Bureaucratic Entrepreneurship and Morality Politics: Dividing Lines within the State

Céline Mavrot[1]

[1]Institute of Social Sciences, University of Lausanne, Switzerland

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Abstract

Based on a qualitative and quantitative research design, this article examines the implementation of a morality policy—the medical cannabis policy in Switzerland—to investigate three understudied aspects of bureaucratic entrepreneurship. First, moving away from mono-professional studies, the focus is on a policy characterized by a dispute between two groups of bureaucrats: physicians and jurists. Second, key conditions triggering bureaucratic policy entrepreneurship are identified, with a focus on mid-level administrative entrepreneurs. Third, vertical alliances between bureaucrats and politicians of the executive and legislative branches are examined and these processes are reflected in the wider perspective of the politics-administration dichotomy. Results show that law obsolescence, disputes between groups of bureaucrats and the need for political arbitration are favorable conditions for bureaucratic policy entrepreneurship. The study also shows that within the traditional separation of powers, bureaucratic entrepreneurship reinforces the executive power and creates dividing lines within the different branches of government.

Keywords: morality politics; bureaucratic entrepreneurship; drug policy; expertise; separation of powers.

Introduction

The vision of bureaucrats acting as "objective technocrats" in a "rational–legal process of administration" has been long challenged in the literature. The potential role of public servants as policy entrepreneurs is now widely acknowledged (Littoz-Monnet 2015, 359). From a practical perspective, public servants need some discretion in their routine practice. Discretion is meant to allow incremental adaptations of the policy to the evolution of needs in the field—and to offer the required flexibility. Research on street-level bureaucrats has, for instance, shown that discretion accounts for a better meaningfulness from the recipients' side, and an increased willingness to implement the policies from the public servants' side (Tummers and Bekkers 2014). Historically, the question of the politics–administration dichotomy in democratic regimes has generated vivid debate as to whether bureaucrats "should advocate particular policies"—and if so, based on which standards—or merely execute them (Sager and Rosser 2009, 1139). Fundamentally, discretion is balanced by the fact that street-level bureaucrats are embedded in multi-layer policy processes in which they are "held accountable in various relations: bottom-up as well as top-down, but also 'sideways'" (Hupe and Hill 2007, 295). Similarly, intermediate and higher-level bureaucrats are also embedded in a complex set of accountability mechanisms. However, beyond simply stretching the law during implementation, administrative discretion can go as far as triggering a legislative change as in the case investigated in this article.

Recently, it has been increasingly highlighted that bureaucrats' leeway can be so significant that it might even turn into policy entrepreneurship (Arnold 2015; Frisch-Aviram, Cohen, and Beeri 2018; Petchey, Williams, and Carter 2008). Drawing a line between bureaucratic discretion and policy entrepreneurship certainly constitutes a theoretical challenge, but opens the path for stimulating questions regarding the role of public servants in the policy-making process, and in democratic systems as a whole. In this article, we analyze a case of mid-level

bureaucratic entrepreneurship, drawing upon a theory-building qualitative and quantitative in-depth case study on medical cannabis policy in Switzerland in the years 2012-2017. Several characteristics of the policy make it an instructive case for examining "bureaucratic policy entrepreneurship" (Teodoro 2009). First, this case is characterized by a sharp confrontation between two highly qualified groups of implementing bureaucrats—physicians and jurists—providing the opportunity to study opposed interpretation of the law at the policy delivery level. This allows for a relational perspective on bureaucracy, where the actions of two professional groups are studied around a same policy as opposed to mono-professional approaches. Second, in Switzerland as in many other countries (Fischer, Kuganesan, and Room 2015), the medical cannabis policy is characterized by widespread political dissent, not the least because it is at risk of triggering controversies that surround wider drug consumption. This study thus focuses on policy entrepreneurship in a case of "morality policy", prone to politicization dynamics (Engeli, Green-Pedersen, and Larsen 2013, 338). In the area of morality policies, the stakes are high because of a strong public and political topic-related emotiveness; these issues involve "conflicts of fundamental moral principles" (Budde et al. 2018, 427). Consequently, in such policy areas, the legitimacy for bureaucrats to engage in policy advocacy behavior is particularly likely to be questioned. Third, polarized policy contexts leave room for complex politico-administrative configurations, including alliances between bureaucratic entrepreneurs and members of the government or the parliament. While this paper focuses on a classic case of morality policy–drug policies–mid-level bureaucratic entrepreneurship and a fight between two professions can be observed in other politicized policy areas.

This article draws theoretical and methodological insights about policy entrepreneurship in multi-professional and politicized policy areas. Current research avenues are identified regarding the conditions under which bureaucrats are likely to turn into policy entrepreneurs.

Theory: Bureaucratic Entrepreneurs in the Policy Configuration

In the following, we identify a double research gap: the tendency of the literature to focus on policy implementation by single groups of professionals, and the overlooking of the role of middle-level bureaucrats in policy entrepreneurship.

When Non-appointed Bureaucrats turn into Policy Entrepreneurs

Policy entrepreneurs deserve closer study "as an explanation of policy change"; they have been identified as actors investing their skills, resources and "efforts to promote significant policy change" (Mintrom and Norman 2009, 649, 651). Research has identified various strategies policy entrepreneurs can use, including elaborating narratives around a policy issue, the capacity to react to different types of opportunities—for example, a shift in the media or in public opinion, technological advancements, or political changes—, networking strategies (i.e., the capacity to capitalize on reputation, expertise, contacts or experience), and the targeted use of knowledge (Gunn 2017, 268-271). Policy entrepreneurs can be politicians, elected officials, high-ranking bureaucrats, or other policy stakeholders such as members of think thanks, of nongovernmental organizations, or private actors.

Recently, bureaucratic entrepreneurship at the lower governance level gained increased scholarly attention. According to Frisch-Aviram et al. (2018), the literature has mainly focused on the influence of high-level bureaucrats, overlooking the role of street-level bureaucrats in policy formulation. Similarly, Eva Petridou and Pär Olausson note that "the entrepreneurial actions of mid-level bureaucrats has been under researched" (2017, 4). If the key to success for policy entrepreneurship is to bring together the streams of problems, politics, and solutions (i.e., policies) (Petchey, Williams, and Carter 2008, 74), then lower-level bureaucrats can rely on crucial resources to do so, namely field knowledge and implementation discretion. Hence, research is currently engaging with the case of middle-level bureaucrats on coproduction,

especially from a public manager's perspective, which has been overlooked so far (Gassner and Gofen 2019). The attention is on how lower-level bureaucrats might exercise "managerial and organizational efforts in order to *expand* implementation options available for clients, according to the particularities of the served community" instead of a focus on the restriction of implementation options (*op. cit*.: 13). In fact, the role of middle-level bureaucrats must be recognized as "the linking tier between strategic and operational levels of the organization", as they "are responsible for reconciling strategic objectives with operational imperatives" (Gassner and Gofen 2018: 554-555). On the other hand, these bureaucrats also face limitations in their entrepreneurial endeavor: their subordinate position in the policy process, the non-elected nature of their mandate, as well as their lack of policy-making legitimacy. The entrepreneurial capacities of lower-level bureaucrats involved in policy implementation, hence, must be conceptualized regarding these resources and limitations.

Einat Lavee and Nissim Cohen (2019) further identify three conditions that might favor street-level bureaucrats' entrepreneurship in policy design: an acute crisis situation, a lack of relevant knowledge and a demand for political activism—that is, implicit expectations on bureaucrats to engage in entrepreneurial behavior in their policy field. At the interface between the top of the state and sectoral policy fields, bureaucrats are caught in different accountability regimes—toward officials, professional groups, customers, or the market—and this plurality of accountabilities can create acute and sometimes irreconcilable dilemmas (Lieberherr and Thomann 2019; Thomann, Hupe, and Sager 2018). Hence, the webs of constraints and loyalties in which bureaucrats evolve must be accounted for, as they weigh heavily on policy entrepreneurship processes.

