KATIE’S LAW: OKLAHOMA’S SECOND PUFF OF MEDICAL MARIJUANA†

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“I stopped all radiation. I basically detoxed off all pharmaceuticals. I started eating raw cannabis three times a day in salads. I am illegally healed because I am in Oklahoma.”

Juliette Freese, Oklahoma City resident cured of a rare bone cancer.¹

I. INTRODUCTION

Marijuana is everywhere. Marijuana (Cannabis sativa) has always been with us and is not leaving any time soon.² Starting at least 3,000 years

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1. Laura Eastes, Two Grassroots Groups Work to Change State Medical Marijuana Laws, OKLA. GAZETTE (Sept. 4, 2015), http://okgazette.com/2015/09/04/cover-story-are-our-states-marijuana-laws-going-up-in-smoke/ [https://perma.cc/7SJD-TSCZ]. Mrs. Freese was told in May 2014 to prepare for the end due to multiple myeloma. Id. She started taking medical marijuana daily and stopped taking prescription medicines. Id. In March 2015, she was told she was cancer-free. Id.

ago, people in China and India used cannabis to treat a variety of ailments. Today, “marijuana is the most commonly used illegal drug . . . across the United States.” Ironically, it is more abundant now than prior to President Nixon’s War on Drugs.

Marijuana is safe. Despite much research, there is little evidence of marijuana harming a healthy adult user—a claim that cannot be said of alcohol or tobacco, both of which are perfectly legal. Despite being illegal under federal law since 1970, marijuana is in some places “as readily available as alcohol,” and attitudes toward its use are changing. As opposed to the past, when marijuana was viewed as harmful, “more Americans now perceive that marijuana is harmless.” The then U.S. Surgeon General, Vivek Murthy, admitted that medical marijuana may help some people.


6. See Steven B. Duke, The Future of Marijuana in the United States, 91 Or. L. Rev. 1301, 1307 (2013) (“In study after study, decade after decade, researchers have found no reliable evidence that marijuana is a serious threat to the physical or psychological health of a normal, adult user.”).


8. Cf. Whitesell et al., supra note 4, at 1311 (noting that for young people, particularly on Native American reservations in the United States, marijuana is much easier to acquire than alcohol because of regulated alcohol sales).


10. Sides, supra note 2, at 38.
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America’s current marijuana policy is a failure. Everyone is frustrated with the War on Drugs. Incarceration numbers (and costs) have skyrocketed. Individual rights have been curtailed. Police forces have become more militaristic in response to the violent drug trade. Punishments have increased. Conversely, the demand for marijuana

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11. _See_ Maria McFarland Sánchez-Moreno, _Winding Down the War on Drugs_, HARV. INT’L REV., Summer 2015, at 35, 36 (noting that the traditional approach of the War on Drugs has failed with devastating consequences as legalization has increased); Will Dana, _A Trillion-Dollar Failure_, ROLLING STONE, July 2, 2015, at 38, 38 (trillion-dollar failure is a reference to the War on Drugs); Vanessa Baird, _Legalize Drugs—All of Them_, NEW INTERNATIONALIST, Sept. 2012, at 12, 13–15 (blaming the War on Drugs for causing a “deadly set of ‘unintended consequences’”); Julien Mercille, _Violent Narco-Cartels or US Hegemony? The Political Economy of the ‘War on Drugs’ in Mexico_, 32 THIRD WORLD Q. 1637, 1650 (2011) (asserting that drug treatment is twenty-three times more effective than our War on Drugs); Marty Ludlum & Darrell Ford, _Oklahoma’s First Puff of Medical Marijuana_, AM. INT’L J. CONTEMP. RES., Aug. 2012, at 91, 91 [hereinafter _Oklahoma’s First Puff_] (“[T]he War [on Drugs] is largely recognized as a complete failure.”).


13. _Cf._ Lawrence D. Bobo & Victor Thompson, _Unfair by Design: The War on Drugs, Race, and the Legitimacy of the Criminal Justice System_, 73 SOC. RES. 445, 445–46 (2006) (arguing that while claiming to support rights of freedom and equality, politicians on both sides have eagerly supported punishments that at any other time in history “would be unthinkable” (quoting Michael Tonry, _Rethinking Unthinkable Punishment Policies in America_, 46 UCLA L. REV. 1751, 1751 (1999))).

14. _See_ Sánchez-Moreno, _supra_ note 11, at 36–38 (noting that the military has increasingly been involved in the War on Drugs in the United States and particularly in countries such as Colombia and Mexico); Mercille, _supra_ note 11, at 1645 (describing the military equipment being used in the War on Drugs in Mexico and the US); Horace A. Bartilow, _Drug Wars Collateral Damage: US Counternarcotic Aid and Human Rights in the Americas_, 49 LATIN AM. RES. REV., NO. 2, 2014, at 24, 24 (discussing the “escalation of drug-related violence,” including mass graves and beheadings).

15. _See, e.g._, ASSOCIATED PRESS, _Oklahoma Senate Okts Life in Prison for Cooking Hash in State_, NEWSOK.COM (Apr. 21, 2011, 9:01 AM), http://newsok.com/article/3560477 [https://perma.cc/Z7YS-9QLL]; _cf._ Jarecki, _supra_ note 12, at 6 (referring to the War on Drugs as “a predatory monster that sustains itself on the mass incarceration of fellow human beings”); Savage III, _supra_ note 12, at 4 (quoting marijuana-legalization activist Chris Simunek’s claim that mandatory twenty-year sentences for marijuana possession are still common); Steven Nelson, _Police Made One Marijuana Arrest Every
remains strong, and the supply keeps coming.\(^\text{16}\) Despite this failure, the federal government seems unwilling or unable to find an alternative to the War on Drugs.\(^\text{17}\)

States have attempted their own solutions. As of November 2016, forty-four states and the District of Columbia have legalized some form of medical marijuana;\(^\text{18}\) eight states and the District of Columbia have legalized marijuana for recreational use.\(^\text{19}\) How can a workable system of selling, regulating, and taxing marijuana develop when the drug is legal at the state level but not the federal? Preemption should solve this legal dispute in favor of the federal government;\(^\text{20}\) however, the federal policy has been nonenforcement. Consequently, medical marijuana is potentially

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\(^{17}\) Mercille, supra note 11, at 1638 (pointing out that Mexico’s drug crops are in the thousands of acres in production, nearly all headed toward the United States); see also Glen Olives Thompson, Slowly Learning the Hard Way: U.S. America’s War on Drugs and Implications for Mexico, 9 NORTeamÉRICA, no. 2, 2014, at 59, 59, 70 (2014) (“According to the U.S. Department of Health and Human Services, drug abuse and dependence as a percentage of the U.S. population in 2010 is essentially the same as it was in 1970 . . . .”).

