

Oklahoma's First Puff of Medical Marijuana

Marty Ludlum

Assistant Professor of Legal Studies
University of Central Oklahoma
100 North University Drive, Edmond, OK 73034, USA.

Darrell Ford

Associate Professor of Legal Studies
University of Central Oklahoma
100 North University Drive, Edmond, OK 73034, USA.

Abstract

In this paper, we will discuss Oklahoma's Compassionate Use Act of 2011. To that end, we will first discuss the recent trend of medical marijuana statutes. Next, we will examine Oklahoma's recent attempt to make a medical marijuana law. Then, we will detail several shortcomings of this law. Finally, we will examine some potential and needed additions to the current proposal. We will conclude with expectations for the future.

The legal history of marijuana has been a cultural myth. Many people assume marijuana has always been illegal. This is not the case. In 1851, marijuana was a legitimate medical compound in America (Pharmacopoeia, 1851). Marijuana was sold in many forms, even liquid. The pharmaceutical giant Eli Lilly sold cannabis in early 1900s as a painkiller (Parloff, 2009). The prohibition against marijuana did not start until 1937 (Vlahos, 2011) with the controlled substances laws. For three decades, following the criminalization, marijuana was illegal but had little popular use and saw a low level of concern. In the 1960s and 1970s, the counter culture movement brought the use of marijuana into the mainstream. President Nixon responded with the War on Drugs. America is in the fourth decade of Nixon's War on Drugs, and the War is largely recognized as a complete failure. Drugs are more abundant and more inexpensive than ever before, the exact opposite of the goals of prohibition (Dickinson, 2009).

Most people mistakenly believe medical marijuana is a new idea from the 1990s. America has had a federal medical marijuana program for several decades (Ludlum and Ford, 2010). The program allowed a small, select group of patients to receive free marijuana from the U.S. government as treatment for a narrow list of illnesses. The marijuana was grown at a federal facility at the University of Mississippi (Ludlum and Ford, 2011). However, enrollment in the program was discontinued in 1991, leaving just four patients on the program currently (Parloff, 2009; Gardiner, 2010). Medical marijuana is not a new idea. The small federal program has served as an inspiration and guide for several large state programs. Oklahoma is one of the states making strides towards a medical marijuana program.

In this paper, we will discuss Oklahoma's Compassionate Use Act. To that end, we will first discuss the recent trend of medical marijuana statutes. Next, we will examine Oklahoma's recent attempt to make a medical marijuana law. Then, we will detail several shortcomings of this law and propose some additions to the law. We will conclude with expectations for the future.

Legally, medical marijuana remains in limbo. At a federal level, marijuana is a Schedule 1 drug, illegal to grow, purchase, sell or consume (Cohen, 2009). During the Clinton and Bush Administrations, several states allowed sale of medical marijuana under various reasons. In 1996, California was the first state to legalize marijuana for medical reasons (Behring, 2006; Ludlum and Ford, 2010). Colorado followed in 2000 (Perez-Pena, 2009; Segal, 2010). As of January, 2012, fifteen states allow some form of medical marijuana and many states are considering similar proposals (Adcock, 2011). Over 25 million Americans are eligible for the medical marijuana program (Pugh, 2011).

However, medical marijuana remains illegal under federal law, and illegal under a majority of states. This left federal agents arresting marijuana sellers who were acting legally in their state. The conflict between state and federal powers continued until 2008. President Obama promised to relax enforcement of the drug laws related to medical marijuana. It was not being enforced by the federal authorities with the same zeal as under the Bush administration (Welch, 2009b; Dickinson, 2009).

In 2011, Obama reversed his position on medical marijuana, and has encouraged increased prosecution from the federal side (Adams, 2011; Yardley, 2011). The new enforcement push under Obama complicated the already confusing medical marijuana landscape. While the legal status was already in limbo, in the fall of 2011, the debate over medical marijuana entered into reality television. A new show, “Weed Wars” started on the Discovery Channel. The show highlights the crusade of Steve DeAngelo and his Harborside Health Center in Oakland, California. The new show demonstrates the legal limbo of legalized marijuana and the unique industry that has emerged to fulfill that need. The show is interesting and entertaining, even for those not interested in this controversy. Weed Wars has also attracted a lot of attention to an issue many did not know existed. However, reality television has a bad track record of swaying public opinion on controversial issues.