Bureaucratic Disputes as Confrontations Between Professional Groups

As entrepreneurship often happens in a contentious context, including different groups of bureaucrats in the scope of investigation offers a stimulating analytical perspective. While

public administration literature has been prolific on the implementation practice of single profession groups of bureaucrats, a stronger focus on the interactions between different groups of bureaucrats is still needed. Because of their subordinated role in the policy delivery system, bureaucrats have been primarily seen as executants in relation to their "principal" (Gailmard and Patty 2017), for instance legislators (Schnose 2017). In contrast, horizontal processes at the operational level between groups of bureaucrats have received less attention. The focus on mono-professional policy settings is not always relevant, since many policies require the collaboration of bureaucrats from various policy sectors and of different professional backgrounds. Furthermore, the more ambiguous and discretion-oriented a policy is, the higher are the chances of implementation conflicts among bureaucrats (Boisseuil 2019, 438). Literature on policy coordination has better taken into account the importance of inter-group dynamics, highlighting that opposition among different groups of public servants during enforcement can hamper the outcome of policy implementation networks and complicate their management in interjurisdictional policy settings (Bland 2017). We hold that beyond coordination issues, a focus on the interactions and confrontations among groups of implementing bureaucrats could also enrich our specific understanding of administrative entrepreneurship. This is especially the case for policies that are at the crossroads of two regulatory areas, such as public health and criminal justice for the medical delivery of controlled substances (Chiarello 2015).

Hence, policy implementation is often undertaken by public servants who rely on a core of professional norms and values and strong professional socialization, like for instance, physicians or jurists. As such, the possible clashes between approaches in cross-sectoral settings are key factors shaping policy trajectories. Professional ethos also conditions their policy entrepreneurship activities, as they enjoy a highly specialized expertise on specific matters. However, administrative behavior still tends to be analyzed from a silo perspective (Maynard-

Moody and Musheno 2003, cited in Durose 2007; Yanow 1996). The implications of a relational perspective are important for policy entrepreneurship research, shedding light on the fact that policy disputes do not only happen within political arenas, but also at the implementation level. In the case of jurists vs. physicians, we are looking at two well-established professions that enjoy a high credibility related to the social recognition of their expert knowledge and the fact that they achieved a high level of control over their own profession (Abbott 2014 [1988]). The confrontation between professional groups adds a layer in the analysis to understand which one will be in the position to make their perspective prevail when they are both involved in a policy: "Given that expert performances crucially depend on dialogue and exchange within networks of expertise, monopoly must be understood not only with respect to occupational credentialing, but also as a local feature of the network, how it arranges the flow of information and credibility" (Eyal 2013: 876-877).

Next to the configuration in which the struggle takes place, the general frame of the policy under consideration, as well as the specificities of each profession, must be taken into account. In this regard, the regulation of the therapeutic use of medical cannabis is mainly embedded in a medical framework. The classification of drugs is a historical construct that was enabled by international treaties on drug control, drawing lines between legitimate and illegitimate uses of narcotic products (Dudouet 1999). Therefore, when a use of cannabis is foreseen for therapeutic reasons, the medical expertise is put in a position of power. The recognition of this expertise might be reflected at the policy subsystem level. Experts with therapeutic convictions invest key organizations in the drug regulation systems, and nurture self-reinforcing networks related to these institutions (Bergeron 1999).

Hence, beyond their status of public servants, bureaucrats with a strong professional socialization and identity can be considered as "professional bureaucrats" (Mintzberg 1978). Their characteristics include a long initial and on-the-job training, the possession of

standardized and complex skills and knowledge, and a high level of control over their own work (*op. cit.*). For such public servants, the professional ethos might prevail over the administrative requirements when carrying out their duty. It is therefore crucial to analyze the medical experts' autonomy—"the most strategic and treasured feature" of this profession—in its ambiguous relationship with the state, which might limit it (Freidson 1988 [1970]: 23-24). In a bureaucratic setting, the jurists might incarnate the state and the legal limitations it imposes on medical expertise. As a reaction, the concerned experts might try to establish new professional relations and a repertoire of actions to reconfigure their activities (Noordegraaf 2016). Hence when institutional logics themselves compete on different aspects of regulatory compliance, a closer look at the resources and strategies of those inside the organization can inform on the final outcome of the competition (Gray and Silbey 2014: 138).

The Divided State: Cross-Group Alliances between Bureaucrats and Politicians

The focus on entrepreneurs and on interactions between opposing groups of bureaucrats consequently draws the attention toward the dividing lines within the state. Beyond the traditional politics-administration gap, the potential of complex alliance games across governance levels, groups of actors, and branches of the state (e.g., administrative, executive, and legislative powers) must be acknowledged. These categories of actors can be fragmented, and more or less discrete alliances between policy implementers and politicians can be established in policy entrepreneurship situations. As Lavee and Cohen (2019, 481) note, a key strategy of street-level policy entrepreneurs is to establish cross-sectorial and cross-hierarchical coalitions. In this view, bureaucrats are no longer conceived as only embedded into hierarchical lines of control. Hence, state structures can be conceptualized in a more fluent fashion than the traditional oppositions between policymakers and policy implementers. Such cross-group alliances deserve a closer look to open the black box of policy change.

Medical Cannabis as a Contentious Policy Configuration: Research Design

Finally, we expect these phenomena—bureaucratic entrepreneurship, policy disputes between groups of bureaucrats, cross-level alliances—to exhibit particular features in the case of morality policies or in highly politicized policy areas. Cannabis is a controversial regulatory area that triggers emotional reactions and polarized debates. Whether for medical or recreational purposes, legislators face numerous challenges in regulating cannabis, because it is a rapidly evolving policy area in which politicians are provided with contradictory evidence (Lamonica, Boeri, and Anderson 2016). In addition, the distinct issues of medical and recreational cannabis have a high interactive potential (Fischer, Kuganesan, and Room 2015, 15), locating the issue within the scope of morality policies.

Importantly, analyses usually focus on the politicization of the topic in the political arenas, especially in parliamentary debates. In this article, we include the conflicts around this issue both in the administrative and the political arenas. While the former certainly are more difficult to examine due to being less publicized, they are crucial in understanding the policy-making process in cases of bureaucratic entrepreneurship. From a study design perspective, the overshadowing of administrative processes by political ones would leave most of the processes unexplained. We therefore not only focus on the moments when bureaucratic entrepreneurs have attempted to establish alliances with politicians, but also on low-salience everyday administrative processes occurring over the years that prepare the field for later political decision-making.

Policy entrepreneurship is likely to be associated with particular constraints in morality policies, in comparison with other topics that are more technical. Bureaucratic entrepreneurship is under more pressure in cases of polarized policies than in consensual ones, where incremental adaptations from bureaucrats can enjoy better acceptance. In morality policies, even minor adaptations might be characterized as dramatic and trigger high levels of conflict (Heichel,

Knill, and Schmitt 2013, 322). Therefore, we assert that the literature should distinguish between different categories of topics when typologizing the characteristics of bureaucratic policy entrepreneurship.

Drawing on these theoretical insights, this article analyzes the following research question:

- RQ: Whereas policy implementation is often analyzed in case studies focusing on a single group of bureaucrats, what dynamics occur when different professional groups are opposed around law interpretation, and turn to active policy entrepreneurs? What are the theoretical and methodological consequences for studies on bureaucratic entrepreneurship?

Methods and Data

This article relies on a comprehensive analysis of the establishment of medical cannabis legislation in Switzerland in 2011 and its implementation over six years, from the beginning of enforcement in 2012 until 2017. The study draws on a policy evaluation conducted by an interdisciplinary research team between July 2017 and November 2018 on behalf of the Swiss Federal Office for Public Health, Federal Department of Home Affairs. The evaluation reviewed the effectiveness and legality of policy implementation regarding the medical cannabis legislation (Mavrot et al. 2019). It examines both the context in which legislators initially decided to allow the exceptional use of cannabis for medical purposes and the later evolution of the policy implementation. All information of the in-depth qualitative case study presented in this article draws on this policy evaluation, whose final report is publicly accessible and contains further information on the dataset and a detailed account of all results.