\(^{18}\) See, e.g., Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 81 Fed. Reg. 53,688, 53,688 (Aug. 12, 2016). The closest Congress has come was in 2014 when a pro-marijuana provision was slipped into a huge spending bill. See Alex Kreit, The 2015 Federal Budget’s Medical Marijuana Provision: An “End to the Federal Ban on Marijuana” or Something Less than That, 35 N. Ill. U. L. REV. 537, 537–38 (2015). The provision purported to disallow the Department of Justice from spending money to stop state implementation of medical-marijuana legalization. Id. It was hidden inside a 1,603-page spending bill, but the marijuana policy was advisory and lacked the force of law. Id.


the biggest preemption controversy of this generation.

This Article explores Oklahoma’s recent and dramatic changes toward medical marijuana. We begin with a brief history of marijuana regulation in the United States, including the tumultuous changes over the past five years. Next, we turn to Oklahoma’s first attempt at legalizing medical marijuana. After that, we explore Katie’s Law, Oklahoma’s second attempt at legalizing medical marijuana, and the future of CBD-oil legislation. Finally, we conclude with a call for similar legal efforts in other states.

II. THE HISTORY OF MARIJUANA IN AMERICA

Marijuana was not always illegal in the United States. In fact, marijuana and hemp, which are both from the same plant species, were considered vital economic crops for the American colonies. Indeed, even George Washington grew hemp at Mount Vernon. Despite the sudden media attention, America has a long history of using medical marijuana. Jamestown settlers used marijuana. Early Americans used marijuana for a variety of medical reasons, and “[b]y the late 18th century, early editions of American medical journals recommend[e]d hemp seeds and roots for the treatment of inflamed skin, incontinence and venereal

21. HEMPTECH, INDUSTRIAL HEMP: PRACTICAL PRODUCTS—PAPER TO FABRIC TO COSMETICS 8 (John W. Roulac ed., 1995) (noting that founding fathers such as George Washington and Thomas Jefferson farmed hemp).
22. Here marijuana and hemp are used interchangeably.
23. See HEMPTECH, supra note 21, at 8; Robin Lash, Comment, Industrial Hemp: The Crop for the Seventh Generation, 27 AM. INDIAN L. REV. 313, 315–16 (2002) (stating colonists were required to grow hemp for its many uses); RICHARD JAY MOLLER, MARIJUANA: YOUR LEGAL RIGHTS 8 (1981).
26. Renehan, supra note 20, at 301.
disease.”

In 1850, marijuana was listed in the United States Pharmacopoeia “as a treatment for numerous ailments, including: neuralgia, tetanus, typhus, cholera, rabies, dysentery, alcoholism, opiate addiction, anthrax, leprosy, incontinence, gout, convulsive disorders, tonsillitis, insanity, and excessive menstrual bleeding.” By the early twentieth century, pharmaceutical giants such as Eli Lilly sold marijuana (often in liquid form) in the United States. Up to the time of alcohol prohibition, marijuana was used as a poor man’s pain reliever. “Marijuana was an integral part of American medicine for over 100 years . . . and was used safely and effectively during that time,’ [according to] Dr. Alan Shackelford, a Harvard-trained physician who prescribes medical marijuana in Colorado.”

After the failed attempt at alcohol prohibition, America started a movement toward criminalizing marijuana. States implemented anti-marijuana laws, often with highly charged racial motives. Studies have shown that anti-marijuana laws have been disproportionately applied to minorities, such as Blacks and Hispanics. Given some states’ recent.
legalization of marijuana, scholar Michelle Alexander notes the irony: For decades poor black men went to prison for selling pot, now white men will “get rich doing the same thing.”

The federal government’s first action, in 1937, was to set high taxes on marijuana. The high taxes (over 100% of market prices) and significant fines for avoiding taxes (100 times the market price) were meant to discourage use. Then, in the 1950s, marijuana was criminalized on a larger scale. This effort was ramped up under Richard Nixon, culminating with the Controlled Substances Act in 1970, which made marijuana illegal in all states and for all uses.

A. The First Federal Program

Federal law prohibited all possession and use of marijuana, and that was the end of the discussion, almost. While the federal government as a whole preached law and order, and destruction of the evil weed, a portion of the federal government moved in the opposite direction. “In 1978, [the] FDA created the Investigational New Drug . . . Compassionate Access Program” (CIND). The CIND program allowed a small number of highly screened patients to receive free marijuana from the federal government.

37. HERER, supra note 25, at 31.
38. Stack & Suddath, supra note 28.
40. See 21 U.S.C. §§ 813(c)(c)(10), 841(a), 844(a) (2012).
41. Gonzales v. Raich, 545 U.S. 1, 27 (2005) (“The CSA designates marijuana as contraband for any purpose . . . .”).
42. MARK EDDY, CONG. RESEARCH SERV., RL33211, MEDICAL MARIJUANA: REVIEW AND ANALYSIS OF FEDERAL AND STATE POLICIES 8 (2010).
43. Id. See generally Michael Eisenstein, Showdown at the Cannabis Corral, 525 NATURE S15, S16 (Sept. 24, 2015) (stating that the free federal marijuana is grown at a research facility at the University of Mississippi); Marty Ludlum & Darrell Ford, Colorado’s 2010 Update to the Medical Marijuana Law: Three Problems, Three Solutions, 2 MUSTANG J.L. & LEGAL STUD., 2011, at 73, 74 [hereinafter Colorado’s 2010 Update] (explaining the research facility at the University of Mississippi was the only provider in the nation that provided legal marijuana); Schwartz, supra note 32, at 49 (the National
The program was not publicized, even among medical circles. Most taxpayers have no idea they simultaneously fund prisons for marijuana sellers and free marijuana for medical users.

The CIND program stopped accepting new patients in 1991, largely because of the dramatically growing number of AIDS patients seeking marijuana and because of media attention of the program. However, the program was not halted. Currently, a handful of the original CIND patients survive, each getting monthly shipments of free marijuana from the federal government.

While the federal government stealthily implemented its CIND program, some states, in their roles as the laboratories of democracy, also tried small medical-marijuana programs. New Mexico was the first state to start a medical-marijuana program in 1978. Forty-three states and the District of Columbia have since followed New Mexico’s lead and legalized some form of medical marijuana.

The FDA approved a synthetic form of marijuana, dronabinol, “marketed under the name Institute on Drug Abuse runs the program).


