, 2023. *Am J Prev Med*. 2024;67(5):776–784. <https://doi.org/10.1016/j.amepre.2024.07.001>
- Eubanks SY, Glantz SA. *Bad Acts: The Racketeering Case Against the Tobacco Industry*. American Public Health Association; 2013.
- Rossheim ME, Zhao X, Soule EK, et al. Aerosol, vapor, or chemicals? College student perceptions of harm from electronic cigarettes and support for a tobacco-free campus policy. *J Am Coll Health*. 2022;70(6):1754–1760. <https://doi.org/10.1080/07448481.2020.1819293>
- National Academies of Sciences, Engineering, and Medicine. *Cannabis Policy Impacts Public Health and Health Equity*. National Academies Press; 2024. <https://doi.org/10.17226/27766>
- Hsu M, Shah A, Jordan A, Gold MS, Hill KP. Therapeutic use of cannabis and cannabinoids: a review. *JAMA*. 2026;334(4):345–359. <https://doi.org/10.1001/jama.2025.19433>
- Meier MH, Meier MA, Anderson SF, et al. The effects of the 4/20 cannabis holiday and adult-use cannabis legalization on medical cannabis sales and medical cannabis patient registration in Arizona. *Int J Drug Policy*. 2023;114:103974. <https://doi.org/10.1016/j.drugpo.2023.103974>
- Mikos RA, Kam CD. Has the "M" word been framed? Marijuana, cannabis, and public opinion. *PLoS One*. 2019;14(10):e0224289. <https://doi.org/10.1371/journal.pone.0224289>
- Rossheim ME, Tillett KK, Vasilev V, et al. Types and brands of derived psychoactive cannabis products: an online retail assessment, 2023. *Cannabis Cannabinoid Res*. 2024;9(6):1478–1481. <https://doi.org/10.1089/can.2023.0266>
- Kephart LL, Rees VW, Giovenco DP, Subramanian SV. The unequal geography of recreational cannabis retailers in the U.S. *Am J Prev Med*. 2025;69(2):107643. <https://doi.org/10.1016/j.amepre.2025.107643>
- Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: results from the 2024 National Survey on Drug Use and Health. Available at: <https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf>. Accessed December 1, 2025.
- Rossheim ME, Treffers RD, Sparks AC, et al. The evolving alcohol landscape: implications for public health and policy. *J Stud Alcohol Drugs*. 2025;86(3):323–329. <https://doi.org/10.15288/jsad.24-00339>
- Jernigan DH, Ramirez RL, Castrucci BC, Patterson CD, Castillo G, eds. *Cannabis: Moving Forward—Protecting Health*. American Public Health Association; 2021. <https://doi.org/10.2105/9780875533186>