The regulation of medical cannabis is a complex issue at the crossroads of medical, juridical, and pharmaceutical concerns. The examination of this policy configuration therefore requires a multi-site investigation including all relevant policy actors and professional settings. The study

draws on a five-dimensional research design to understand the various aspects of the policy trajectory. First, to assess the social and political background, a qualitative context analysis was performed on the basis of a 14-year study of Swiss national parliamentary debates on medical cannabis (i.e., since the first debates on a revision of the Narcotic Act to allow the exceptional use of medical cannabis) and a 17-year media keywords analysis.[1] Exploratory tests were made to define the most relevant keywords for the search in the parliamentary and media databases. Because of the manageable number of parliamentary debates on the topic, the data was not coded but treated through a qualitative content analysis, in the chronological order of the debate to observe the evolution trends. The media analysis identified the articles through three (groups of) keywords (e.g., cannabis, Narcotic Act, cannabis + exceptional authorization). As these keywords gave up to 2,000 results per category, the qualitative content analysis was done on a sample of 10 articles for each of the three peak years of media reports in each category.

Second, to retrace the evolution of medical cannabis use in Switzerland since the beginning of law enforcement, a quantitative database of the Swiss Federal Office of Public Health (FOPH) of the approved requests for the exceptional use of medical cannabis from 2012 to 2017 was coded and analyzed (N=8'400). The research team was granted access to this confidential database in an anonymized form in the context of the policy evaluation. The database included patients' socio-demographic information, conditions, symptoms, and medical history. In line with international standards, we coded the diagnoses for which authorizations were granted using the World Health Organization's International Classification of Diseases, 10th Revision (ICD-10).[2] The results of the coding gave a comprehensive overview of the types of indications for which medical cannabis had been granted over the implementation years, both in absolute numbers and in proportion of the total number of authorizations.

Third, the analysis included an online survey among physicians (private actors) who had prescribed medical cannabis to their patients within 18 months prior to the time of the

evaluation. The survey was organized by the evaluation team with the support of the FOPH. The referring physicians were contacted through the FOPH database of cannabis-prescribing physicians. They were informed of the objectives of the study, and a reminder was sent after two weeks. On a total of 1,406 physicians having prescribed, at least once, cannabis to their patients over the last 18 months, 72.2% were addressed by the survey (no valid email address was available for the others), and 353 participated in the survey. The survey questioned the physicians on the medical situations in which they opted for cannabis prescriptions and their opinions on the medical cannabis regulation and delivery system. Referring physicians are key actors in the medical cannabis system in Switzerland because they are the primary gatekeepers: they apply to the FOPH for a special authorization for each patient when they want to prescribe cannabis.

Fourth, to assess policy implementation, an organizational and process analysis of the policy delivery system was performed including all formal and informal aspects of task division, workflow, decision-making, hierarchical chain of command, communication procedures, and resource allocation within the FOPH, with a focus on the relationship between the FOPH's physicians and jurists involved in the granting of authorizations (public servants). This analysis was based on a set of internal administrative documentation (organigrams, internal notes and reports, administrative directives, meeting minutes), and on 21 qualitative, semi-structured interviews with key actors in the medical cannabis policy. All policy implementation actors were interviewed, including current and former FOPHs physicians and jurists, their administrative hierarchy (four-level hierarchy analysis), the owners of the two pharmacies delivering cannabis in the country, producers of medical cannabis, and public health representatives at the national and subnational levels. Interviews lasted between 45 minutes and 3.5 hours. For a visual presentation of the policy delivery system, see Figure 1, and for a list of the interviewees and a further presentation of the dataset, see the online Appendix.

Fifth, a legal expertise was conducted to compare the evolution of implementation practice over the years with the initial legislation on medical cannabis. The legal expertise was done according to the scientific standards in law's field. This expertise was performed by the law expert of the multidisciplinary policy evaluation team and is therefore not the focus of the present article. In the evaluation context, its objective was to provide an external second opinion next to the one of the agency's juridical team. This multi-dimensional approach allowed for robust results based on method, investigator, and data triangulation (Creswell 2005).

The sets of data aim at a comprehensive research design that fits the theoretical standpoint which is to include the whole policy configuration to achieve an in-depth understanding of the policy dispute. The parliamentary and media reports highlight the sensitive nature of the topic and the frequent confusion between the medical and the recreational drug debates. The quantitative database objectivates the social trend of medical cannabis as an increasingly known therapeutic option. The survey among referring physicians captures the relationship of the implementation partners with the policy delivery system at the state-patients interface. Finally, the organizational and process analysis within the FOPH sheds light on the less visible part of policy implementation at the crossroads between the juridical and medical expertise. The case study is structured as follows: First, the juridical framework and organizational features of the policy delivery system is described. Second, the historical development of a system of exceptional authorizations for medical cannabis as decided in the parliament is retraced to show the origin of the policy's contradictions and its disputed developments. Third and fourth, a detailed account of the jurists' and the physicians' standpoints is given in the light of their respective professional ethos. Fifth, the analysis details how this dispute among professionals evolved in the wider administrative and political configuration.

Case Study

Medical Cannabis Policies in Switzerland: A Regime of Exception

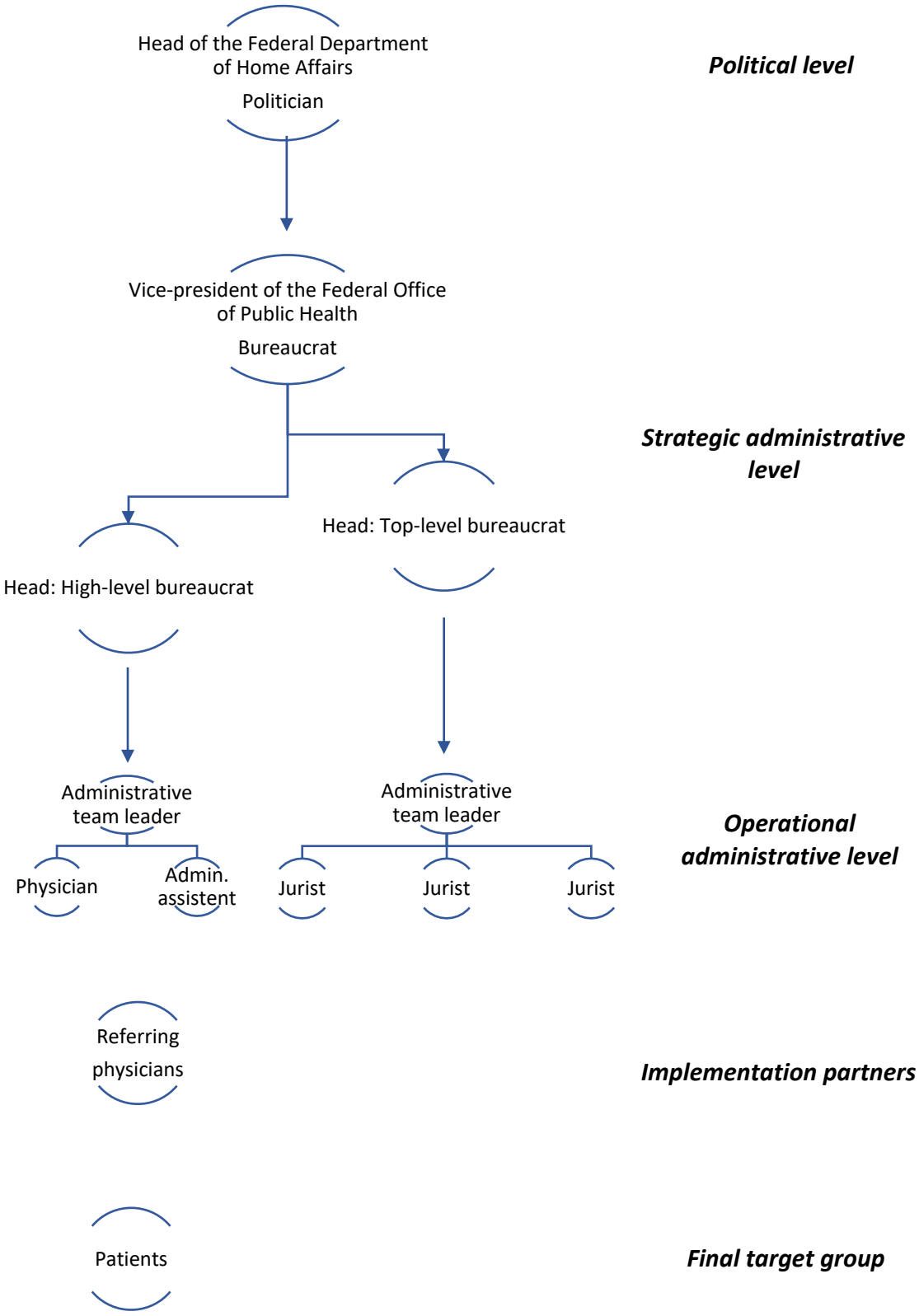
Cannabis use has been regulated since 2011 in the Federal Act on Narcotics and Psychotropic Substances (FANPS, art. 8, § 5),[3] which stipulates that "the Federal Office of Public Health may issue exceptional licences for (…) restricted medical use", not only of cannabinoids, but also of opium, diacetylmorphine, and lysergide (LSD) (FANPS, art.8, §3). To restrain the use of medical cannabis to an exception regime, legislators have defined two main conditions: authorizations can be granted for medically recognized indications only, and all alternative therapeutic options (i.e., approved medications) must have been tried. These two conditions remain vague and give room to interpretative dispute during policy implementation. In other words, this ambiguity opens the door to implementation conflicts (i.e., Boisseuil 2019). In addition, as this is an exceptional authorization system (as opposed to an automatic license system), fulfilling these two conditions does not automatically grant a right to an authorization. Decisions remain at the discretion of the national sanitary authorities. In the first step of the double-gatekeeper system, requests must be filed by the attending physician (general or specialist; mainly neurologists, anesthetists, and oncologists) and submitted to the FOPH. Patients must sign a consent form stating they understand the risks of using a non-industrialized drug (magistral formulas), and authorizations are renewed every six months. In the second step, a small medical team of three mid-level bureaucrats led by a physician reviews the requests within the FOPH.[4] The legal aspects of this process are supported by a legal team of four bureaucrats led by a jurist, also based within the FOPH. We define these public servants as mid-level bureaucrats. As they are not in direct contact with citizens (i.e., the patients) during policy implementation, they are not street-level bureaucrats, and in addition, they enjoy a high level of responsibility and decisional power in reviewing the requests. Because of their position, they can significantly steer the implementation options (i.e., Gassner and Gofen 2019). The medical