45. Id.


48. Parloff, supra note 30, at 142, 152 (fewer than ten of the original patients are still living). The most vocal advocate and patient from the program is Irvin Rosenfeld, a stockbroker who, since 1982, continues to get his marijuana provided by the U.S. government. Mayo, supra note 44. See generally Gardiner Harris, Researchers Find Study of Medical Marijuana Discouraged, N.Y. TIMES, Jan. 19, 2014, at A14 (describing the federal government’s resistance now to even permitting the research into smoking medical marijuana).


51. State Medical Marijuana Laws, supra note 18.

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Marinol,” in 1980. Marinol is an FDA-approved form of THC, the active chemical in marijuana. Since marijuana was now available in pill form, the interest in medical pot waned, especially after Marinol was moved to Schedule III in 1999.

While Marinol has had some positive results, it is too early to celebrate. As a pill, Marinol is “difficult for people with nausea and vomiting to swallow.” And Marinol is much more expensive than marijuana. Is Marinol the solution for those who desire the medical benefits of marijuana? We don’t know. As Professor Rob MacCoun of Stanford Law School has pointed out, research in medical marijuana has been limited by politics.

Certainly, the proponents of medical marijuana claim a host of benefits from the plant. Neurosurgeon and CNN correspondent Sanjay
Gupta has claimed that the American public has been misled into believing that cannabis is harmful.\(^\text{62}\) While the medical research is beyond the scope of this article,\(^\text{63}\) some research shows that marijuana helps settle the stomachs of chemotherapy patients and others.\(^\text{64}\) Additional research has indicated that marijuana helps regenerate brain cells.\(^\text{65}\)

While the benefits of marijuana can be debated within medical circles, it has many practical benefits as a medicine. Marijuana can be administered in many forms, such as smoke, edibles, liquids, or aerosols.\(^\text{66}\) Marijuana is inexpensive, and patients can grow their own in a backyard or closet.\(^\text{57}\) Most importantly, marijuana is safe. History has not recorded a fatal overdose in over 3,000 years of use.\(^\text{68}\)

Medical marijuana provides a largely untapped reserve of information. In addition to THC and CBD, marijuana contains “dozens of other cannabinoids.”\(^\text{69}\) But researchers have conducted few studies on these other chemicals.\(^\text{70}\) The best anecdotal evidence is 3,000 years of use. The side effects, such as hunger and disorientation, are mild and predictable, and according to some sources, harmful drug interactions seem nonexistent.\(^\text{71}\) For many, the benefits outweigh the harms.

\(^\text{62}\) Id.
\(^\text{63}\) For an in depth discussion of the medical research on marijuana see Cohen, supra note 31.
\(^\text{64}\) See, e.g., id. at 72.
\(^\text{65}\) See Dease, supra note 61, at A6; see also Wen Jiang et al., Cannabinoids Promote Embryonic and Adult Hippocampus Neurogenesis and Produce Anxiolytic- and Antidepressant-like Effects, 115 J. CLINICAL INVESTIGATIONS 3104, 3104 (2005).
\(^\text{67}\) See Marty Ludlum & Darrell Ford, Medical Marijuana and Employment Discrimination, 23 S. L.J. 289, 291–92 (2013) [hereinafter Medical Marijuana]. The ease of acquiring marijuana has been a burden for the drug-free workplace initiatives. Id. at 289.
\(^\text{70}\) See id.
\(^\text{71}\) See Leo E. Hollister, Interactions of Marihuana and THC with Other Drugs, in
Of course marijuana is not all good. Even proponents of medical marijuana acknowledge that the hazards of smoking marijuana are as bad, if not worse, than the hazards of smoking cigarettes. Some sociological research suggests that legalizing medical marijuana leads to more access for recreational users. That is difficult to imagine since marijuana is currently omnipresent.

B. Different State Approaches

As of November 2016, forty-four states, the District of Columbia, Guam, and Puerto Rico allow the use of medical marijuana in some form. This represents a shift in American political opinion, with the majority now favoring legalization. Marijuana is no longer an East Coast/West

MARIJUANA AND MEDICINE 273 (G.G. Nahas et al., eds. 1999) (noting the lack of reported harmful drug interactions but pointing out a significant lack of published research on the topic and inferring that “[u]sually, such silence indicates that no meaningful interactions have been observed in real life use of marihuana as compared with experimental studies”); Leo E. Hollister, Interactions of Cannabis with Other Drugs in Man, in STRATEGIES FOR RESEARCH ON THE INTERACTIONS OF DRUGS OF ABUSE 110–15 (Monique C. Braude & Harold M. Ginzburg eds. 1986) (NIDA Research Monograph No. 68), https://pdfs.semanticscholar.org/99b6/3a216b411477d807cc6c68e855e6ae8487.pdf#page=117 [https://perma.cc/GTY2-HQN7] (“It does not appear, at least now, that such adverse effects are likely to be associated with unexpected interactions between the active components of cannabis and other drugs.”)


74. State Medical Marijuana Laws, supra note 18; Alexandra Sifferlin, Puerto Rico Governor Signs Executive Order to Legalize Medical Marijuana, TIME (May 4, 2015), http://time.com/3845638/puerto-rico-medical-marijuana/ [http://perma.cc/CSJ5-PC59]. The states with some form of medical-marijuana laws are Alabama (CBD only), Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia (CBD only), Hawaii, Illinois, Iowa (CBD only), Kentucky (CBD only), Louisiana (CBD only), Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi (CBD only), Missouri (CBD only), Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina (CBD only), North Dakota, Ohio, Oklahoma (CBD only), Oklahoma (CBD only), Texas (CBD only), Utah (CBD only), Virginia (CBD only), Vermont, Washington, Wisconsin (CBD only), and Wyoming (CBD only). State Medical Marijuana Laws, supra note 18.

Coast issue. Minnesota legalized medical marijuana in 2014. Georgia legalized medical marijuana in 2015. And Arkansas, Florida, and North Dakota legalized it in 2016. So even the conservative southern states are considering it.

Just one state can have a large impact on marijuana production. The average “indoor and outdoor yields” is approximately “40 grams per square foot per harvest.”