Perhaps this would be a good point to back up a step and answer “why?” Why do people want medical marijuana? Many people have this same concern. Why should ill people be using marijuana? The medical research on this is beyond the scope of this paper, but for perspective, a short synopsis is included. Numerous studies confirm effectiveness of marijuana as a pain reliever (Cohen, 2009). Besides being a general pain reliever, marijuana has secondary effects which have special medical uses. Marijuana’s main chemical (THC) has a side effect of increasing hunger. This side effect has a great benefit for patients with wasting diseases like cancer, HIV, or multiple sclerosis (MS). Marijuana relieves nausea and improves appetite for those getting chemotherapy or other treatments (Gardiner, 2010; Adcock, 2011). In layman’s terms, marijuana helps patients keep their food intake high so their bodies can continue to fight the illness.

Marijuana is also quite safe, especially compared to many prescription drugs and over the counter medicines. The risk of overdose is zero. Marijuana has been used for thousands of years without a fatality (Cohen, 2009; Parloff, 2009; Walker & Huang, 2002; Welch & Martin, 2003). The main side effect, hunger, is actually one of the main benefits. Even for recreational users, marijuana is safe with no chance of overdosing for the novice user. Marijuana, by comparison, is safer than alcohol or aspirin. With these benefits in mind, many states have proposed legalizing marijuana for medical uses.

Oklahoma’s Medical Marijuana Proposal

Oklahoma’s proposed medical marijuana law was Senate Bill 573 of 2011, authored by Constance Johnson (Dem.-Oklahoma City). It did not go well. Oklahoma is very conservative politically. It always has been. The Senate committee refused to hold any hearings (Adcock, 2011). Commentators said that political support was lacking in Oklahoma (Kimball, 2009). Republican Governor Mary Fallin has indicated she would not support any medical marijuana legislation (Association Press 2011a; Marie, 2011). In fact, the opposite view has been dominant. Oklahoma has recently voted in favor of a bill to increase punishment for cooking hashish from two years to a life sentence (Associated Press, 2011b). The medical marijuana proposal was dead on arrival. We will now examine the specifics of the Oklahoma medical marijuana proposal. We will examine several clarifications which need to be made to make the law workable. In addition, we will mention several potential additions which should be added if the proposal has any possibility of being functional. To aid in understanding, we have included the full text of Senate Bill 573.

AS INTRODUCED:

An act relating to medical marijuana; creating the **Compassionate Use Act of 2011**; providing short title; clarifying scope of act; prohibiting penalties against physicians in certain circumstances; exempting certain provisions of law in specified circumstances; defining term; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA: SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2-800 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. This act shall be known and may be cited as the **Compassionate Use Act of 2011**.

B. Nothing in this section shall be construed to supersede laws or regulations prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes. In addition, this section shall not affect any other rule or law that regulates:

1. Penalties for sales to minors;
2. Penalties for the possession of marijuana by minors;
3. Driving under the influence;
4. Workplace protections against accommodations for marijuana use; or
5. Health insurance or pharmacy policies.

C. Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.

D. The provisions of Section 2-402 of Title 63 of the Oklahoma Statutes relating to the possession of marijuana and Section 2-509 of Title 63 of the Oklahoma Statutes relating to the cultivation of marijuana shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

E. For the purposes of this section, *primary caregiver* means the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health or safety of that person.

SECTION 2. This act shall become effective November 1, 2011

The heart of the proposed law is in the last three sections. We will discuss each briefly and identify some hidden shortcomings in the proposal. Section C is designed to protect physicians who wish to recommend medical marijuana to patients. While it protects doctors who recommend medical marijuana, it does not create an affirmative duty to recommend. In other words, a doctor who wishes to participate is protected, but an unwilling doctor is not required to recommend medical marijuana to patients. This means a potential patient would have to search from doctor to doctor trying to locate one which will prescribe medical marijuana. There is no record for or against medical marijuana by the Oklahoma medical profession. This background research would need to be done before any proposal has a chance of working. If no (or very few) doctors in Oklahoma would recommend medical marijuana to a patient, the program would fail. Legal support for the program is meaningless unless the medical community will participate. For the program to be viable there must be at least a significant number of Oklahoma doctors willing to support the program. There is no finding in our research of any Oklahoma medical community support for marijuana.