and legal teams are embedded in a distinct hierarchical line. Each of them have their own higher-level superior, because they do not belong to the same administrative section. Their first common leader is at the highest level of the FOPH's vice-presidency. This scattering of the delivery system along two parallel hierarchical channels within the same administrative office exacerbates tensions during implementation.

Although not interacting with citizens, the members of the administrative medical team reviewing the requests are in direct contact with implementation partners, namely the physicians who prescribe cannabis, concerning the following aspects: they answer questions on legal and medical aspects, contact them on a case-by-case basis for complementary information, and stay in touch regarding emergencies and authorization renewals. The FOPH's physicians are also in contact with the other implementation partners who need authorizations: intermediaries producing the cannabis and its extract (growers, laboratories), pharmacies producing the cannabis-based magistral formulas, and physicians requesting authorization for research. The FOPH's jurists do not have direct contact with the prescribing physicians or the patients. They exert their support role within office, and their main function is to ensure the legality of the authorization-granting process, without FOPH's physicians being subordinated to them. Overall, the policy delivery system is however strongly situated into the medical area: existence of a law authorizing the therapeutic use of cannabis, referring physicians as main implementation partners, location of the policy within the Office for Public Health, and predominance of the administrative medical team in the granting of authorizations.

Figure 1 illustrates the policy delivery system and shows who are the final policy targets (patients), the main implementation partners (referring physicians), and that the operational level of the policy delivery system is split into two lines (agency's physicians and jurists), embedded in a different hierarchical structure at the agency's strategic level, under a common political head.

Figure 1: Key Actors of the Medical Cannabis Policy Delivery System



Medical Cannabis: Between Medical Policy and Political Moral Panic

In Switzerland, the cannabis debate revolves much around the issue of youth protection (Milic 2009, 1128). Regarding medical cannabis specifically, like in other countries (Gorman and Huber 2007), the core challenges lie in the fear that the authorizing of cannabis consumption for medical purposes might also increase its recreational use in general. Therefore, when medical cannabis is discussed in the parliament, the debate often shifts to the wider controversy on drug legalization, moving away from the specific patient issue. In the study years, cannabis was a salient topic discussed 38 times in the two Swiss legislative chambers. Debates mainly focused on three sub-topics: legalization, medical cannabis, and the initiatives of Swiss cities to experiment with cannabis regulation at the local level. The most striking feature of the debates was the systematic association between medically prescribed cannabis and wider controversies on recreative consumption and drug legalization. Causing further confusion was the flourishing of the CBD-cannabis[5] market since 2016. The Swiss People's Party (SPP, nationalist extreme-right) was especially active on the topic, initiating 21 of the parliamentary debates and strongly contributing to politicizing the issue. However, parties from all sides of the political spectrum also placed the question on the agenda. None of them was satisfied with the existing legislation, which was the product of a consensus. Several parties asked for a tolerance of personal possession and consumption.

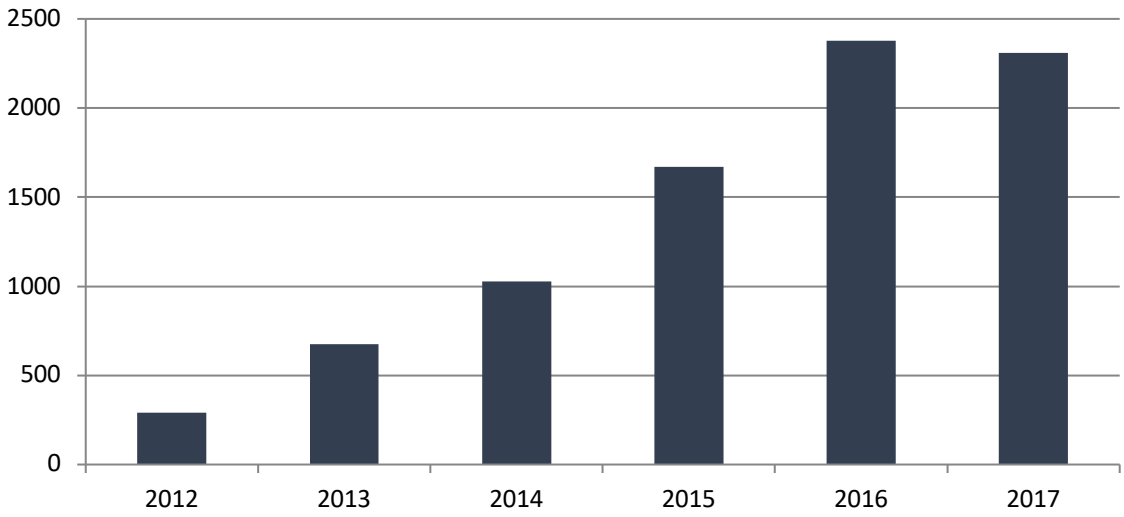
Regarding medical cannabis, the SPP claimed that the therapeutic use of cannabis was serving a hidden agenda aimed at legalizing the substance and resulting in insecurity by requiring the growth of cannabis in Swiss fields. On the flip side, the Green-Liberal Party (GLP) filed a parliamentary motion in 2014 to facilitate access to medical cannabis for the seriously ill, underlining its virtue as a pain reliever in end-of-life situations. The Christian Democratic Party (CDP) submitted a similar motion in 2017 with a focus on the red tape associated with the exceptional authorization system.[6] In highly emotional debates, medical cannabis opponents

underlined the dangerous signal that authorized medical consumption was sending to youth. Proponents accused the opposing side of lacking compassion for people in severe pain and of neglecting patients' rights. Swiss media echoed these debates by offering broad coverage: between 200 and 2,000 articles addressed the topic of cannabis every year between 2000 and 2017. Media coverage contributed to further dramatizing the issue of medical cannabis by placing a strong focus on individual stories—especially those of patients struggling to access cannabis products (Mavrot et al. 2019, 8-13).

