Medical Marijuana, Part 2: What It Is, and What the Law Says Now

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In Part 1 we looked at CBD, the cannabis compound that does not get you high. This time we turn to the part of the plant that does, and to the products that are sold under the name "medical marijuana."

I want to say up front that this is a much more complicated subject than CBD, and not only medically. It is complicated legally, because federal law changed in a significant way this past April and is still changing. It is complicated practically, because what a patient can buy in a dispensary is very different from what a pharmacist hands across the counter. And it is complicated spiritually, which is why I have set aside a separate post for that question. In this post I want to do something simpler: define the terms, lay out where the law actually stands as of this writing, and describe what is really being sold. Part 3 will take up whether it works and what it does to the body.

First, some definitions

The plant is *Cannabis sativa* (with a second species or subspecies, *Cannabis indica*, depending on which botanist you ask). It contains several hundred chemical compounds, of which more than a hundred are cannabinoids. The two that matter most are delta-9-tetrahydrocannabinol, or THC, which produces the "high," and cannabidiol, or CBD, which does not.

"Hemp" and "marijuana" are the same plant sorted by THC content. Under federal law, hemp has been cannabis with no more than 0.3 percent THC. Everything above that line is marijuana. (As I noted in Part 1, the hemp definition tightens on November 12, 2026.)

"Medical marijuana" or "medical cannabis" refers to cannabis or cannabis products used to treat a medical condition, usually under a state program that requires a physician's certification and a patient registry. It is important to understand that in most cases this is not a prescription in the ordinary sense. A physician certifies that a patient has a qualifying condition. The patient then goes to a dispensary and chooses among products. The physician usually does not specify the product, the dose, or the route. I will come back to why that matters.

Dispensaries sell many "strains," and customers are told that different strains produce different effects. The honest scientific answer is that the names on the jars tell you very little. What reliably differs between products is the percentage of THC and CBD in each, and that is what a careful patient and physician should pay attention to.

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Where the law stands in September 2026

This is the section that had to be rewritten almost entirely from the drafts I began two years ago, so bear with me. It matters.

In 1970 the Controlled Substances Act placed marijuana in Schedule I, the category reserved for drugs with "no currently accepted medical use and a high potential for abuse," alongside heroin and LSD. For more than fifty years that classification did not change, even as states began legalizing medical and then recreational use.

In 2022 the Biden administration asked the Department of Health and Human Services to review the classification. In August 2023, HHS recommended moving marijuana to Schedule III, the category that includes ketamine, anabolic steroids, and Tylenol with codeine. In May 2024 the Justice Department formally proposed the change, received about 43,000 public comments, and scheduled a hearing that was then delayed through 2025.

On December 18, 2025, President Trump signed an executive order directing the Attorney General to finish the job "in the most expeditious manner." On April 23, 2026, the Acting Attorney General issued an order that took effect April 28 and did two things. First, it moved two categories of marijuana from Schedule I to Schedule III immediately: marijuana contained in an FDA-approved drug product, and marijuana manufactured, distributed, or dispensed under a state medical marijuana license. Second, it ordered an expedited hearing on whether all marijuana, including recreational marijuana, should be rescheduled. That hearing ran from June 29 to July 15, 2026. As of this writing, the administrative law judge has not issued his recommendation, and recreational marijuana remains in Schedule I. On September 9, 2026, a federal appeals court declined to block the April order, so the medical rescheduling stands.

So what does Schedule III actually mean for a patient? Less than most people think.

It does not make marijuana legal. Schedule III drugs are still federally controlled substances. What changed is that the federal government now formally acknowledges that marijuana has an accepted medical use, and that state-licensed medical products are regulated rather than prohibited. It opens the door to research that Schedule I made nearly impossible, and it relieves dispensaries of a punishing tax rule. It does not turn a dispensary gummy into an FDA-approved medicine. And it does nothing at all for recreational use, which remains a federal crime everywhere in the country regardless of state law.

