Federal Prohibition of Medical Marijuana in Pain Management: Undue, Unimportant, and Irrational

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Introduction

“For now, federal law is blind to the wisdom of a future day when the right to use medical marijuana to alleviate excruciating pain may be deemed fundamental. Although that day has not yet dawned, considering that during the last ten years eleven states have legalized the use of medical marijuana, that day may be upon us sooner than expected. Until that day arrives, federal law does not recognize a fundamental right to use medical marijuana prescribed by a licensed physician to alleviate excruciating pain and human suffering.”1

Medicine has come a long way since the days of bloodletting and leeches; yet, the one consistent factor (at least until relatively recently) has always been the right of a physician and patient, acting in concert, to explore or seek out alternative drug therapy or treatment options based on the individual patient and their specific condition.2 Different individual patients may require alternative pain management or treatment options due to inconsistencies in levels of drug sensitivity, allergic tendencies, addictive impulses and tolerance, ineffectiveness given the procedure involved, or net suffering due to side effects.3 Given these concerns, the availability of a menu of treatment options aimed at the management of pain or other symptoms associated with varying illnesses seems not to require much of a logical leap. However, the state of medical marijuana under the Federal Controlled Substances Act4 remains prohibitory, with little attention paid to treatment efficacy or the rights of individual patients.

The purpose of this paper is to provide a review of the historical right of the people of the United States to seek, and use, alternative medicinal treatment options in the realm of managing

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1 Raich v. Gonzales, 500 F.3d 850, 866 (9th Cir. 2007).


3 See Lars Noah, Challenges in the Federal Regulation of Pain Management Technologies, 31 J.L. MED. & ETHICS 55, 61 (2003) (“For a variety of reasons, patients respond variably to opioids, which explains the need for a range of alternatives and the interest in using powerful analgesics in different combinations. For instance, a certain genetic polymorphism found in more than 5 percent of patients makes them poor metabolizers of codeine.”

both the pain and symptoms associated with a variety of illnesses. The focus will then turn to the right involved, a patient’s ability to employ medical marijuana instead of a commonly prescribed narcotic or mass-market non-steroidal anti-inflammatory analgesic (NSAIA) drug to manage pain and increase quality of life under the advice and consent of a treating physician. Research indicates that no one article has argued that there is a fundamental, important, or at least recognizable right associated with a patient and doctor’s ability to seek the best course of symptomatic drug therapy. Thus, the legal analysis to follow will explore jurisprudence relating to fundamental rights, focusing on those cases in which the Supreme Court has affirmed the right of an individual to personally control their own medical treatment. That right, based in the uniqueness of the individual patient, will be put to the constitutional test at every tier of analysis to show why the prohibition of cannabis in medical treatment and pain management is undue, unimportant, and irrational.

**History of “Alternative” Treatment Options in Pain Management**

The “modern” pharmaceutical industry and its impact on pain management originated more than a century ago, around the time that the German company Bayer first synthesized aspirin and began marketing it as an analgesic in 1897. However, the impact of narcotics on pain management in the United States was seen prior to 1800, almost a century before the production of that lauded analgesic. Due to this history, by 1905 there were more than 28,000 pharmaceuticals containing psychoactive drugs readily available throughout the nation, sold in a relatively unrestricted manner by a variety of both medical and commercial sources.

Opium and its derivatives were historically employed as a children’s sedative, teething remedy, anti-diarrhea medication, and for “eye problems.” The United States was no stranger

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5 28 C.J.S. Drugs and Narcotics § 6 (West 2012) (The word “marijuana” is of Mexican origin, and is variously spelled as “marijuana,” “mariguana,” “marihuana,” “marajuana,” “maraguana,” or “marihuana.” Although marijuana is not a scientific or technical term, it is synonymous with the term “cannabis sativa” or simply “cannabis,” and those terms will be used interchangeably because “marijuana” has been held identical with “cannabis” as a matter of law).

6 See supra n. 3.

7 See supra n. 2 at 1 (“Before 1800, opium was available in America in its crude form as an ingredient of mult.drug prescriptions.”).

8 JAMES A. INCIARDI, AMERICAN DRUG POLICY: THE CONTINUING DEBATE IN THE DRUG LEGALIZATION DEBATE, 1, 3 (James A. Inciardi, ed. 2d ed., Sage Publications, Inc. 1999) (merchants distributing such remedies included: physicians, apothecaries, grocers, postmasters, printers, department stores, and medicinal “show wagons” as they traveled throughout rural and urban America).