The political and media coverage caused enforcement actors to be cautious about the policy's politicization potential. However, they faced an important issue: the spectacular increase in requests for medical cannabis. As Figure 2 shows, the number of applications that the FOPH approved increased from 291 in 2012 to 2,309 in 2017.[7] The online survey among physicians conducted in our study suggested that this was mainly related to the growing notoriety of cannabis as a therapeutic option.[8] This sharp increase put the administration under pressure: the FOPH's physicians had to respond to requests using the same number of human resources and had to answer every request within three days (regulatory requirement). In addition, the jurists had to ensure that the authorization practice remained within the legal framework. Both professional groups feared that the parliament questioned their activities. For the physicians, the fear was first rooted in the high interactive potential (i.e., Fischer, Kuganesan, and Room 2015) between debates on medical and on recreational cannabis. Second, the dispute between the jurists and the physicians had intensified in parallel to the increase in requests, and the jurists had sounded the alarm at the top-administrative head of the FOPH, which resulted among others in the commissioning of the external policy evaluation on which this study is based. Finally, some crucial aspects of the work of the FOPH's medical team lacked solidity, like missing information in the monitoring database over the years (Mavrot et al. 2019, 39, 74).

Interestingly, the records of the parliamentary commission that prepared the 2011 legislation allowing cannabis use for medical purposes showed that the legislator purposefully designed a high-threshold exception system because politicians strongly believed that cannabis-based industrialized drugs would be created in the near future. The policy assumption was that the exception regulation would bridge the gap until new drugs were marketed. However, drug companies turned out not to be interested in this too small market, and such products were not developed (Mavrot et al. 2019, 36-37).

Figure 2: Number of Application for the Medical Use of Cannabis Approved by the FOPH (2012-2017) (N=8'400)



The therapeutic burden was placed on referring physicians, who faced the dilemma of prescribing complex-to-access and non-standardized products to their patients with the associated costs and risks (for instance regarding the adequate dosage or possible side-effects). The burden was also placed on the FOPH, which had to deal with the increasing discrepancy between a regulation adopted years ago on a quickly evolving topic (i.e., the criteria of "medically recognized indications"). The surveys of referring physicians showed that they undertook their gatekeeper functions in selecting patients to whom to prescribe cannabis: more

than 38% of respondents had already refused to prescribe cannabis to patients, and 78.7% declared prescribing cannabis only when no other therapeutic option was available. The coding of the 8,400 requests that the FOPH approved also showed important trends. First, there was no evidence of a significant extension of the indications for which authorizations were granted. Diseases of the nervous system, of the musculoskeletal system, and pain relief in cancer situations accounted for 82.5% of authorizations and remained stable over the years. Similarly, the main accepted symptoms—chronic pain and spasticity—remained stable and amounted to 85.3% of total authorizations. These results suggest that the request increase was due to a changing social trend versus a change in administrative authorization practices. However, although indications for medical cannabis remained fairly stable, a change occurred regarding the authorizations for treatments involving other substances covered under the Narcotic Act: 40 authorizations were granted for methylenedioxymethamphetamine (MDMA, i.e., ecstasy), and 30 for LSD between 2014 and 2017, mainly for the treatment of psychiatric conditions such as post-traumatic stress disorder. The available data also showed that very few cannabis requests were rejected, which was an important concern for jurists (Mavrot et al. 2019, 14-18). Two main reasons existed for request refusal by the FOPH: missing or incomplete information in the requests, and psychiatric of psychological indications (Mavrot et al. 2019, 18). This may indicate that the FOPH was flexible regarding granting authorizations, and/or that referring physicians undertook their gatekeeping duties and presented only sound requests for admissible patients.

The Jurists' Standpoint: Institutional Continuity and Juridical Security

In this context, the FOPH's jurists pointed out issues on which they disagreed with the medical bureaucrats in charge of the authorizations. First, from a juridical perspective, the fact that a very large proportion of requests were granted stretched the exception system toward an automatic authorization system. Consequently, for jurists, the system had lost sight of the

legislators' intention of allowing cannabis prescriptions only in exceptional circumstances. They sometimes disputed the indications for which FOPH physicians granted requests: "According to the current state of scientific research, cannabis works in pain therapy related to cancers, AIDS, and multiple sclerosis. (…) in addition comes the criteria of having exhausted all therapeutic alternatives. The system of exceptional license is not a system of automatic approval. This is a prohibited narcotic that can only be used in unique cases. (…) [by clarifications] I always ask the disease history [of the patient]".[9] In such cases, the physicians underlined that the jurists went beyond the scope of their legal expertise. The jurists also sometimes tried to back up their position by bringing a counter-expertise based on their own searches in the medical literature, e.g., "There are problems with too many, qualitatively questionable studies that cannot be used for approvals. There is a wide gap between the public perception and the scientific evidence regarding the efficacy [of medical cannabis]".[10] The physicians, however, discredited the jurists for not having the required competencies in the matter.

Second, the jurists felt that FOPH was not monitoring the criteria for the exhaustion of alternative therapeutic options closely enough. Third, the jurists contested an external expert commission put in place by the FOPH's physicians to advise them. The commission was made up of physicians from different specializations who had experience with cannabis treatments and intervened in complex cases upon request. In the jurists' view, the establishment of the commission lacked a juridical basis. They felt that the physicians had chosen experts with similar views. After they voiced this criticism, the existence of the external expert commission was officialized within the agency (i.e., the mandate of the commission was officially validated by the FOPH's hierarchy).

Fourth, the process and the division of work between jurists and physicians within the public agency were not clearly defined. Thus, the jurists often felt that the FOPH physicians bypassed

them during request processing: “The whole implementation in this area had been messy for a long time. The implementation was neither visible nor traceable for the Juridic Section. (…) The main responsibility of the Juridic Section is the respect of the legislation. In this area, there are binding processes with an obligation to include us (…) In the last three-four years, the Juridic Section has been only informed in a restrained way and a lot has been kept secret”.[11] The jurists were indeed in a delicate position to lead this fight because of the asymmetry of position, and network between them and the FOPH’s physicians. While the FOPH medical team was in direct contact with the referring physicians, the jurists did not enjoy this access to the main implementation partner. In this context, crucial processes and information flows happened out of their watch.

Fifth, the jurists underlined that the authorization system suffered from a lack of transparency, as a monitoring system keeping detailed track of the requests had not been fully established until 2016—four years after the beginning of enforcement. The jurists warned that this could put the office in danger from a political and a juridical perspective. Sixth, the FOPH’s physicians were making contacts with referring physicians during the request process, for instance to answer questions. However, the jurists argued that any interaction prior to the treatment of requests could be deemed “prior involvement” and thus constitute a juridical problem (Mavrot et al. 2019, iii, 39, 76). The jurists accused the physicians of informally advising referring physicians on how to present their requests to enhance their chances of success: “This is especially the issue of prior involvement. (…) some members of the [medical] team are not concerned with the actual procedure but with networks, politics…”.[12] To minimize these contacts, the FOPH physicians wanted to include more information on medical cannabis on the administration’s website. However, the jurists rejected this idea, as they argued that this would constitute an advertisement for narcotic products.

Finally, the jurists insisted on the importance of sticking with the initial will of the legislator at the time of the formulation of the law. They argued that beyond the FOPH physicians' specialized expertise, their administrative duties were to stick as close as possible to parliamentary decisions. In the jurists' professional ethos, respecting the separation of roles between implementing agents and elected representatives was fundamentally a question of democracy. Contrary to that, in the jurists' eyes, "the Medical Section has only been doing drug policies".[13]

The Physicians' Standpoint: Medical Expertise and Patients' Rights

On the contrary, the professional ethos of the FOPH physicians made them prioritize patients, leaning toward a more flexible interpretation of the compassionate use of medical cannabis. The core reference of the physicians was patients' rights (e.g., the right to pain alleviation), which did not align with the jurists' priorities: "People ask for cannabis for health reasons. (…) The focus [in the agency] lies too much on legal aspects. There is almost no room for ethical or scientific questions. I don't recognize these aspects of my own profession anymore. Of course the FOPH is a public administration, (…) but I am a physician and I will stay a physician". [14] Next to the medical expertise strongly attached to their person, the agency's physicians claimed to have secured the best available medical expertise in the country with the commission of external experts advising them regularly on limit-cases—the call to external expertise being a usual feature in Swiss public administration.