Support for medical marijuana is growing in unlikely places. A majority of American doctors support medical marijuana. And famously,
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a sitting New York judge uses medical marijuana to alleviate his pain.83

Demand for pot is, well, high. According to a study conducted by ArcView Market Research, “[t]he U.S. market for legal cannabis products grew 74 percent in 2014 to $2.7 billion, up from $1.5 billion in 2013.”84 The numbers are staggering. The highly competitive pot markets are saturated with sellers. In 2015, it was estimated that Seattle had 103 medical-marijuana dispensaries.85 In some areas of California and Colorado, legal marijuana merchants outnumber McDonalds and Starbucks.86

Back in 2010, Denver had nearly twice as many marijuana dispensaries as public schools, and that was before it was legalized for recreational use.87 The number of marijuana dispensaries in Colorado has grown to nearly 1,000—even though the number of marijuana smokers has not changed.88 The change is that now those smokers are not criminals; in fact, by 2015, Denver’s crime rate has fallen by seven percent since legalization.89

Medical marijuana is not the only area of growth. Although that use of marijuana remains illegal under federal law,90 in the last five years,
Colorado, Washington, Oregon, Alaska, Maine, Massachusetts, California, Nevada, and the District of Columbia have legalized the recreational use of marijuana. However, the Obama administration had a policy of nonenforcement, leaving states, pot businesses, and their customers in limbo, experimenting with a program that is explicitly illegal under federal law. At the time of this writing, it is unknown what the new administration’s approach will be.

Of course not all states are the same. Absent federal guidance, a state
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Katie’s Law can develop a legal framework for legalizing marijuana. At one extreme is the lax California regulatory model. In 1995, California became the first state post-Marinol to allow medical marijuana. California’s law was marketed as a solution for a small number of terminally ill patients. In practice, it became a de facto legalization of recreational marijuana. In 2009, seven years before recreational marijuana was actually legal, California had “between three hundred thousand and four hundred thousand medical-marijuana patients and over seven hundred marijuana [dispensaries].”

State Senator Mike McGuire has suggested that California medical-marijuana laws have been “impotent.” While appearing strict, California’s law has had a huge loophole. The law allows for marijuana to be used for “any other illness for which marijuana provides relief.” This vague standard allows a person to receive medical marijuana after a brief medical consultation for a number of complaints, including better concentration, more energy, and relaxation. Initial California regulations were “murky” and difficult to apply. To correct these errors, McGuire introduced a bill in 2015 to bring some legitimacy into the system, even if it was “20 years too late.” Governor Brown signed the reforms into law October 2015.

100. See § 11362.5(b)(1)(A).
101. Three Lessons, supra note 86, at 69.
102. Kreit, supra note 17, at 541.
104. § 11362.5(b)(1)(A).
105. See Whitehall, supra note 59, at 41–42 (noting that other listed complaints from Californians included back and neck injuries, sleep disorders, muscle spasms, headaches, depression, anger control, diarrhea, seizures, and itching).
106. Johnson, supra note 103.
108. Johnson, supra note 103.
At the other end of the spectrum is New Jersey. While the Garden State allows medical marijuana, it has placed heavy restrictions on all users.\textsuperscript{110} In New Jersey, a patient must have one of the specified physical ailments, and only approved doctors can recommend medical marijuana.\textsuperscript{111} For example, initially PTSD was not an approved ailment in New Jersey, despite longstanding claims of success from other states.\textsuperscript{112} New Jersey’s law is burdensome on patients, only allowing five dispensaries for the entire state.\textsuperscript{113} Additionally, Rutgers University declined an offer from the governor to grow medical marijuana for research.\textsuperscript{114}

New Jersey also makes doctors jump through various hoops before prescribing medical marijuana. Doctors must complete state training and registration programs in order to qualify to recommend medical marijuana to their patients.\textsuperscript{115} As a result, there are only 362 registered physicians actively prescribing medical marijuana\textsuperscript{116} out of the 28,464 active physicians in the state.\textsuperscript{117}

\textbf{C. The Executive Administration}

At the federal level, America is currently stuck. Marijuana remains illegal under the Controlled Substances Act, but federal enforcement has

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\item \textsuperscript{110} New Jersey Compassionate Use Medical Marijuana Act, N.J. STAT. ANN. §§ 24:6I-1 to -16 (West 2016); \textit{see also} Glenn Townes, \textit{Medical Marijuana Comes to New Jersey}, N.Y. AMSTERDAM NEWS, Aug. 16–22, 2012, at 4.
\item \textsuperscript{111} \textit{See} Townes, \textit{supra} note 110.
\item \textsuperscript{114} Mary Beth Marklein, \textit{Colleges See Risk to Easing Pot Bans}, USA TODAY, Mar. 7, 2011, at 3A.
\item \textsuperscript{117} Total Professionally Active Physicians, HENRY J. KAISER FAM. FOUND. (Sept. 2016), http://kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22new-jersey%22:%7B%7D%7D%7D [https://perma.cc/3BTV-C56J].
\end{itemize}
slowed because of the Obama administration’s political views. Marijuana is still illegal under federal law, but the validity of the states’ laws depends on the Obama administration’s nonenforcement policy.\textsuperscript{118}

This policy shift started with the Ogden memo in 2009.\textsuperscript{119} It instructed all U.S. Attorneys to give marijuana possession a lesser priority, especially for individuals complying with a state’s medical-marijuana law.\textsuperscript{120} The Ogden memo was not a mandate, nor did it repeal the Controlled Substances Act or amend it in any way. The memo was to encourage (but not require) federal prosecutors to consider state medical-marijuana laws when deciding whether to prosecute.\textsuperscript{121} In essence, it was “a guide to the exercise of investigative and prosecutorial discretion.”\textsuperscript{122}

The Cole memo followed in 2013.\textsuperscript{123} By then, several more states had added medical-marijuana programs, and a few were discussing legalizing recreational marijuana.\textsuperscript{124} The Cole memo explained that federal prosecutors should (but were not required to) rely on states enforcing state law unless the “marijuana-related conduct” fell within one of eight “enforcement priorities that are particularly important to the federal government:” (1) keeping marijuana away from minors; (2) preventing sales to criminal enterprises; (3) preventing distribution to states where marijuana is illegal; (4) ensuring “state-authorized marijuana activity” is not a cover for illegal activity; (5) keeping cultivation free of firearms and violence; (6) preventing impaired driving; (7) ensuring marijuana is not grown on public lands; and (8) ensuring marijuana is neither possessed nor used on federal property.\textsuperscript{125} Like the Ogden memo, the Cole memo did not

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\item[118.] Price, supra note 98, at 1133–36; see also Sullum, supra note 98; Keeler, supra note 98.
\item[120.] See id. at 1–2.
\item[121.] Id. at 2.
\item[122.] Id.
\item[125.] 2013 Memo, supra note 123, at 1–2.
\end{enumerate}
\end{footnotesize}
repeal the Controlled Substances Act or amend it. The memo just advised (but did not mandate) prosecutors to consider state law when deciding how to use limited government resources.