Two things have not changed. Since 2014 Congress has attached a rider to every federal budget that bars the Justice Department from spending money to interfere with state medical marijuana programs, so patients and dispensaries that follow their state's rules have been protected from federal prosecution for a decade. That protection continues. And because the April order covers only

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state-licensed medical products, it did not resolve the legal status of hemp-derived THC products, unlicensed sellers, or cannabis sold as food or supplements.

What the states say

As of this summer, 40 states plus the District of Columbia allow medical use of cannabis, and 24 states plus D.C. allow adult recreational use. A handful of states, including my new home state of Georgia, allow only low-THC oil products through a patient registry rather than a full dispensary program. Only a few states prohibit cannabis in every form.

The rules differ enormously from one state to the next. States vary in which conditions qualify, whether smoking is permitted, how much a patient may possess, whether home cultivation is allowed, and, critically for this series, how rigorously products are tested for potency and contaminants. Before you assume anything about "medical marijuana," find out what your state's program actually allows. And remember that a state's decision to list a condition as qualifying is a political decision, not a medical finding. It does not mean cannabis has been shown to help that condition. I will sort the evidence in Part 3.

Two places where "legal in my state" does not protect you

The first is your job. In May 2026 the Department of Transportation confirmed that rescheduling changed nothing about federal drug testing. A positive THC test is still disqualifying for pilots, commercial drivers, train and transit operators, and other safety-sensitive workers, and a state medical card, a physician's certification, or a dispensary receipt does not count as a legitimate medical explanation. Many private employers and the military take the same position. If your livelihood depends on a clean drug screen, a state program will not save it.

The second is firearms, and here the ground has shifted but not settled. For years federal law treated anyone who used marijuana, including patients with a medical card, as an "unlawful user" of a controlled substance who could not lawfully buy or possess a gun. On June 18, 2026, the Supreme Court ruled unanimously in United States v. Hemani that the government could not prosecute a man simply for using marijuana while keeping a securely stored gun at home. The Court called its ruling narrow, and it left room for restrictions tied to intoxication, addiction, or evidence of danger.

Here is the practical catch, which a careful reader pointed out to me. Hemani changed what prosecutors can do. It did not change the paperwork. Anyone buying a gun from a licensed dealer still fills out ATF Form 4473, and question 21.f still asks whether you are an unlawful user of marijuana or any other controlled substance, followed by a bold warning that marijuana remains unlawful under federal law no matter what your state has legalized. That leaves a marijuana user at the gun counter with an unhappy choice: answer "yes" and

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have the sale stopped, or answer "no" and commit a separate federal felony for making a false statement on the form, a crime Hemani did not touch. In May 2026 the ATF published a draft revision that reworded this question and dropped the medical marijuana warning, reflecting the April rescheduling of state-licensed medical products. As of this writing that draft has not been finalized, and dealers must keep using the current form until it is. If you own firearms and use or are considering cannabis, talk with an attorney in your state before you assume anything. And whatever you decide, answer the form honestly.

The medicines your pharmacist can actually dispense

Set aside the dispensary for a moment. The FDA has approved a small number of cannabinoid drugs that are manufactured to pharmaceutical standards, dosed precisely, and dispensed by prescription.

Epidiolex, purified CBD in an oral solution, for seizures in Lennox-Gastaut syndrome, Dravet syndrome, and tuberous sclerosis complex.

Dronabinol, a synthetic THC, sold as Marinol capsules and Syndros oral solution, for nausea and vomiting from chemotherapy and for loss of appetite and weight in people with AIDS.

Nabilone, a synthetic cannabinoid sold as Cesamet, also for chemotherapy-induced nausea and vomiting.

A fourth product, nabiximols (Sativex), a mouth spray containing both THC and CBD, is approved in Canada, the United Kingdom, and much of Europe for muscle spasticity in multiple sclerosis. It has not been approved in the United States.