Section D is the source of many problems. This section protects patients and caregivers from any criminal violation related to possessing and cultivating marijuana. This sounds clear enough. Several important components are missing from this section, including the definition of a patient. As we discuss in the next section, this sounds simple but is very difficult in the case of medical marijuana. In addition, the statute assumed that all transactions are altruistic. Nothing in the Compassionate Use Act explained whether the medical marijuana can be sold between patient and caregiver, or between two caregivers. Since there are criminal prohibitions for selling marijuana, it would seem sale of marijuana intended for medical use was not protected under the act. While many people involved in medicine volunteer their time and efforts, for a large system to work there must be some profit opportunity. Caregivers and suppliers of medical marijuana must have some ability to be compensated, or at a minimum reimbursed for their costs. Nothing in the Oklahoma proposal explains how medical marijuana will be obtained or transferred from supplier to caregiver to patient. The federal program with only a handful of patients required federal funding to fill this void, allowing those who grew, processed, and distributed the medical marijuana to be paid. Nothing similar exists in the Oklahoma proposal. With a lack of financial incentives, the Compassionate Use Act may not be workable.

Section E attempts to close one open end, the definition of a "primary caregiver." While appearing to be helpful, this section created more questions than it answered. For example, does the primary caregiver require any special training? Does a potential primary caregiver have to complete a criminal background check?

Does a primary caregiver have to be registered with the State of Oklahoma? Does the primary caregiver have to be a US citizen? Can a primary caregiver provide care for one patient or many? Can a primary caregiver be compensated? All of these issues are thorny concerns when dealing with health care. (For purpose of this paper we are ignoring the obvious problems of adding health insurance into the discussion, but that issue would also need to be handled prior to implementing this policy). These questions, along with the ambiguity of whether the marijuana can be sold make being a primary caregiver vague even after the definition provided in the Compassionate Use Act.

The law appears straightforward. However, the problem is not the text of the law, it is what is missing. Several amendments must be added to make this type of program workable. This paper is not a criticism of Senator Johnson, as she has acknowledged that more specifics to the bill would be needed (Adcock, 2011). What should be added? We do not have to reinvent the wheel. The leading states can serve as examples for Oklahoma on medical marijuana (Ludlum and Ford, 2010; Adcock, 2011). In other words, we can learn from California and Colorado's mistakes. We have identified four desperately needed additions to the Oklahoma medical marijuana proposal.

Define "Patient"

First and foremost, the Oklahoma medical marijuana proposal must define a "patient." Upon first glance, the definition of a "patient" stirs little controversy. In most medical matters, this is straightforward. However, with medical marijuana, both the needs of the patient and the benefits of the drug cause problems. The Oklahoma proposal must define "patients" in such a way as to include those who legitimately are in need of medical care and exclude those who are recreational users of marijuana.

When the medical marijuana laws were first enacted, the expectations were that only those truly ill would seek a recommendation for medical marijuana. If only the truly ill patients were buying medical marijuana, the hundreds of dispensaries in California and Colorado could not stay in business. With a large number of dispensaries, they must be selling to someone. Obviously there have been a large and growing number of patients. Two factors contribute to the rapid increase in medical marijuana patients in other states. First, the recreational users of marijuana have sought fraudulent means to obtain legal marijuana, and avoid the risk of jail. Second, doctors who provided the recommendations are in a for-profit industry. As a result, they have a financial incentive to recommend medical marijuana, and gain more patients and income.

How should Oklahoma define a medical marijuana patient? Two strategies are used in other states. Some states use a list of specific conditions (cancer, MS, AIDS, etc.). Any patient being treated for one of the listed conditions is a valid patient. This system is the most foolproof as far as avoiding recreational users from getting access to medical marijuana. However, this program is also the most limiting. Since most legislators have no medical training, there would constantly be political force used to add new conditions to the approved list. The medical community is still battling on the legitimate use (if any) for medical marijuana. They are a long, long way from creating a specific list of agreed conditions which would benefit from marijuana with a consensus in the medical community.

In the alternative, some states use a narrow list of acceptable conditions and add a catchall, "for any other purpose deemed beneficial by the doctor." This would eliminate having the legislature constantly amend the law to add acceptable ailments which would benefit from marijuana. However, by adding a potentially unlimited screen for defining a patient, the abuse of medical marijuana can increase.