9 See Peter J. Cohen, Medical Marijuana: The Conflict between Scientific Evidence and Political Ideology, 2009 Utah L. Rev. 35 (2009). (“The earliest available references to the cultivation of poppies and preparation of opium date back to about 5000 BC as seen in clay tablets left by the Sumerians . . . [and was] used in Egypt as far back as 2000 BC”).
to its use; the U.S. Public Health Service estimated that between 1859 and 1899 about 7,000 tons of crude opium was imported into the United States for legitimate medical purposes. However, the popularity of opium and its derivatives as a pain relieving medication stemmed primarily from its use by the North in United States’ Civil War as Morphine. Too expensive for the beleaguered South, whiskey took Morphine’s place in the realm of post-surgical and general pain management. Cocaine, on the other hand, entered the United States market in the late 18th century and achieved popularity in the United States as a general cure-all. It was used for such far-reaching purposes as: sinusitis, hay fever, and as a cure for opium, morphine, and alcohol habits. It was so popular that academic journals, medical entrepreneurs, a former Surgeon General and even Sigmund Freud “swore by it.”

Cannabis, more commonly referred to as marijuana, has a history of medical and industrial use in this country and worldwide. European settlers first brought marijuana to

10 Id.


12 See supra n. 2 at 1.

13 Id.

14 Id. at 7.

15 Id. at 6-7.

16 Id. (“[Cocaine] was so popular that learned journals published accounts which just avoided advising unlimited intake of cocaine.” Neurologist William Hammond, former surgeon general of the army, took a wineglass of it with each meal and announced cocaine as the official remedy of the Hay Fever Association. Freud recommended and wrote articles suggesting cocaine as a general tonic and an addiction cure after discovering it initially in American medical journals).

17 See supra n. 5.

18 See Deborah Garner, Up in Smoke: The Medicinal Marijuana Debate, 75 N.D. L. Rev. 555, 557-60 (1999) (“[c]olonists used the fiber of the plant to produce clothing, twine, rope, paper, blankets and canvas”).

19 Supra n. 1 at 865.

20 Supra n. 9 at 35 (“Accounts dating back as far as 2700 B.C. describe the Chinese using marijuana for maladies ranging from rheumatism to constipation. There are similar reports of Indians, Africans, ancient Greeks and medieval Europeans using the substance to treat fevers,
what would become the United States in 1611.\textsuperscript{21} One scholar even claims that “evidence suggests that George Washington cultivated hemp [or cannabis] for the medical benefits of its resin.”\textsuperscript{22} While that claim remains contentious, it is undisputed that Americans were using marijuana as a medicine as early as 1840.\textsuperscript{23} It was included in the United States Pharmacopoeia from 1850 thru 1941 as a way to treat numerous conditions including: neuralgia, nausea, gout, rheumatism, tonsillitis, tetanus, typhus, rabies, hydrophobia, epidemic cholera, convulsions, chorea, dysentery, alcoholism, opiate addiction, hysteria, mental depression, insanity, senile catarrh, delirium tremens, menorrhagia, chronic cystitis, incontinence, excessive menstrual bleeding, and uterine hemorrhage.\textsuperscript{24} In addition to actual consumption, cannabis seeds were combined with ointment to remedy inflammatory and neuralgic symptoms.\textsuperscript{25} More recently, in 1974 an herbal medical text proposed that marijuana’s principal use in medicine is for easing pain and inducing sleep, and for soothing nervous disorders.\textsuperscript{26} By 1890 the medicinal use of marijuana declined due to the development of “more reliable” synthetic drugs such as aspirin, chloral hydrate and barbiturates.\textsuperscript{27}

**Federal Prohibition and the Controlled Substances Act**

Although the Pure Food and Drug Act of 1906 required any quantity of cannabis and other narcotics to be clearly marked on the labels of any drug or food sold to the American public,\textsuperscript{28} scholars indicate that the prohibition of marijuana resulted from the widespread fear


\textsuperscript{23} Supra n. 9 at 71.

\textsuperscript{24} See id; see also supra n. 21 at 361-62.

\textsuperscript{25} Id. at 72.

\textsuperscript{26} Id. at 71.

\textsuperscript{27} Supra n. 18 at 558.

\textsuperscript{28} Supra n. 2 at 216-8.
and hatred of intoxicants in general most commonly associated with the federal prohibition of alcohol through the enactment of the 18th Amendment in 1919. By, 1932 the Federal Bureau of Narcotics warned that marijuana had come into widespread and increasing abuse and encouraged the passage of rigid marijuana laws. Although the 18th Amendment was repealed in 1933, by 1937 nearly every state had laws restricting marijuana along with other “narcotics” and the federal Marijuana Tax Act of 1937 prohibited the use of marijuana as an intoxicant; although it only restricted its use as a medicine. However, because the Act required physicians seeking to prescribe marijuana to file extensive paperwork (and given the presence of “more reliable” pain remedies) medical use of marijuana continued to decline; providing the Federal Bureau of Narcotics with grounds to remove it from the United States Pharmacopeia in 1941.