These are what the Christian Medical and Dental Associations means when it says physicians should recommend only "FDA-approved, pharmaceutical-grade" cannabinoids. They have known contents, known doses, known side effects, and a prescribing physician who is accountable for the choice. Whether you agree with CMDA that the line should be drawn there, and I will take that up in Part 5, the distinction itself is real and worth keeping in mind.

What the dispensary sells

Dispensary products come in every form you can imagine. Dried flower for smoking or vaporizing. Concentrates such as wax, shatter, and vape cartridges, some exceeding 60 percent THC. Edibles, drinks, oils, and tinctures taken by mouth. Lozenges, lollipops, and sprays absorbed under the tongue. Creams, patches, and suppositories.

The route matters more than most patients realize, because it changes how fast the drug works, how long it lasts, how easy it is to dose, and what it does to your lungs. A widely cited 2021 safety review by Canadian clinicians concluded that oral oil is preferred for most patients because it avoids respiratory harm

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and allows accurate dosing. If a patient needs the fast onset of inhalation, vaporizing dried flower is safer than smoking or than vaping extracts in an electronic device. Concentrates should be avoided because of contaminants, dosing difficulty, and potency. For sprays, suppositories, topicals, and edibles, the authors found too little safety evidence to make recommendations at all.

You will also hear about the "entourage effect," the idea that whole-plant cannabis works better than isolated THC or CBD because its hundreds of compounds act together. Some clinicians believe it. Some researchers doubt it. It has not been settled.

Here is the practical bottom line for anyone comparing a dispensary product to a pharmacy product. The dispensary product is usually cheaper and comes in far more forms. The pharmacy product is manufactured under federal quality standards, has a known dose to the milligram, and has been through clinical trials. State-licensed dispensary products are labeled with THC and CBD percentages and in most states are tested for pesticides and solvents, which makes them far more reliable than anything from an unlicensed source. But the testing requirements vary by state and the enforcement is uneven. And the person advising you at the counter is a salesperson, not a clinician. Dispensary staff are not licensed health professionals and cannot give you unbiased, evidence-based medical advice about your condition or your other medications.

A word to my Christian readers

Some of the most careful Christian writing on this subject, including a 2023 article in the journal Themelios by law professor Melvin Otey, argued that Christians must abstain from cannabis entirely, medical use included, because Romans 13 calls us to obey governing authorities and any use was a federal crime. That was a serious argument, and I respected it. The April 2026 order changed the ground it stood on, at least for state-licensed medical use. It did not change it for recreational use, which is still a federal offense no matter what your state says. I will work through what that means for a believer's conscience in Part 4. For now, notice that "is it legal" and "is it wise" are two different questions, and the law answering the first one does not answer the second.

The bottom line

- "Medical marijuana" is not one thing. It ranges from FDA-approved prescription drugs to dispensary flower, edibles, and concentrates that no federal agency has evaluated.
- As of April 2026, FDA-approved cannabinoid drugs and state-licensed medical marijuana are federal Schedule III substances. Recreational marijuana remains Schedule I and federally illegal, pending a decision from the DEA that has not yet been issued.

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- Forty states and D.C. have medical programs, but the programs differ widely, and a state listing a condition does not mean cannabis has been shown to help it.
- A state medical card will not protect your job if you are federally drug-tested, and the federal firearms purchase form still asks about marijuana use even after the Supreme Court narrowed the law behind it. Answer it honestly, and get legal advice if it applies to you.
- If you and your physician are considering cannabis, oral products allow accurate dosing and spare your lungs. Concentrates and smoking carry the most risk.

Next time: what the evidence actually shows, condition by condition, what the side effects are, and who should never use it.

This post was accurate to the best of my knowledge when written. Cannabis laws and regulations are changing month to month. Nothing here is legal advice, and any decision to use cannabis medically should be made with your personal physician and pharmacist.

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