Regarding the composition of the external expert commission, the FOPH physicians felt that they could not avoid nominating physicians whom they knew. This is because Switzerland is a small country and medical cannabis a niche topic, with only a few specialized physicians. This group of external experts made of physicians highly familiar with medical cannabis are significant interlocutors for the FOPH's medical team. Next to sharing a common professional background and values, they are authoritative in the field. They bring actualized knowledge and

field experience to the FOPH's physicians. Through their regular meetings around specific authorization request, they develop a common understanding on the use of the product (Mavrot et al. 2019, 41, 72-73). Some of the external experts are proactive in trying to normalize medical cannabis in the public and medical arenas. None of the FOPH physicians specialized in medical cannabis before taking office. Before joining the administration, the medical team leader at the operational level specialized in jail medicine and was active in the field with Doctor Without Borders. The other physician specialized in preventive medicine. Regarding its network outside of the FOPH, the medical team is also in regular contact with the other players involved in the legislation on medical cannabis within the frame of its control and supervision duties: pharmacies delivering the product, producers, and growers. In this context, they are also made aware of the difficulties the legislation generates for these actors—for instance a supply shortfall happened once when the jurists introduced more detailed reporting obligations (Mavrot et al. 2019, v, 45-46). These contacts also contribute to shape the physicians' vision on the topic, contrary to the jurists who do not have contact with the field.

The main constraints that the FOPH physicians faced include the increase in request numbers, which were eight times higher in 2016 than in 2012 (Figure 2) and led to a work overload. Furthermore, FOPH physicians and their hierarchy trusted the referring physicians who requested authorizations for their patients and did not deem it necessary to proceed to excessively close controls of the exhaustion of alternative therapeutic options: "The applications are indeed assessed according to the legal criteria. The Medical Section however notes that a cannabis-based treatment is totally unquestionable for a lot of patients. By 80-year-old cancer patients in final stage, no extensive clarifications are necessary to show that a cannabis-based therapy is adequate. The risk [of product misuse] with such patients is exceptionally low. (…) This is an idiotic situation, in which [referring] physicians are asked to address the disease with a Panzer tank first, before having the right to turn to an air rifle".[15]

They argued that referring physicians were in the best position to choose the adequate treatments for their patients. Sharing the same professional norms and values as their colleagues in the field, they saw no need to go against their medical judgement. Concerning the legislators' will, FOPH physicians considered that even though a set of indications was recognized at the time of the legislation's adoption,[16] medical knowledge had evolved, and new indications could have emerged since then. In their opinion, the legislators' will was not to stick with the initial conditions explicitly mentioned at the time but rather to grant patients with an access to narcotic products when needed, on conditions to be evaluated by specialized physicians according to the latest medical knowledge. Hence, the moral compass of FOPH physicians was primarily oriented toward the Hippocratic oath, toward prioritizing the relief of patients' suffering, and toward having strong faith in field medical expertise.

Vertical and Horizontal Dividing Lines: A Complex Policy Configuration

This situation led to enduring conflicts between the two groups of public servants. Both had strong professional values and highly specialized expertise that they called on to make their cases. Each group invoked higher-level ethical standards: the legality of public action and democratic order for the jurists, and patients' rights for the physicians. Each of them also invoked immediate threats. The jurists argued that the office was vulnerable to political attacks if it stretched the law, and the physicians stated that the equal treatment of patients would be endangered if the number of granted requests was artificially lowered due to a transition toward a more restrictive interpretation. The fact that the two professional groups were not embedded in the same administrative hierarchy amplified the conflict by scaling it up several layers higher in the hierarchy. Unsurprisingly, their respective immediate superiors backed them, and the conflicts were regularly escalated to a common higher superior. This led to a case-by-case problem resolution approach, which never solved the heart of the disagreement.

The hierarchical superiors of the medical and juridical teams (strategic administrative level) were themselves in open conflict around the issue. Both are career public servants who have served at the FOPH for a long time. However, the strategic head of the medical team is a strong figure known for past involvement as a key architect of the reform of the Swiss drug policy toward harm reduction, in the nineties in the context of the HIV/AIDS epidemic. This biographic aspect fueled the suspicion among jurists that he had a political objective regarding the liberalization of cannabis consumption, which he strongly denied: "My main objective is a clear separation between recreative consumption and the medical use of cannabis. (…) I am convinced that medical cannabis has a huge potential, especially (…) in the pain relief area. We have to do everything to exploit this potential, and we therefore need a separation between medical and recreative consumption".[17]

Because law enforcement was under the control of the Office for Public Health, the arbitrations tended to be more favorable to physicians at the higher administrative levels. Hence, despite the existence of two strongly recognized types of expertise in the policy delivery system, the physicians enjoy a more favorable position in this particular configuration (i.e., Eyal 2013). FOPH officials primarily saw their mission as serving patients. At the political level, the physicians' point of view was also better represented within the executive power through the head of the Federal Department of Home Affairs, which the Federal Office of Public Health is part of. Accordingly, the Swiss government—made of seven departments—consistently supported the administration's practice in front of the parliament.

Next to having internal support from the administrative and executive hierarchies, acting as policy entrepreneurs, the FOPH's physicians also established alliances with members of the parliament. When important parliamentary motions were submitted in 2014 ("Facilitation of the access to medical cannabis for strongly ill patients") and 2017 ("Medical prescription of cannabis for patients with chronic illnesses – reducing health costs and the red tape"), the FOPH

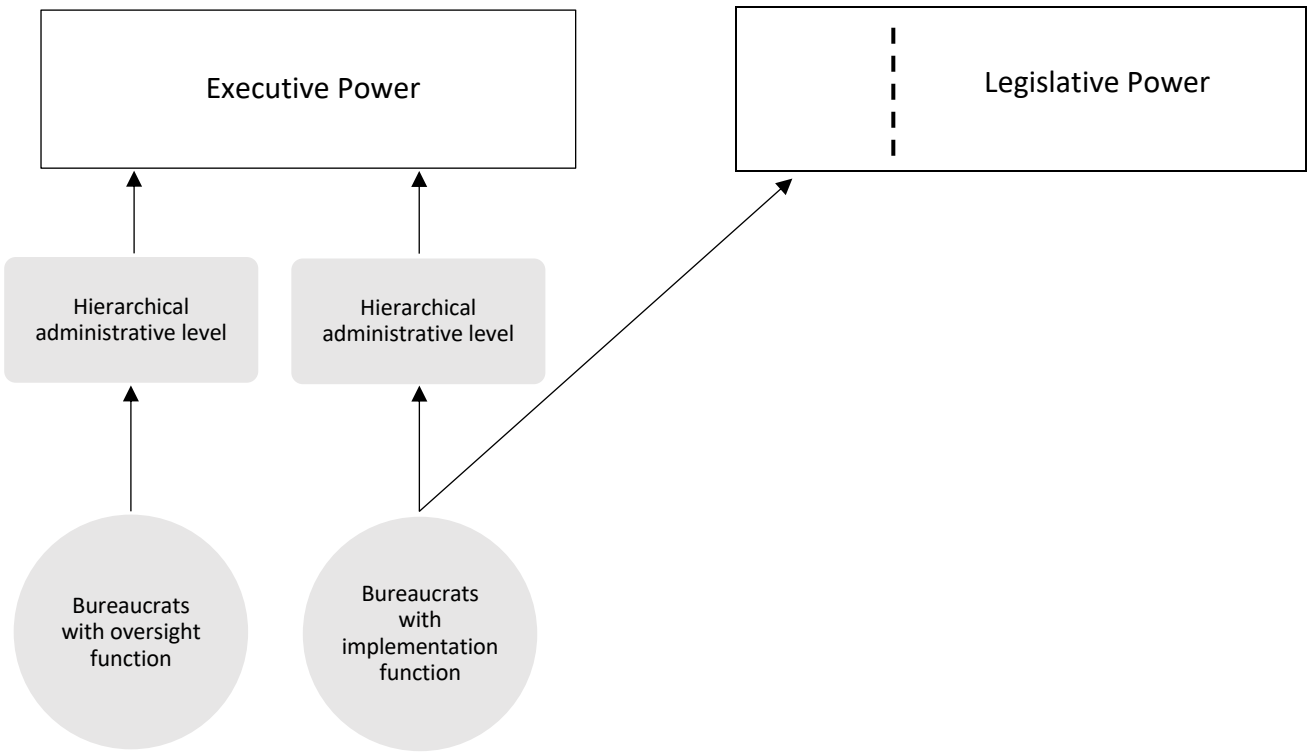
physicians met with members of the political parties that were preparing these motions, they supported further development and actualization of the law and ultimately, they provided the administrative background work to prepare the answers of the Department of Home Affairs to the motions in front of the parliament. Hence, core conditions favorable to bureaucratic entrepreneurship were present: a crisis situation, a demand for knowledge, and an expectation on bureaucrats to engage in policy issues (i.e., Lavee and Cohen 2019). The jurists held that their expertise was ignored during the process of informing the members of parliament and answering the motions. Had they been included in the process, they would have argued against the support of these two motions in the name of the FOPH.[18] The jurists also argued that the answer to motions led by the medical team included juridical mistakes (e.g., on the technicalities of a potential refunding of medical cannabis through health insurances).[19] On the contrary, the physicians explained their cautious involvement of the legal team based on past experience, during which the jurists had, according to them, overstepped the boundaries in attempting to argue themselves on the medical field by bringing up scientific studies (e.g., on a past motion on the psychoactive effects of CBD).[20]