Neither of these memos had the force of law nor did they repeal or reform federal drug laws. The memos did not prevent existing cases from proceeding. The memos also did not bar prosecutors from filing new cases against marijuana defendants. Instead, the memos identified Controlled Substance Act enforcement priorities and encouraged prosecutors to avoid enforcing federal drug laws against “seriously ill individuals” prescribed marijuana consistent with state laws.126 The authors cannot remember any similar requests of federal prosecutors in criminal matters.

In reality, the law has not changed. The Controlled Substances Act is still the law of the land. Possession, manufacture, or transportation of marijuana remains a federal crime.127 Nothing has changed except the attitudes of those who enforce the law.

From a marijuana investor’s point of view, this is “rolling the dice.”128 Will the current policy of nonenforcement continue under the Trump administration? If not, and the laws are suddenly enforced, participants (merchants and their customers) face grave legal danger.

III. OKLAHOMA’S FIRST ATTEMPT AT MEDICAL MARIJUANA

Into this political context, deep in America’s heartland, Oklahoma joined the marijuana fight. Oklahoma is a small state by population and highly conservative.129 Any efforts to legalize marijuana in any form seemed unlikely. Despite the political climate, marijuana use is common in conservative Oklahoma. More than one in ten “Okies” (an estimated 11.28%) has used marijuana in the last year, even with the state’s harsh criminal penalties.130 In 2011, Oklahoma’s first attempt at medical

126. Id. at 3.
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marijuana (Senate Bill 573) was unsuccessful. The proposed statute lacked details on the transfer of marijuana, definition of primary caregiver, and even the definition of patient. A viable medical-marijuana law requires precise and unambiguous details. As a result, Senate Bill 573 “was dead on arrival” at the Oklahoma capitol.

To understand Oklahoma’s new law, we must understand some of the chemistry of marijuana. Marijuana contains thousands of chemicals, only a few of which have been studied. The most common, delta-9 tetrahydrocannabinol (THC), was first discovered in 1963 by Israeli scientist Raphael Mechoulam. THC is the chemical that causes the “euphoria” (makes the user high) that marijuana is known for.

The second-most-researched chemical in marijuana is CBD, or cannabidiol. CBD causes muscles to relax. Oklahoma lawmakers investigated allowing patients to use marijuana that is very low in THC and very high in CBD. In other words, users would experience muscle relaxation without any euphoric high. The marijuana is neither smoked nor eaten as in recreational use. Instead, the extracts are concentrated into an oil high in CBD but low in THC, hence the name CBD oil.

In marijuana, CBD and THC work as opposing forces. Through selective breeding, recreational strains of the plant high in THC have low

-AJFB].
131. Oklahoma’s First Puff, supra note 11, at 92.
132. Id. at 93–94.
133. Id.
134. Id. at 92.
136. Sides, supra note 2, at 39 (describing Mechoulam as “the patriarch of cannabis science”); Schwartz, supra note 32.
137. Whitehall, supra note 59, at 39.
138. Helen Lippman, Can Medical Marijuana Help Pediatric Patients?, NEUROLOGY REVVS., Dec. 2014, at 1, 1 (describing CBD as a non-psychoactive phytochemical); Bradford, supra note 135 (noting that CBD counters the psychoactive effects of THC).
139. Vorenberg, supra note 69, at C1.
140. Emily Summars, A Different Kind of Oil: Legislative Hear of Benefits of Marijuana Compound, J. REC. (Okla. City, Okla.), Nov. 24, 2014, at 2A; Eastes, supra note 1.
141. See Summars, supra note 140, at 2A.
CBD levels, while medical strains high in CBD have low THC content.143 CBD is “non-psychoactive and not addictive.”144 In fact, CBD counters the psychological effects of THC.145 Marijuana with high CBD levels usually has to be specially grown.146 Most recreational users want high THC content for a stronger “high” effect and would not desire strains high in CBD (and low in THC).147 Medical marijuana can contain over twenty percent CBD, while most marijuana on the street has, at most, one percent CBD.148

IV. KATIE’S LAW IN OKLAHOMA

Katie is a little girl, the niece of Oklahoma State Representative Jon Echols.149 Katie had “tried everything” to treat her epilepsy.150 She had taken multiple medications, including some not FDA approved, but none really worked, except to nearly give her kidney failure—not even brain surgery helped.151 Then, in desperation, her parents turned to CBD oil and the fight to legalize it for Katie and children like her.152 Instead of epilepsy constraining her for a lifetime, it is the hope that CBD will allow Katie to live the life of an ordinary young girl.153 The law was named after her and her struggle to obtain needed medication154 despite a cultural belief that marijuana is solely for recreational use.

143. Vorenberg, supra note 69, at C1.
144. Summars, supra note 140, at 2A.
145. Tom Ireland, Cannabis May Help Treat Psychosis, GUARDIAN WKLY., Nov. 28–Dec. 4, 2014, at 34, 34. See generally Craig A. Press, Kelly G. Knupp & Kevin E. Chapman, Parental Reporting of Response to Oral Cannabis Extracts for Treatment of Refractory Epilepsy, 45 EPILEPSY & BEHAV. 49 (2015) (studying efficacy of nonpsychoactive CBD for epilepsy treatment); Eastes, supra note 1 (quoting Oklahoma Governor Mary Fallin who described the CBD oil used in the Oklahoma pilot program as not intoxicating).
146. Vorenberg, supra note 69, at C1.
147. Id. at C1.
148. Id.
150. Id.
151. Id.
152. Id.
153. See Eastes, supra note 1.
154. Id.
The benefits some have experienced from CBD oil appear to be nothing short of miraculous. Dr. Francis Filloux, chief of pediatric neurology at the University of Utah School of Medicine, indicated that CBD oil is a “potential treatment for epilepsy” because it helps combat seizures. Consider Charlotte Figi, a child with Dravet syndrome, a severe form of epilepsy. Charlotte started having seizures at the age of three months. By age five, she was developmentally far behind other children, not able to walk or talk. She had exhausted all other medical treatments. She started treatment with CBD oil and went seven days without a seizure for the first time in her short life. After twenty months on CBD oil, she “has only 2-3 nocturnal seizures per month.” She is walking and talking and no longer taking any other seizure medicines.