Subsequent Acts increased the penalties associated with marijuana use; “[f]or instance, the Boggs Act of 1951 established mandatory prison terms and large fines for the violation” of federal narcotics and marijuana laws and “[t]he Narcotic Control Act of 1956 further strengthened those penalties.” However, marijuana was not prohibited under federal law until Congress passed the Controlled Substances Act in 1970. The Federal Controlled Substances Act (CSA), unlike its state-level predecessors, created no exemption for medical use by qualified patients. The goal of the CSA was to provide for uniformity in the scheduling (or

29 See supra n. 20 at 974-85.

30 Supra n. 18 at 558.

31 See supra n. 5 (Marijuana is not technically a narcotic; however, it is treated for all purposes just like an opiate under many drug scheduling laws); see also Garner, supra n. 18 at 558 (“Under most… laws, use of marijuana was subjected to the same penalties applicable to morphine, heroin, and cocaine, even though designating marijuana as a narcotic was technically incorrect”).

32 Supra n. 18 at 558.

33 See id. at 558-59.


35 Id at 559.

36 Raich, supra n. 1 at 864 (citing Gonzales v. Raich, 125 S.Ct. 2196, 2202 (2005)).

37 See supra n. 4; and supra n. 1 at 865 (9th Cir. 2007) (citing Leary v. United States, 395 U.S. 6, 16–17 (1969)).

categorization) of all drugs, and subjected them to increasing levels of control on the basis of abuse potential and lack of therapeutic usefulness. There are five scheduling categories, and marijuana occupies the first (and most restrictive) of the five.

Under the Act, a drug placed in Schedule I, has “no currently accepted medical use in the United States” and purportedly cannot be safely used, even under medical supervision. To qualify as “currently accepted medical use” the drug must satisfy both safety and efficacy standards (outlined by the DEA) and must be widely accepted by qualified experts. On the other hand, the CSA maintains that a drug shall be placed in Schedule II if there is a currently accepted medical use in treatment in the United States, even if it must be accompanied by severe restrictions due to its propensity to result in psychological and/or physical addiction. “Schedules III, IV, and V, which all have ‘a currently accepted medical use in treatment in the United States,’ contain drugs with progressively lower potentials for abuse and severity of dependence.” Although the CSA provides for the periodic updating of schedules marijuana

39 Supra n. 18 at 559-60.


41 Id.; 28 C.J.S. Drugs and Narcotics § 221 (West 2012) (“Schedule I is the most restrictive Schedule, and a drug or other substance is included in Schedule I if it has no currently accepted medical use in treatment in the United States, has a high potential for abuse and has a lack of accepted safety for use under medical supervision. Schedule II is the next category and a drug or other substance is categorized on Schedule II if it has a high potential for abuse, has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions, and its abuse may lead to severe psychological or physical dependence. A drug or other substance is included in Schedule III if it has a potential for abuse less than the drugs or other substances in Schedules I and II, has a currently accepted medical use in treatment in the United States, and its abuse may lead to moderate or low physical dependence or high psychological dependence. A Schedule IV drug or other substance is one which has a low potential for abuse relative to the drugs or other substances in Schedule III, has a currently accepted medical use in treatment in the United States, and its use may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III. Finally, a Schedule V drug or other substance is one which has a low potential for abuse relative to the drugs or other substances in Schedule IV, has a currently accepted medical use in treatment in the United States, and the abuse of which may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV. Federal law has set forth what drugs and other substances are to be included within each Schedule.” (citations omitted)).

42 Supra n. 3 at 60.


44 Supra n. 3 at 58.
remains a Schedule I drug alongside substances such as heroin (diacetylmorphine).\textsuperscript{45} In contrast, Schedule II includes drugs like OxyContin® (oxycodone hydrochloride) and dihydrocodeine (opiates), cocaine extracts, and methadone;\textsuperscript{47} while Schedule III includes products such as Tylenol® (acetaminophen) with codeine.\textsuperscript{48} This confirms that, “[f]or the purposes of the Controlled Substances Act, Congress has determined that marijuana has no currently accepted medical use at all.”\textsuperscript{49}