We only have to look at other states to see how this catchall has been a failure. How do potential patients convince doctors to write the recommendation? Use vague symptoms. Over 90% of Colorado patients cited "severe pain" as a justification (Livio, 2010). The pain did not have to be documented, previously treated, or tied to any diagnosed condition. Severe pain have been the "magic words" that have allowed medical marijuana to flourish. Anyone who could stumble up to the computer and make an online doctor appointment and say the words "severe pain" would get a recommendation for medical marijuana. This is not an exaggeration. This result was far beyond the original intentions of the act. As a result of these abuses, Colorado has revised their medical marijuana laws (Ludlum and Ford, 2011), and Montana is attempting to repeal the law entirely (Adcock, 2011). Defining a "patient" is the biggest issue in making the medical marijuana system workable. We can look to other states and see their mistakes, which we should not want to repeat.

The system is being abused, and it will only get worse. In 2010, Colorado received 1000 new patient medical marijuana applications each day (Livio, 2010; Reuterman, 2010; Segal, 2010). Nearly 55,000 medical marijuana applications were pending, which would dramatically increase the number of legal pot buyers (Potter, 2010b). It is not possible that Colorado has 55,000 new cases of terminal cancer in the past year. It is clear that the vague definition of a patient has allowed thousands of Colorado recreational users to apply for medical marijuana approval and overload the screening system.

Oklahoma does not have to reinvent the wheel. Other states have workable systems for defining legitimate patients for medical marijuana. We will discuss a couple of them. The system for establishing patients can be organized in various ways. The state can mandate that any potential patient go to a specific list of doctors who will evaluate the patients' need. This can be done by state employee health facilities (to avoid the profit incentive for recommending marijuana) or by allowing private doctors (already licensed by the state) to recommend medical marijuana to any patients they have.

Requiring patients to go to a state-run medical facility has good and bad sides. A state-run facility has no interest (profit motive) for recommending medical marijuana to all who apply. In addition, recreational users might be more hesitant to deceive a state doctor, and so would avoid the program. This could limit recreational users from access to medical marijuana. However, state-run programs cost the taxpayers a great deal of money. Budgets on state health care spending are already tight, and we can easily see the political fights about which programs will be cut to allow for funding of medical marijuana screening.

The alternative to a state-run screening program is one monitored by private (for profit) doctors. In states that allow this type of referrals, doctors advertise on billboards and the internet and implicitly promise marijuana to anyone who shows up and pays the fee. The private system however would not cost the taxpayers any money. All costs would be borne by the seekers of medical marijuana (both legitimate and not legitimate). Such is the trade-off in a screening program. Are the taxpayers willing to spend money to screen those who legitimately need medical marijuana? We do not have an answer for this.

Several other basic questions remain to have a workable medical marijuana program. Does a person have to be a state resident to be a patient? Can a person apply for medical marijuana while on vacation in another state? Can a person apply in another state after being denied marijuana in another state? This would allow recreational users to "forum shop" from state to state until he/she finds a doctor willing to recommend marijuana. Does a person have to be a US citizen to be a patient? All these questions and others must be specified in the statute to make the medical marijuana program function.

The Abuse of Doctor Referrals

The expectations of medical marijuana advocates are for a real doctor-patient relationship. In reality, many are nothing more than websites who sell a recommendation for a small fee. This concern was not mentioned in the first state laws which first allowed medical marijuana. California and Colorado did not require any specific type of relationship to exist with the doctor. Then the abuses started. Several internet based "medical offices" emerged which briefly interviewed patients online and emailed them a recommendation, provided the patient paid the fee (around \$200). A recent search of the internet by the authors (June 7, 2012) for "California medical marijuana referral" yielded 700,000 hits. Some of these websites are likely to be legitimate, but certainly there are not 700,000 physicians in California who specialize in medical marijuana. The system is being abused.

Stopping the internet medical offices may be an easy task. Colorado's 2010 amendments also required a bona fide doctor relationship (NPR, 2010; Ludlum and Ford, 2011). At a minimum, the proposal should require a physical visit to a doctor with an office located in the state. This would prevent the online referral scam. This should be written into any proposed law to prevent the online marijuana referral shopping centers. Prevention and planning are the best remedy.

Limited Number of Marijuana Dispensary Locations

As we already mentioned, the Oklahoma proposal is silent on how medical marijuana will be supplied, but it must come from somewhere. If the program is going to work, there must be some legitimate means of obtaining the marijuana, and that will require some form of dispensaries.