For children with Dravet syndrome and similar illnesses, seizures can be fatal. Just “[o]ne seizure can be fatal.” This is particularly true for those individuals resistant to traditional seizure medication, an estimated “25 percent of children and 37 percent of adults.” These children and their families are desperate due to the lack of FDA-approved options. They have tried all available drugs, at substantial cost, and either the drugs failed to reduce seizures or reduced the seizures but left the child nearly

155. Lippman, supra note 138, at 1, 31.
156. John Ingold, Pot Oil Could Open Doors, DENV. POST, Mar. 30, 2014, at 1B.
158. Maa & Figi, supra note 157, at 783.
159. Id.
160. Id.
161. See id.
162. Id. at 784; see also Zita Toth, Altering Rules on Cannabidiol Therapies, ST. LEGIS., Sept. 2015, at 11.
163. Maa & Figi, supra note 157, at 784.
164. Id.
165. See Whitehall, supra note 59, at 41 (stating that in addition to fatal convulsions, “sudden unexpected death” affects six percent of children with Dravet syndrome each year); Summars, supra note 140, at 2A.
166. David Wahlberg, Boy’s Seizure Disorder Prompts Bill to Legalize Ingredient in Pot, WIS. STATE J. (Madison, WI), Mar. 3, 2014, at A1; accord Orrin Devinsky, Commentary, Medical Marijuana Survey & Epilepsy, 56 EPILEPSIA 7, 8 (2015) (“[M]ortality of severe epilepsy is horrific.”).
167. Summars, supra note 140, at 2A.
168. Id.
comatose. For patients and their parents who have tried everything else, CBD is their “last hope.”

CBD oil was first used to treat children on a large scale in Colorado. The findings, while anecdotal, are amazing. In one finding, CBD oil reduced seizures by forty percent. In another, CBD stopped all seizures. In still another, seizures dropped by ninety-nine percent. The time it takes CBD to be effective, varies. In one case, CBD reduced seizures within two weeks. In another, when the CBD oil was given to a child having a seizure, the seizure “immediately subsided.” For parents, these are miracle cures. However, by medical standards, they are anecdotes, not clinical trials.

Scientific studies would be difficult to accomplish with children as subjects and ethically troubling, since a clinical trial would require giving placebos to some critically ill children. However, these results in Colorado were rays of hope in an otherwise all-too-dark situation. Unfortunately, this left parents with only two choices: sneaking the CBD oil out of Colorado or uprooting their family to move there. These Colorado migrant families feel trapped, labeling themselves “medical marijuana

169. Farley, supra note 149.
170. Id.
171. Cf. John Ingold, Desperate Journey, DENV. POST, Dec. 7, 2014, at 1A (describing the medical migration to Colorado many parents have made in a last-ditch effort to save their children with CBD oils); Press, Knupp & Chapman, supra note 145, at 49–50 (studying the results of seventy-five children whose epilepsy was treated with CBD oils in Colorado); Tom McLaughlin, Legislators Weigh CBD Arguments, NW. FLA. DAILY NEWS, Jan. 10, 2014, at A1 (“In Colorado, . . . strains of the weed rich in CBD and extremely low in THC have been grown and successfully used to treat children.”).
175. Summars, supra note 140, at 2A.
176. Eastes, supra note 1.
177. Summars, supra note 140, at 2A.
refugees. “[179] As a public policy, the decision whether to treat ill children “should not be determined by one’s ZIP code.”[180]

While the benefits of medical marijuana have become public knowledge fairly recently, the findings are not new. Actually, marijuana research goes back to 1843 when British doctor William O’Shaughnessy described how cannabis oil stopped an infant’s convulsions. [181] But the criminal stigma prevented many researchers from working with marijuana. [182] Marijuana’s illegal status and the War on Drugs has slowed, if not stopped, most research into the drug.[183] However, CBD research has been rekindled. [184] Pediatric doctors in a Colorado Children’s Hospital study found that parents for fifty-seven percent of the patients “reported at least some improvement in seizures” from using cannabis extracts. [185] In a separate study, one-third of children with Dravet syndrome became seizure free after three months of CBD-oil therapy. [186] Further clinical research is imperative. Fear of “reefer madness” should not dictate medical policy. [187] And a failure to recognize the desperate state of parents is “foolish at best and dangerous at worst.” [188]

Seizure disorders are not the only illnesses for which marijuana treatments have proven effective. Many multiple-sclerosis (MS) patients report benefits from taking medical marijuana. [189] Additionally, marijuana

179. Sides, supra note 2, at 54 (describing these families as “medical refugees”).
180. Wahlberg, supra note 166, at A7.
181. Sides, supra note 2, at 54.
183. Id.
184. See Ingold, supra note 60, at 1A.
185. Press, Knupp & Chapman, supra note 145, at 50. A third of children saw more than fifty percent reduction in the number of seizures with no side effects from taking cannabis extracts. Id.
186. Lippman, supra note 138, at 31 (reporting on a study by Dr. Francis Filloux of Utah).
188. Maa & Figi, supra note 157, at 785.
has been used to treat a variety of psychological disorders, such as PTSD. In a real way, “marijuana has given [many patients] a second chance at life.”

Marijuana is an attractive substitute for expensive medications. Even refined CBD oil can be relatively affordable, at around $300 per month, far less than some prescription alternatives. Nolan Kane, an evolutionary biologist, describes cannabis as “an embarrassment of riches.”

Katie’s Law is Oklahoma’s first successful attempt at a CBD-oil law. The Oklahoma system is a highly regulated medical program bearing little resemblance to the lax California program. The statute requires that an Oklahoma “medical school [or] its affiliated teaching hospitals” administer the CBD oil. The CBD program must be overseen by the U.S. Department of Health and Human Services, and the producer of CBD must be approved by the U.S. Food and Drug Administration. The statute also allows for a provider from outside the United States so long as they are approved by the FDA.


192. Ingold, supra note 156, at 1A. By contrast, most epilepsy drugs cost between $8,500 and $11,000 a year. Bruenig, supra note 66, at 25.

193. Sides, supra note 2, at 57.


198. §§ 2–801(1)(b), 2–802.

199. § 2–801(2)(a) to (b).

200. Id. § 2–801(2)(a).
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The statute requires that the CBD be in liquid form and must have been tested on animals prior to human trials. The oil’s THC level must be less than 0.3%. Originally, a “qualifying patient” was required to be eighteen years old or younger. A 2016 amendment made adults eligible for the program. In addition, the qualifying patient must have one of three conditions: “[(1)] Lennox-Gastaut Syndrome, [(2)] Dravet Syndrome, also known as Severe Myoclonic Epilepsy of Infancy, or [(3)] any other form of refractory epilepsy that is not adequately treated by traditional medicine therapies.” The physician who wishes to become a “principal investigator” for a clinical trial must regularly treat patients with epilepsy and must obtain a license from the U.S. Drug Enforcement Agency. Additionally, the principal investigator must be registered with the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control (OBNDD). The OBNDD can “inspect and test [all] samples of [CBD oil].” Clinical trials may only use CBD “from an approved source.”