The decision of the DEA to classify marijuana as a Schedule I controlled substance has been appealed on numerous occasions.\textsuperscript{50} In response to such appeals the scheduling decision was resubmitted to Administrator Robert C. Bonner for reconsideration in light of the available evidence.\textsuperscript{51} Mr. Bonner’s review of the evidence adduced at a merits hearing failed to convince him that marijuana in fact was capable of effectively treating any of the conditions referenced above.\textsuperscript{52} Mr. Bonner’s recommendation is replete with typographical errors and inflammatory statements,\textsuperscript{53} and he seems to have missed the point of adducing medical marijuana as a pain management treatment\textsuperscript{54} altogether, focusing instead on its failure to cure symptoms of the diseases for which it might be prescribed.\textsuperscript{55} Finally, he relies heavily on expert medical

\begin{itemize}
\item \textsuperscript{45}Supra n. 9 at 88.
\item \textsuperscript{46}Supra n. 3 at 58.
\item \textsuperscript{47}See 21 U.S.C.A. §812(Schedule II); see also supra n. 3 at 58-59.
\item \textsuperscript{48}See 21 U.S.C.A. §812(Schedule III); see also supra n. 3 at 58-59.
\item \textsuperscript{50}See e.g. Alliance for Cannabis Therapeutics v. Drug Enforcement Admin., 15 F.3d 1131 (D.C. Cir. 1994), and Conant v. McCaffrey, 172 F.R.D. 681 (N.D. Cal. 1997).
\item \textsuperscript{51}See Marijuana Scheduling Petition; Denial of Petition; Remand, 57 FR 10499-02 (1992).
\item \textsuperscript{52}See id.
\item \textsuperscript{53}See e.g.: id. (“Threee [sic] studies show. . .;” “A librarian can help locate copies of theses [sic] studies should you want to see them for yourself;” “Those who [sic] insist marijuana has medicinal uses would serve society better by promoting or sponsoring more legitimate scientific research, rather than throwing their time, money, and rhetoric into lobbying, public relations campaigns and perennial litigation;” and, “The Controlled Substances Act of 1970 divides the universe of all drugs [sic] of abuse into five sets or schedules”).
\item \textsuperscript{54}See supra n. 3 at 59.
\item \textsuperscript{55}See supra n. 51 (“[A]ny mind-altering drug that produces euphoria can make a sick person think he feels better” and “patients who claim marijuana helps them may be the result of the mind-altering effects of the drug, not the results of improvements in their conditions”).
\end{itemize}
testimony supporting the position that marijuana is ineffective in managing illnesses while simultaneously stating, in reference to those whom testified in its favor, that “[i]mpressions or beliefs of physicians, no matter how fervently held, are treacherous.” Given the contradictory and arbitrary nature of Mr. Bonner’s findings, it is not surprising that advocates for the use of medical marijuana in pain management continue to contend that the scheduling of the drug is neither in accordance with due process, related to an important governmental interest, nor rational.

**The Federal CSA’s Scheduling “Process”**

The placement of a narcotic on any Schedule of the Controlled Substances Act requires the Food and Drug Administration (FDA) to act in concert with the Drug Enforcement Agency (DEA) to balance the medical utility of a drug against appropriate law enforcement concerns. The FDA was created in 1906 largely due to shocking disclosures of unsanitary conditions in food processing plants. The FDA was further empowered to regulate labeling and drug safety under the Food, Drug, and Cosmetic Act of 1938 and the Kefauver-Harris Amendment in 1962, both of which resulted from a series of public health crises related to unsafe mass-marketed drugs. The modern FDA now requires that drugs entering commerce be tested for both safety and efficacy; although it does not require that the new drug be proven superior to already approved drugs. All initial studies and testing phases of the pharmacological and

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56 See supra n. 51.

57 See supra n. 3 at 59.

58 See supra n. 9 at 45-52.

59 Id. at 45 (referencing e.g.: Upton Sinclair, The Lost First Edition of Upton Sinclair's The Jungle (Gene DeGruson ed., Peachtree Publishers 1988) (1906): “There would be meat that had tumbled out on the floor, in the dirt and saw-dust, where the workers had tramped and spit uncounted billions of consumption germs. There would be meat stored in great piles in rooms; and the water from leaky roofs would drip over it, and thousands of rats would race about on it. It was too dark in these storage places to see well, but a man could run his hand over these piles of meat and sweep off handfuls of the dried dung of rats. These rats were nuisances, and the packers would put poisoned bread out for them; they would die, and then rats, bread, and meat would go into the hoppers together. This is no fairy-story, and no joke; the meat would be shoveled into carts, and the man who did the shoveling would not trouble to lift out a rat even when he saw one . . . .”)