On the initiative of the Department of Home Affairs, the political Head of the Department and the government finally supported the necessity to adapt the law. Thus, the conflict also escalated to the parliament. Through the preparatory work around the motions, an alliance was established between the FOPH physicians and the green liberal and Christian parties, which were, respectively, willing to adopt a more liberal and a more compassionate approach to medical cannabis. The physicians felt they were in a position to establish an alliance with the parliament because the initiative came from several political parties. They sensed the time was ripe for a change in the legislation, and that they had both the political and the popular support: "There is now a popular will to ease the access to medical cannabis. The chosen implementation

system with exceptional licenses is unsuitable. The current system does not fit the population's opinion anymore".[21]

In the meantime, although not satisfied with the events, the FOPH jurists were not in a position to create another alliance with parliamentarians outside the activities surrounding the motions. On such a sensitive topic, they knew that leaking information would create a political controversy that was potentially harmful for the entire office. Being the Section responsible for the legality of the FOPH, they felt they would be held accountable in case of a political controversy, being at risk of criticism for the loosening of the authorization practice. Hence, in this configuration, the physicians had more leeway than the jurists to create a vertical alliance with the legislative power. As Figure 3 shows, the physicians both had support within the executive branch through their hierarchy and allied with members of the parliamentary branch that were seeking to change the law, while the jurists fully remained in their executive hierarchy line. The latter suffered from the decoupling of their legal responsibility and the authorization responsibility (in the hands of the physicians): "The Medical Section insists–rightly—on being the substantive competent decision-maker. But when it comes to total failure, the jurists have to take over. This divergence is contradictory and not consistent. Either the [medical] experts are responsible, if which case they should also take the responsibility in case of mistakes…".[22] These efforts have been followed by results, as the Swiss Parliament finally adopted the two motions and is moving the legislation toward flexibilization. The two national legislative chambers adopted the latest motion in 2018 and 2020, respectively, and simplified the access to medical cannabis by abolishing the double-gatekeeper system.[23]

Figure 3: Bureaucratic Entrepreneurship: Cross-Level and Cross-Actor Alliances



However, far from only provoking an administrative dispute, the dissent between the two groups of bureaucrats also led to a strong consolidation of law enforcement. As a result of the jurists' close monitoring of legal aspects, the physicians were able to correct or secure different aspects of their praxis that might have been subject to criticism. In the physicians' view, the legal overview took time and as a consequence, endangered patients' access to medical cannabis, as legal controls had once induced a supply shortfall. However, crucial elements of the policy implementation are in place due to the confrontation between the two professional groups. These especially include the introduction of a systematic monitoring database, the officialization of the expert group, and the attention given to the prior involvement issue (i.e., formal communication requirements the FOPH's physicians must respect to ensure the legality of the process) (Mavrot et al. 2019, 68-77). Hence, the confrontation between the administrative physicians and jurists led to consolidate the FOPH's practice. The temporal factor was also crucial in the development of the enforcement dispute. As noted, the parliamentary commission

that formulated the initial legislation chose an exceptional authorization system because it strongly expected a cannabis-based drug to be marketized. The legislators could not have anticipated the evolutions of the policy, which led to unforeseen tensions in the field among professional groups, regarding the sharp increase in requests. This caused FOPH physicians to engage in bureaucratic entrepreneurship. They became involved in the entire policy cycle, ranging from daily enforcement decisions (e.g., accepted indications for medical cannabis, experimentations with MDMA and LSD) to more political work around the parliamentary motions, that is, from policy implementation to policy designing.

Discussion

This case shows the importance of considering the entire politico-administrative configuration for understanding the role of bureaucratic entrepreneurship in the policy process. The question at hand not only involves the degree to which implementing bureaucrats stretch laws, regulations, or the political will, but also the dividing lines that exist within the state. These dividing lines can be vertical and involve different types of actors across hierarchical levels. This is what we observed when bureaucrats established alliances with the government or the parliament, exploiting the opening of "problem windows" (i.e., proposing a specific framing to a currently discussed problem) (Herweg et al. 2015, 443). Such alliances might especially happen in controversial fields that trigger political conflict, such as morality policies. In such cases, bureaucratic entrepreneurs are likely to look for political support to change the rule, and in return, politicians might seek bureaucrats' field expertise to justify the change. In this context, "professional bureaucrats" can also rely on their specialized network to strengthen their case (Mintzberg 1978).

Moreover, polarized issues induce specific dynamics. In this case, bureaucrats opposed to a policy change had fewer network resources and no interest in escalating the issue to the political

arenas and risking public controversy. Public controversies on drug policies have proven tricky in Switzerland, especially given the existence of the public referendum instrument which can be used by moral entrepreneurs to politicize the issue (Papadopoulos 2003, 481, see also Kübler 2000). Therefore, the jurists had a negative interest in publicizing the case, which discouraged them from establishing a counter-coalition with other political actors. In this situation, we observe an unequal repartition of the entrepreneurial capital among the involved bureaucrats, leaving the field to the medical cannabis proponents. As such, the repartition of the entrepreneurial capital among bureaucrats in a specific policy configuration must be mapped.

These observations have implications at the theoretical and methodological level. The fight for authority can be seen as "a relationship between actors in a structured social space (…). (…) the question of which types of actors are authoritative, or what type of "sources" of authority is prevalent, emerges from the empirical analysis rather than being imposed as the analytical framework" (Sending 2015: 6, citing Bourdieu 1986 and Gorski 2013). Hence, all actors of the politico-administrative configuration must be included in the research design. There is a risk that some are left outside, such as mid-level bureaucrats with oversight functions. However, even though they are less visible, they potentially make strong contributions to shaping policy issues. Policies are the result of interactions and conflicts not only in the policy designing phase but also during the implementation phase. Hence, in the medical cannabis case, by pointing out legal issues, the jurists contributed to consolidate and secure the implementation praxis despite opposing it. The dispute was thus not only confrontative but also generated constructive changes.