The statute provides that persons complying with the law “shall not be subject to arrest, prosecution, or any civil or administrative penalty, including a civil penalty or disciplinary action by a professional licensing board, or be denied any right or privilege, for the use . . . of [CBD].” To avoid any conflict with criminal laws, Katie’s Law also modified Oklahoma’s definition of marijuana in the Uniform Controlled Dangerous Substances Act to exclude CBD oil.

Supporters were quick to point out that Katie’s Law was “not a litmus test for medical marijuana.” Katie’s Law, in contrast to the prior attempt for medical marijuana, had a great deal of support. Both the Oklahoma

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201. Id. § 2–801(3).
202. Id. § 2–801(2)(b).
203. Id. § 2–801(3).
204. Id. § 2–801(5).
206. Id.
207. OKLA. STAT. tit. 63, § 2–802(B) (Supp. II 2015).
208. Id. § 2–802(B)(2).
209. Id. § 2–802(B)(3).
210. Id. § 2–802(F).
213. OKLA. STAT. tit. 63, § 2–101(23) (2011 & Supp. II 2015). “Marijuana” under Oklahoma law now does not include CBD that is derived from seeds, stalks, fiber, oil, cake, or industrial hemp. Id. Therefore, participants in the clinical trials are specifically excluded.
214. Farley, supra note 149.
Medical Association and the Oklahoma Bureau of Narcotics supported the measure. The *Tulsa World*, one of the state’s premier newspapers, supported the CBD-oil plan as well.

Politically, this could have been a challenge. Oklahoma’s Republican governor, Mary Fallin, did not support any efforts for marijuana legalization or a broad medical-marijuana program. However, because of the strict regulation and small chance of abuse, Governor Fallin supported this CBD program.

The bill shot through the legislative process starting with a 7–0 committee vote. The Oklahoma House then approved the bill 99–2. And the Oklahoma Senate unanimously approved Katie’s Law. A pilot program “to study CBD to treat children who suffer from epileptic seizures” became law with the Governor’s signature on April 30, 2015.

V. FUTURE OF CBD POLICY

Oklahoma is not alone in allowing use of CBD oil. The permitted use of CBD oil is becoming a national trend. A similar CBD bill passed in Utah in 2014. Missouri’s 2014 CBD law had unanimous approval.


218. Eastes, supra note 1 (reporting that Fallin described CBD oil as “life-saving medicine . . . [for] children in need”).

219. Farley, supra note 149.

220. Hertneky, supra note 173; accord Shanahan, supra note 172.

221. Hertneky, supra note 173.


223. See *State Medical Marijuana Laws*, supra note 18; Bruenig, supra note 66, at 20.

224. Ingold, supra note 156, at 1B.

Currently, seventeen states allow CBD oil.\textsuperscript{226} CBD-oil bills recently passed in Tennessee and Montana.\textsuperscript{227} CBD is becoming popular even in conservative states, such as Georgia and Texas,\textsuperscript{228} and even among “soccer moms.”\textsuperscript{229}

The state laws have varying levels of restrictiveness. For example, Wisconsin’s CBD law, known as Lydia’s Law, is restrictive, and many families “have not found a physician or hospital with the resources or time” to pursue the clinical-trial process the law requires.\textsuperscript{230}

Outside the United States, CBD oil is still in its infancy, but countries are moving toward accepting it along with medical marijuana more generally. In 2013, regulations prohibited the use of CBD oil but allowed “Canadian patients [to] obtain access to cannabis for medical purposes by visiting a health care practitioner.”\textsuperscript{231} However, in 2015, the Supreme Court of Canada ruled the CBD-oil ban violated the Canadian constitution, making all forms of medical marijuana legal.\textsuperscript{232} Israel has allowed medical marijuana since 1993, two years before California’s experiment.\textsuperscript{233}

Commercially, GW Pharmaceuticals of England has been developing CBD oil and other marijuana-based medicines for some time now.\textsuperscript{234} Its

\begin{footnotesize}
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\item \textsuperscript{226} State Medical Marijuana Laws, supra note 18; Bruenig, supra note 66, at 20.
\item \textsuperscript{227} See State Medical Marijuana Laws, supra note 18.
\item \textsuperscript{228} Id.; Ingold, supra note 156, at B1 (“A Colorado marijuana innovation is changing the way lawmakers in even the most conservative parts of the country talk about cannabis and is poised to create a rapid expansion in the number of states that have legalized marijuana in some way.”); Ben Felder, Fallin Backs Marijuana Oil in Limited Medical Use, OKLA. GAZETTE (Aug. 13, 2014), http://okgazette.com/2014/08/13/fallin-backs-marijuana-oil-in-limited-medical-use/ [https://perma.cc/JE4W-QEWY] (stating CBD oil makes the marijuana issue mainstream and acceptable to conservatives).
\item \textsuperscript{229} Ingold, supra note 156, at 1B; see also Felder, supra note 228.
\item \textsuperscript{230} Mark Schaaf, Treatment Still Eludes Children, WIS. ST. J., Apr. 20, 2015, at A1; David Wahlberg, Boy’s Seizure Disorder Prompts Bill to Legalize Ingredient in Pot, WIS. ST. J., Mar. 3, 2014, at A1.
\item \textsuperscript{232} R. v. Smith, [2015] 2 S.C.R. 602, 617–18 (Can.).
\item \textsuperscript{233} Maayan Lubell, Israeli Firm Takes the High Out of Marijuana, WASH. POST, July 17, 2012, at E6.
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two primary products are Sativex and Epidiolex. According to the U.S. National Institutes of Health’s database, GW has conducted multiple clinical trials for its marijuana-based medicines in the United States. Sativex, although not yet approved in the United States, has been approved to treat MS spasticity in twenty-eight countries. Likewise, United Cannabis of Denver has begun to develop CBD. However, the company is losing money. Besides established pharmaceutical companies, Indian tribes could become significant contributors in CBD-oil production. An Israel-based company is also developing CBD oil.

It’s too early to celebrate. The medical successes, while heartwarming and impressive, are anecdotal. And the results have not always been positive. Results from treating seizures with CBD vary widely. The limited amount of scientifically valid research is itself a cause of concern. Animal tests, though encouraging, have yet to be fully confirmed in medical studies using people. Scientific validation is not likely soon. Experimenting on ill children is difficult, and many researchers are hesitant to examine marijuana as a medicine.