60 Id.

61 Id.

62 There are three clinical testing phases. Phase I tests the drug’s toxicity in fewer than 100 human participants; Phase II is employed to determine a drug’s effectiveness in clinical settings;
physiological effects of a new drug must be completed by its sponsor through both animal and
clinical lab testing.\textsuperscript{63} Upon completing testing a new drug’s sponsor may seek approval of the
drug for presentation to the mass-market through a New Drug Application (NDA) with the FDA
including therein all testing results and proposed labeling.\textsuperscript{64} This process is demanding, yet the
FDA generally leaves judgments about addiction liability to the DEA and comparative efficacy
with physicians and patients.\textsuperscript{65}

If the FDA finds that a drug’s addiction liability requires additional regulation under the
CSA it petitions the DEA to Schedule it.\textsuperscript{66} This process involves a scientific review performed
by the FDA’s Department of Health and Human Services (DHHS) and the National Institute on
Drug Abuse (NIDA) which make a preliminary recommendation that is generally rubberstamped
by the FDA.\textsuperscript{67} The DEA is then presented with these findings and places the drug on a Schedule
“based on objective and verifiable scientific findings” as verified through a series of questions
relating to the use of the drug as a legitimate medical substance in light of potential abuse
factors.\textsuperscript{68} Finally, Congress, through the CSA, may take any action it wishes to reschedule a
drug based on scientific evidence.\textsuperscript{69}

Scheduling decisions relate to the intrinsic characteristics (such as addiction liability) of a
drug’s active ingredients, rather than dosage and formulation.\textsuperscript{70} Lars Noah’s commentary on this
topic provides a useful example in Fentanyl citrate, a Schedule II analgesic derived from

\begin{itemize}
  \item Phase III, in much larger studies, determines complications and efficacy in the general
        population. \textit{See id.} at 47.
  \item \textit{Id.}
  \item \textit{Id.} at 49.
  \item \textit{Supra} n. 3 at 56.
  \item \textit{Supra} n. 9 at 50.
  \item \textit{Id.} at 51.
  \item The DEA schedules a drug through objectively answering “the following questions: (1) Does
        the drug have a “currently accepted medical use” in the United States? (2) What is the drug’s
        safety under medical supervision? Will it be a hazard to those using it or to others? (3) What is
        its addiction liability? (4) Is there a potential for (or history of) significant diversion for illegal
        use? (5) Are individuals using it on their own initiative or only on physician’s prescription? (6) Is
        the drug similar in its pharmacology to other controlled drugs?” \textit{Id.} at 52.
  \item \textit{Id.}
  \item “[A]lthough the DEA’s differential treatment of smoked marijuana and THC encapsulated for
        ingestion may represent an exception.” \textit{Supra} n. 3 at 61.
\end{itemize}
According to Noah, this substance has been approved by the FDA for use in the form of a patch and a lollipop, intended for use by children, even over objection that it would promote abuse. Given that example, some argue that “[t]he potential relief afforded to seriously and terminally ill patients by smoked marijuana should not be overshadowed by the federal government’s overall policy against drug abuse” because it allows for the open marketing of other addictive substances in easily abused forms.

**State-sanctioned use of Medical Marijuana**

Twenty-two states currently accept supervised use of marijuana for research purposes, medical treatment, or provide for the use of a medical necessity defense to criminal possession charges. Some states, such as New Mexico and Tennessee, have reformed the scheduling of medical marijuana (from Schedule I to II) when it is used for medical purposes pursuant to Compassionate Use Acts. New Mexico’s Controlled Substances Act and its scheduling procedure mirrors the Federal Controlled Substances Act except for the provision enumerated in the Lynn and Erin Compassionate Use Act, which maintains that “the enumeration of

71 Id.

72 Id.

73 See Dogwill *supra* n. 38, 289-91.


75 See N.M. Stat. Ann. § 26-2B-1 et seq. (West 2012); Tenn. Code Ann. § 39-17-408 et seq. (West 2012); *see also* Dogwill *supra* n. 38.


marijuana … as Schedule I controlled substances does not apply to the use of marijuana … by certified patients.”

Qualified patients under the act are those whom have a debilitating medical condition such as: Cancer, Glaucoma, Multiple Sclerosis, a nervous or spinal cord injury, epilepsy, HIV or AIDS, hospice admission, or “any other condition accepted by the department [of health].” “Any other condition” refers to a “debilitating medical condition” which results in pain, suffering or debility for which there is credible evidence that the medical use of cannabis could be of benefit. Under the Act, practitioners seeking to prescribe cannabis are required to explain both its potential risks and side effects, much like with any other prescription medication.