Some current Oklahoma residents may not desire medical marijuana dispensaries in their city limits or neighborhoods. States that allow sale of medical marijuana have seen an explosion of retail sellers. Colorado has reacted to this dramatic growth. Boulder, Colorado has more medical marijuana dispensaries than Starbucks and liquor stores combined (Segal, 2010). What if an Oklahoma town or neighborhood did not want any medical marijuana primary caregivers or patients in their area? Can they have deed restrictions?

Colorado wrestled with this problem (Ludlum and Ford, 2011). Under the new 2010 amendments, a Colorado city can restrict or completely prohibit dispensaries inside their city limits (C.R.S. 12-43.3-310-1). City governments have jumped into action to ban dispensaries in their communities (Ingold, 2010; NPR, 2010). Vail has already banned dispensaries (Ingold, 2010). Aurora and Greenwood Village have considered ballot initiatives to ban dispensaries (Ingold, 2010). Giving individual communities the right to ban medical marijuana may be an acceptable political alternative if the Oklahoma Compassionate Use Act is set to become law.

Because of the conservative political climate, it is easy to assume many communities would not support dispensaries in their area. Would the medical marijuana system really work if the only dispensaries are 150 miles from population centers? This is something else to consider.

The alternative to for profit dispensaries for marijuana is to have state-run dispensaries. While these would appear to be more legitimate, they would involve more spending by the taxpayers on an issue that already has a great deal of controversy. There is not an easy way to make the medical marijuana system effective and inexpensive. That is the tradeoff which will cause the political fight.

Generate Tax Money

Oklahoma, like all states, needs money. One easy solution is to make medical marijuana subject to the state sales tax. The city of Boulder made \$74,000 in one quarter through the tax on medical marijuana (Reuterman, 2010). The ability to generate sales tax seems high. Again, predictions are difficult with an industry only in existence for ten years, but medical marijuana is very popular with consumers and should generate a significant amount of money.

Cities have also started licensing fees, similar to permits required for other industries. The City of Denver will gain \$1.4 million in annual licensing fees (\$5000 per dispensary) from medical marijuana (Livio, 2010). In fact, a recent episode of Weed Wars discussed a new \$2 million tax on the Harborside Clinic. While many conservatives may not favor medical marijuana, they would certainly support the tax revenue from this endeavor.

Expectations for the Future

Should the State of Oklahoma attempt medical marijuana legislation again? That we cannot answer. We do know that if the proposal is going to be considered, it must contain the details of a workable, well-designed program. Rejection is politically easy if the proposal is incomplete. Legislators on the fence of the issue can vote against the bill because of the incompleteness. By setting up all details in the proposal, the legislators must make a political decision either for or against it. What medical marijuana advocates fail to realize is that the proposal has two enemies. First, and most obvious, are those who do not think marijuana has a legitimate medical use and should be avoided. Against this group of opponents, advocates of medical marijuana are doing a good job of explaining the benefits of marijuana and the patients who benefit from it.

The second group of opponents of medical marijuana (which we assume would be larger) would be those who might mildly support medical marijuana or be apathetic on the issue. However, this group is opposed to this and similar proposals because they do not see these programs as practical. In their words, the programs would either be a revolving door to get marijuana for recreational users (which is terrible) or the program would be a large and very expensive state program which would screen for legitimate patients but cost a fortune to operate (which is also terrible). The biggest obstacle to medical marijuana is designing a program which can be cost-effective (nothing is free) and reduce as much as possible illegitimate seekers of marijuana (no screening program is perfect). By advocating the idea of medical marijuana without the functional details in place, the opposition to medical marijuana will always win. In other words, if a proposal had developed a detailed plan to remedy many problems, opposition to the program will be decrease substantially.

Conclusion

Many other states have attempted medical marijuana legislation. Some have worked; others have been little more than a disaster. By studying the statutes of the other states or nations, and examining the results, a proposal can be designed which can create a successful program. To make the program viable, the details must be carefully examined. Luckily, we can examine other states and learn from their successes and failures. The only remaining step is to find the will to support the program. Currently, there is no political support for the program. There is no evidence in support of the program by the Oklahoma medical community. With the conservative climate, public support will be difficult to obtain. In Oklahoma, finding broad based support for such a program will be a daunting task indeed. The only conceivable way to make the program a political reality is to work out the details in advance and to inform the public about the medical benefits of marijuana. Only those two actions can hope to overcome the political opposition to the current proposal.

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