Dr. Orrin Devinsky, a professor of neurology at NYU Langone Medical Center, explained that treating epilepsy with marijuana must be scientifically verified as anecdotal evidence is “only a sliver of the full

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236. GW’s Epidiolex Clinical Program, GW Pharm., https://www.gwpharm.com/epilepsy-patients-caregivers/patients [https://perma.cc/J5UX-V43W]; see also Borchardt, supra note 234; Lippman, supra note 138, at 31 (stating Epidiolex is all natural, 100% CBD).
238. Sativex, supra note 235.
240. Id.
241. Keeler, supra note 98.
243. Ingold, supra note 156, at 1A.
244. Barton, supra note 178; Timothy E. Welty, Adrienne Luebke & Barry E. Gidal, Cannabidiol: Promise and Pitfalls, 14 EPILEPSY CURREN T S 250, 250–51 (2014) (“While animal experimental data clearly suggest a potential benefit, supportive clinical data are quite sparse.”).
245. Barton, supra note 178.
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dataset. To date, little scientifically validated evidence supports using CBD oil to treat epilepsy patients. Even less evidence exists that treating children with marijuana is safe. In addition, CBD-oil products are not standardized. Many variations of CBD oil exist. The wide array of CBD levels makes systematic study difficult but not impossible.

Much is still left to discover. A meta-analysis of medical use of cannabis in the Journal of the American Medical Association in 2015, involving seventy-nine studies and over 6,000 patients, found support for using marijuana to treat chronic pain and spasticity, weight gain, sleep disorders, Tourette syndrome, and the nausea and vomiting associated with chemotherapy. However, the study’s authors cautioned that larger, more robust studies are needed for a variety of factors, such as determining the dosages for effective use, minimizing side effects, and regulating the drug’s THC and CBD content.

The epilepsy medical community is split on the issue of medical marijuana, with the majority of specialists being more cautious about recommending medical marijuana until more testing is done. With more support and government encouragement for marijuana research, those specialists could soon have the data they need. However, if politicians continue with their “reefer madness” mentality, research will stop.

As a collateral issue, allowing CBD oil could affect the movement to legalize marijuana. There is an argument that legalizing CBD oil is just the first step in a three-step plan to fully legalize marijuana. After

246. Devinsky, supra note 166, at 7.
247. Rollins, supra note 9, at 59.
248. Id.
249. Bruenig, supra note 66, at 22.
250. Id. (reporting that FDA testing of CBD products showed a third of the products contained no CBD, and most contained only one percent); Lippman, supra note 138, at 1.
252. See id. at 2468; Welty, Luebke & Gidal, supra note 244, at 251 (recognizing a possible role for CBD but concluding that “given the lack of well-controlled trials, we must also ask if we are getting ahead of ourselves”).
253. Gary W. Mathern, Laurie Beninsig & Astrid Nehlig, Fewer Specialists Support Using Medical Marijuana and CBD in Treating Epilepsy Patients Compared with Other Medical Professionals and Patients: Results of Epilepsia’s Survey, 56 EPILEPSIA 1, 4–6 (2015) (surveying over 600 doctors, the majority of whom agreed that medical marijuana has potential, but fewer specialists than general practitioners thought enough safety information existed).
254. See Ingold, supra note 156, at 1B.
255. Cf. id.; Felder, supra note 228 (“CBD oil has become a gateway drug of sorts in
showcasing medical marijuana’s benefits, low costs, and few side effects, the second step would be to legalize all forms of medical marijuana, including those smoked and eaten. After a period of time, society would recognize that marijuana has many benefits and few, if any, potential problems and would take the third and final step—full recreational legalization. Of course, this strategy assumes a lot about the public’s reaction to marijuana. This plan also could take decades to come to fruition. It certainly would not happen overnight.

Yet in Oklahoma, medical marijuana’s (or at least CBD oil’s) reach expanded almost before the governor’s ink was dry on the original bill.256 As noted above, Katie’s Law originally limited CBD oil to those under eighteen years old.257 Within a year the law was amended to allow CBD oil for adults with the same untreatable illnesses, effective November 1, 2016.258 Medical marijuana has found a home in Oklahoma. Currently, seventeen states allow CBD oil,259 and the numbers are growing. The future favors using CBD oil for a variety of ailments.

Nationally, interest in the 2016 elections has recently derailed the previously steady movement for medical marijuana. Despite an overriding interest in the presidential election, some in Congress took steps toward ending marijuana’s prohibition. Bipartisan bills in both the House and Senate attempted to “end the federal ban on medical marijuana,” reclassifying it as a Schedule II drug and “allow[ing] VA doctors to prescribe medical marijuana” to their patients.260 This would have been good news for veterans suffering from PTSD.261 At present, the doctors are not allowed to even discuss medical marijuana with those veterans.262 Marijuana issues are on the horizon.

conservative states.”).

257. Id.
258. Rick M. Green, Gov. Fallin Signs Bill Approving Expanded Use of Cannabidiol, DAILY OKLAHOMAN, May 14, 2016, at 4A.
259. Bruenig, supra note 66, at 20; State Medical Marijuana Laws, supra note 18.
260. Drew Brooks, It Works for Me, FAYETTEVILLE OBSERVER (N.C.), Mar. 19, 2015, at 1A.
261. Id.; see also Betthauser, Pilz & Vollmer, supra note 190, at 1283.
Recent regulatory changes have made it easier for scientists to study marijuana. Research grants involving marijuana no longer undergo a Public Health Service review, speeding up the approval process. In addition, studies can now use a variety of marijuana strains, including strains not grown at the University of Mississippi farm. These changes should increase the number of researchers employing marijuana or its derivatives in medical discoveries. But these changes will take time.

VI. CONCLUSION

This Article examined Oklahoma’s recent and dramatic changes toward medical marijuana. We started with a brief history of marijuana regulation in the United States, including the tumultuous changes of the past five years. Next, we discussed Oklahoma’s first attempt at medical marijuana. After that, we explored Katie’s Law, Oklahoma’s second version of medical marijuana. We concluded with recommendations for the future of CBD-oil legalization in other states.

Marijuana policy is currently built on a house of cards, relying on a nonenforcement policy of a former president’s administration. Everything can and will change under the Trump administration. The pressing question is how. The answer to that question hangs like a sword of Damocles over the states’ marijuana laws. Regardless, these are exciting times in marijuana-policy research.

Oklahoma’s unique, well-detailed policy is rationally related to its goals and has minimized the potential for recreational abuse. CBD oil’s life-changing effects in severely ill children are breathtaking. Katie’s Law should serve as a model CBD-oil law for the nation.

264. Id.