**Risks and Benefits of Marijuana in Pain Management**

According to the CSA, marijuana has no known use in medical practice in the United States. Many scholars disagree. Lester Grinspoon, for instance, indicates that marijuana has been used to treat pain associated with surgery, headache, migraine, menstrual cramps, and muscle spasms associated with paralysis, nerve damage, multiple sclerosis and cerebral palsy. It has also been used to treat seizures, asthma (in spray form), glaucoma, cancer, aids, and depression. Additionally, a 1991 survey indicates that nearly fifty-percent of responding physicians said they would prescribe the drug. Given this contradiction, it is useful to briefly survey both the benefits, and risks, associated with marijuana use in the medical setting.

Cannabis Sativa (marijuana) originates from the leaves of the hemp plant. The most traditional and common mode of consumption of the drug is through inhalation of raw prepared marijuana buds. In this form the plant’s flowing buds are stripped of their leaves and the

78 Id.


80 N.M. Admin. Code § 7.34.3 (West 2012).

81 2010 NM Regulation Text 5565 (Lexis 2012).


85 Supra n. 18 at 563.

86 Supra n. 21 at 350.

remaining composites are allowed to dry.88 Prior to inhalation marijuana in this state is said to contain over 460 chemical compounds, 60 of which are commonly referred to as “cannabinoids.”89 Delta-9-tetrahydrocannabinol (or THC) is the cannabinoid most generally associated with both the psychoactive and physiological effects of marijuana.90 Recently, THC has been synthesized into dronabinol, which occupies a position on Schedule III of the CSA.91 The distinctions between synthetic forms of THC and raw cannabis are examined in later sections. As such, the discussion to follow will focus primarily on the benefits, and risks, associated with the consumption with raw cannabis, only.

Benefits Associated with Use

Anecdotal evidence suggests that cannabis and its derivatives have several uses in the treatment of the symptoms of a wide range of diseases and disorders, including: anorexia,92 multiple sclerosis, paraplegia, quadriplegia, muscle spasms, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), migraine headaches, and cancer.93 For instance, reports from patients and limited studies indicate that it is very effective in treating nausea and vomiting94, symptoms associated with chemotherapy (for cancer patients) and “wasting” (or the gradual loss of weight in HIV/AIDS patients), through stimulating appetite, alleviating pain, and calming gastrointestinal distress.95 The effects in this context are not limited, as those symptoms can cause severe dehydration, malnutrition, and depression in mal-

88 See The Union: The Business Behind Getting High, Motion Picture Documentary (Adam Scorgie, 2007).

89 Supra n. 21 at 350.

90 Id.


93 Supra n. 18 at 561-65; see also Pfeifer supra n. 21 at 350-54.

94 Supra n. 9 at 72 (“George Annas provides an especially telling description of its use by Stephen Jay Gould, a respected scientist, who had smoked marijuana to alleviate the nausea and discomfort he experienced during chemotherapy for abdominal mesothelioma: Absolutely nothing in the available arsenal of anti-emetics worked at all. I was miserable and came to dread the frequent treatments with an almost perverse intensity. . . . Marijuana worked like a charm. The sheer bliss of not experiencing nausea--and not having to fear it for all the days intervening between treatments--was the greatest boost I received in all my year of treatment, and surely the most important effect upon my eventual cure”).

95 Supra n. 18 at 563-64.
adjusted patients. Thus, “[w]hile smoking marijuana may not cure the symptoms associated with these disabilities[,] it may help the [patient] live a somewhat normal life.”

Scientific evidence adduced by studies on the effects of cannabis indicate that its benefits are not merely confined to the reports of patients. This additional proof is necessary if proponents wish to see legalization, as “[t]he standard of review, as set forth by the FD&C Act, demands ‘evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified by scientific training and experience to evaluate the effectiveness of the drug involved.’” As applied to HIV/AIDS, reports from the AIDS community were confirmed by a scientific, peer-reviewed publication by Donald Abrams and coworkers. Abrams found that smoked marijuana reduced daily pain by an average of 34 percent, and no serious adverse effects were noted. In a related study examining the effects of marijuana on patients with Hepatitis C, researchers “concluded that marijuana use ‘may offer symptomatic and virological benefit to some patients undergoing… treatment by helping them maintain adherence to the challenging medication regimen.” Another study, conducted in 2007 by Wallace, evaluated marijuana’s ability to mitigate artificially induced pain “through the injection of capsaicin (similar to injecting an extract of jalapeno peppers) under the skin in a randomized, double-blind, placebo trial involving fifteen healthy volunteers.” Their study concluded that, at the proper dose, marijuana is in fact effective at relieving pain as compared with other analgesic remedies. Finally, a study showed that marijuana reduced intraocular

96 Id. at 563.

97 Id. at 565.


99 Id. at 73 (“In this investigation, a prospective randomized placebo-controlled trial involving adults with painful HIV-associated sensory neuropathy, volunteers were randomly assigned to smoke either marijuana (3.56% Δ9-tetrahydrocannabinol) or identical placebo cigarettes three times daily for five days. The investigators evaluated both the individual subjects’ quantitative description of chronic pain intensity and the percentage of subjects who reported more than a 30 percent reduction in pain intensity”) (citations omitted).