Hence, in addition to the vertical alliances, horizontal confrontations between groups of bureaucrats are crucial. Although far from being unusual in reality—complex policies often require the cooperation of different specialists—the policy implementation literature rather focuses on mono-professional issues involving one group of bureaucrats. Research on

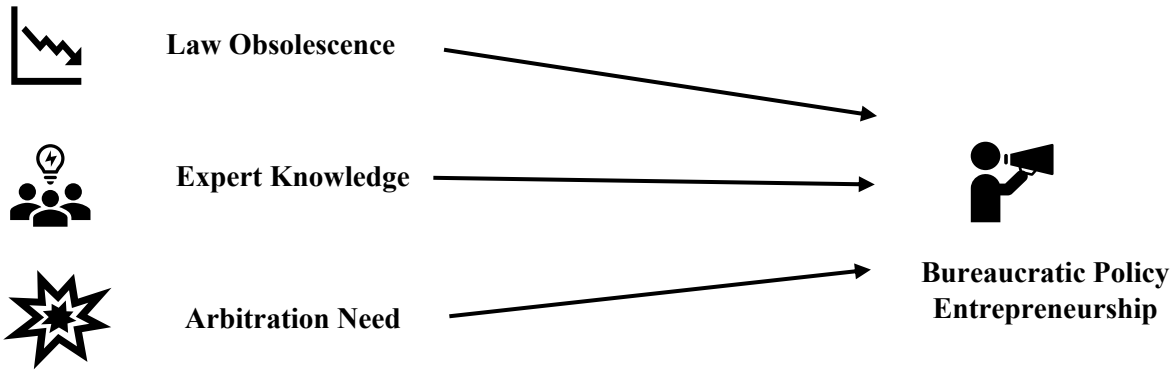
bureaucratic politics could benefit from an examination of policy interactions and negotiations among different groups of bureaucrats. This is especially important with the role of the professional ethos of bureaucrats in shaping the policy. As Isabelle Engeli, Christoffer Green-Pedersen and Lars Thorup Larsen (2012) have noted, the role of left- and right-wing political parties and of the political system in shaping morality issues has already been well-studied. The medical cannabis case points out the interest of further focusing on the interplay between professional and political actors in shaping morality policies, or politicized issues in general.

This case also draws the attention to the temporal factor of policy entrepreneurship. As bureaucrats reformulate policies by implementing them, the time sequence is crucial. Policy implementation should not only be compared with the public decision as expressed during the initial legislative sequence but also, during implementation, notably through their contact with the policy clientele, the notions of policy costs and benefits are constantly redefined by bureaucrats (Ellermann 2006), and various types of accountability come into play. This is especially important in policy fields in which the law becomes rapidly obsolete. Physicians, for instance, must constantly adjust their praxis to changing medical evidence and evolving social norms, and the expert rationality supersedes potentially outdated rules. In such situations, implementation praxis might contribute to the further development of the policy, strongly relying on bureaucrats' professional ethos (e.g., the priority given to patients' rights). This case shows the importance of the medical identity and loyalty of these bureaucrats, that took over juridical considerations on the limits of administrative action. Therefore, a systematic account of the temporal factor, allows to identify which kinds of accountabilities take over along the timeline of policy implementation.

Furthermore, to avoid validating a "heroic" approach to advocacy, the specific conditions under which entrepreneurship succeeds or fails must be taken into account (Zahariadis and Exadaktylos 2016, 77). Studying bureaucrats at the street level, Lavee and Cohen (2019) note

that while too little is known of the conditions that induce entrepreneurial behavior, the following factors can be highlighted: crisis situations, a lack of knowledge and a demand for political activism. Our study confirms these elements and adds further insights related to bureaucratic entrepreneurship when a *highly specialized administrative expertise* exists in a context of *law obsolescence*. Figure 4 pictures these complementary theoretical elements. Increased discrepancy between the law and the needs in the field, combined with the existence of specialized expertise, has driven the bureaucrats to initiate entrepreneurship both at the policy implementation level (i.e., exceptional authorization practice) and the formulation level (i.e., parliamentary motion processes). The disagreement between two groups of bureaucrats reinforced the policy entrepreneurship process, leading them to seek arbitrage from higher political levels. Without the existence of a disagreement at the enforcement level, the physicians might have maintained a low-key strategy and continued to stretch the law without necessarily seeking a legislative change.

Figure 4: Factors Leading to Bureaucratic Policy Entrepreneurship



These results rely on a single case study. Additional research would be required to further conceptualize the role of bureaucratic policy entrepreneurship within the wider politico-administrative configuration. This case was also characterized by a salient policy issue and clearly delineated opposition between two groups of bureaucrats. The situation might not be so clear-cut in other policy contexts. In addition, because this study stemmed from a policy evaluation mandate, the research team had privileged access to confidential information. Being caught in a policy dispute, it was in the bureaucrats' interest to display information to make their points. Data on sensitive policy issues might, however, be difficult to gather depending on the context.

Conclusion

The medical cannabis case as a highly politicized issue draws attention to an interesting avenue for bureaucratic entrepreneurship research. It showed that under certain conditions, bureaucrats "may become part of the political game, not just by engaging in informal practices (…), but also through their direct involvement in the design of that policy" (Lavee and Cohen 2019, 489). Whereas bureaucrats have to overcome barriers to participate in policy formulation, especially their lack of formal legitimacy to engage in this activity due to their positions, they also possess a crucial resource—their field knowledge (Frisch-Aviram, Cohen, and Beeri 2018, 42). Politicians actively seek this knowledge at one crucial moment of the policy formulation: when the administration is mobilized to prepare and answer parliamentary queries. We underlined that bureaucratic policy entrepreneurs can use these requests as windows of opportunity to push their agendas. In this regard, light must be shed on the alliances that can emerge across governance levels around contested issues that trigger bureaucratic entrepreneurship. In particular, public servants are in a good position to provide members of parliaments with informal feedback—in the sense of complaints or support by constituents or intermediaries (Kingdon 2013 [1984])—as parliaments are dependent on administrative

expertise and knowledge. Answering parliamentary queries and participating in the preliminary work related to them constitute a privileged window of opportunity. Following on Kingdon's model, bureaucrats can undertake an active role both in the problem stream (raising awareness) and the policy stream (identifying solutions). Acknowledging power games along non-unified hierarchical lines allows one to observe how policy conflict and entrepreneurship trickle up and down in the policy system. Conceptualizing these fragmented vertical alliances between administrative and political actors (i.e., Figure 3) might help to advance the understanding of bureaucratic politics.

Finally, these processes refer to the fundamental issues of state theory, constitutional order, and the separation of powers. Adopting such a macro lens allows one to take a step back and consider the role of bureaucratic policy entrepreneurship from a wider perspective. Administrative theory holds that in a balance-of-power perspective, a wide range of possible nuances exist regarding the degree of oversight of each constitutional power (i.e., executive, legislative, judiciary) over the administration (Rosenbloom 2000). Identifying the directions in which bureaucratic entrepreneurship pulls administrative action and oversight within the wider structure of the state opens stimulating paths. When bureaucratic entrepreneurs succeed in engaging in the policy design process beyond simple policy implementation, bureaucrats partly escape the executive oversight in participating in legislative processes through alliances. Various groups of bureaucrats also engage in different alliances within the executive hierarchy. As such, the policy process is less a matter of one constitutional power balancing the other than of dividing lines across and within branches of government. Considered under this perspective, bureaucratic policy entrepreneurship has much to reveal about the dynamics of policymaking.

Endnotes

[1] The parliamentary and media analyses included the two main national languages, German and French.

[2] https://www.who.int/classifications/icd/en/

[3] https://www.admin.ch/opc/en/classified-compilation/19981989/index.html

[4] The team comprises two physicians and an administrative assistant.

[5] Cannabidiol, a cannabis product with a weak psychoactive effect due to its low tetrahydrocannabinol (THC) concentration.

[7] At the time of the study, the available data for 2017 went only until September 15.

[8] 111 physicians out of 353 respondents named this reason as a factor explaining the increase in requests (Mavrot et al. 2019, 23).

[9] Source: Interview transcription Jurist 1, December 12, 2017. All interview citations are translated from the German.

[10] Interview transcription Jurist 3, December 13, 2017.

[11] Interview transcription Jurist 2, December 8, 2017.

[12] Interview transcription Jurist 1, December 12, 2017.

[13] Interview transcription Jurist 2, December 8, 2017.

[14] Interview transcription Physician 1, December 7, 2017.

[15] Interview transcription Head of the Medical Section, December 22, 2017.

[16] For a list of parliamentary proceedings, see Appendix 3.

[17] Interview transcription Head of the Medical Section, December 22, 2017.

[18] Interview transcription Jurist 2, December 8, 2017.

[19] Interview transcription Jurist 1, December 12, 2017.

[20] Interview transcription Head of the Medical Section, December 22, 2017.

[21] Interview transcription Head of the Medical Section, December 22, 2017.

[22] Interview transcription Jurist 3, December 13, 2017.

[7] Mentioned in the message accompanying the promulgation of the law.

[23] https://www.parlament.ch/de/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20183389

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