100 Id.

101 Id. at 75.

102 Id. at 73.

103 Id. (“Three doses of marijuana were administered: low (2 percent), medium (4 percent), and high (8 percent Δ9-tetrahydrocannabinol by weight). While the low dose had no analgesic effect, there was a significant decrease in capsaicin-induced pain within forty-five minutes after the medium dose was smoked. However, as with some other analgesic agents, the highest dose actually produced an increase in subjective pain perception”).
pressure (alleviating impending damage to the optic nerve) and reduced tear flow in Glaucoma patients, thereby (at least temporarily) ameliorating its effects.\textsuperscript{104}

**Risks Associates with Use**

A common thread in prohibitory rhetoric focuses on the fact that smoked marijuana is made up of many different chemicals which may provide little benefit to the user.\textsuperscript{105} Scholars reference potential side-effects in the form of acute toxic psychosis, panic attacks, flashbacks, delusions, depersonalization, hallucinations, paranoia, depression, uncontrollable hostility, Amotivational Syndrome, and impairment of perception, judgment, thinking, memory and learning.\textsuperscript{106} Additionally, many claim that marijuana is addictive, if only at the psychological level, and can lead to the use of other, harder, drugs through a “gateway” experience with marijuana’s psychotropic effects.\textsuperscript{107} Although historical evidence tends to contradict some of these later claims,\textsuperscript{108} there is no question that there are certain respiratory health risks associated with the inhalation of any potentially carcinogenic substance.\textsuperscript{109} This article, however, is focused on concerns associated with the medical (as opposed to recreational) use of marijuana.

Most common concerns regarding marijuana are linked to its alleged propensity to cause cognitive dysfunction, and even death or mental illness.\textsuperscript{110} Ironically, in contrast to many legal

\textsuperscript{104}See supra n. 18 at 564-65.

\textsuperscript{105}Id. at 555.


\textsuperscript{107}Id.

\textsuperscript{108}Supra n. 2 at 216-18 (“Not even the [early] reformers claimed… that cannabis was a problem of any major significance in the United States. Congress rarely heard any witness defend opiates or cocaine, but during the January 1911 hearings on a federal antinarcotic law before the House Ways and Means Committee, the National Wholesale Druggists’ Association’s representatives protested the inclusion of cannabis alongside opiates and cocaine. Charles A West, chairman of the NWDA legislative committee, testified that cannabis was not what might be called a habit-forming drug. Albert Plaut, representing the New York City pharmaceutical firm of Lehn and Fink, also objected to the inclusion of cannabis: he attributed its reputation more to literary fiction… than to informed opinion. When questioned whether cannabis might be taken by those whose regular supply of opiates or cocaine were restricted, Plaut responded that the effects of cannabis were so different from those of opiates and cocaine that he would not expect an addict to find cannabis attractive”).

\textsuperscript{109}See supra n. 51.

\textsuperscript{110}See supra n. 87 at 547.
drugs subject to the CSA, marijuana has never been linked to death relating to overconsumption or improper dosing, even in the course of recreational use. While marijuana is associated with psychological addiction liability, its incidence of actual physical dependence is scarce, at best. Extended marijuana use has been shown to cause cognitive impairment and, possibly, structural changes in the brain. However, other studies have discounted these findings. Relatedly, available scientific data suggest that there may be an association between some forms of psychiatric abnormalities (such as psychosis, depression, and schizophrenia) and the use of marijuana when administered in higher doses. However, such studies also suggest that those developing mental illness through the course of marijuana abuse also illustrated genetic predisposition for such disorders.

In addition to those conditions mentioned, the most widely-supported risk involved with marijuana use is its potential to cause lung cancer due to its inhalation. The bottom line is that there are several findings produced by respected research to support this hypothesis. One caveat, however, is that such studies often relied upon the “chemical composition of tobacco smoke” and “the presence of known and suspected carcinogens” in marijuana smoke. Such studies also stressed the distinction between the modes of inhalation, with marijuana users generally inhaling (and holding the smoke) for longer stints of time; but less frequently that those using cigarettes, who generally exhale immediately. Thus, although it is generally accepted that inhalation of marijuana may lead to pulmonary cancers, actual hard data relating to medical

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111 See supra n. 9 at 52-58 (2009) (“Many legal drugs subject to the CSA are both indispensable to modern medical practice and potentially lethal (e.g., morphine, Fentanyl™, Demerol™, and Phenobarbital”).

112 Id. at 56.

113 Id. at 58-63.

114 Id. at 76 (“An important observation in Wallace’s study was that there was no significant impairment of performance among volunteers in the study as evaluated by neuropsychological testing”).

115 Id. at 62-63.

116 Id. at 63.

117 Id. at 65.

118 See id.

119 See id.

120 See id. at 65-66.
marijuana use, specifically, “awaits further epidemiologic studies.”\textsuperscript{121} It is undisputed that long-
term inhalation of marijuana bears risks similar to those of cigarettes and carries the additional
risk of infection by fungal spores (similar to tobacco products) if improperly stored.\textsuperscript{122} In
response to such concerns, it is argued that particulates “can easily be addressed by... developing
the technology to” purify the cannabinoids therein.\textsuperscript{123} In fact, such technology is already in
existence in the form of ceramic vaporizers.\textsuperscript{124}

Finally, the “gateway” hypothesis maintains “that while marijuana itself may not cause
significant harm, it can serve as a ‘gateway’ or ‘trigger’ that predisposes the user to... become
dependent on more harmful drugs.”\textsuperscript{125} Proponents of this theory argue that marijuana may
“‘trigger’ a biochemical craving for other psychoactive substances;”\textsuperscript{126} however, use of harder
drugs has also been linked to “permissive atmosphere associated with [marijuana’s recreational]
use.” Arguments in this vein have been refuted on the basis that, at least currently, a large
proportion of the United States’ population has used marijuana at some point in time and has not
progressed to using other illegal substances.\textsuperscript{127} Medical studies conducted on same-sex twin
pairs indicated that peer and social context, rather than marijuana use alone or even genetic
predisposition, is a stronger indicator of hard-drug experimentation and abuse.\textsuperscript{128}

\textsuperscript{121} Supra n. 9 at 67.

\textsuperscript{122} Supra n. 87 at 570.

\textsuperscript{123} Supra n. 84 at 102.

to half of the active ingredients. According the PubMed Central Harm Reduction Journal, this
process will release harmful toxic elements including carbon monoxide and tar. Smokers inhale
these bi products which causes serious health complications. Sufferers may experience
respiratory problems, irritation of the voice box and windpipe, and swelling of the lung airways.
Directly smoking these substances can also cause excessive smoking which can increase the
chances of a lung infection. To lessen possible permanent damage to the lung and throat, ceramic
vaporizers can be used. Ceramic vaporizers are far less toxic to body than smoking because it
does not release tar and carbon monoxide into the system”).

\textsuperscript{125} Supra n. 9 at 67.

\textsuperscript{126} Id. at 66 (citing Peter J. Cohen, Drugs, Addiction, and the Law: Policy, Politics, and
Public Health 30 (2004)).

\textsuperscript{127} Supra n. 9 at 67.

\textsuperscript{128} Id. at 67-68.
A variety of alternative treatment options and substance ingredients including depressants (such as amobarbital, pentobarbital, and alcohol), stimulants (such as caffeine and amphetamines), Schedule II opiates (like codeine, hydrocodone, morphine, oxycodone, raw and powdered opium, and methadone), radioactive treatment therapies, and hallucinogenic substances such as (nabilone and dronabinol (synthetic THC)) remain available to patients under the Controlled Substances Act. With these exceptions the Food and Drug Administration recognizes and recommends certain mandatory warning and cautionary statements. In light of this fact, “[t]he decision of whether or not to grant approval of any new drug requires a careful balancing of its potential risks and benefits. All approved medications used in the legitimate practice of medicine are associated with adverse effects; [and] there is no a priori reason why marijuana should be different.” Professor Cohen concludes that it “would be contrary to the basic principles of medical ethics to forgo the use of these medications to treat the physical and emotional effects of chronic pain due to metastatic cancer because of fear that they might cause addiction.” Thus, the following discussion relates to the evaluation of the side-effects of legal substances in relation to the medicinal efficacy and side-effects associated with marijuana.

Many cancer patients take drugs such as prochlorperazin or zofran to relieve symptoms, but these drugs are extremely expensive and in some cases do not work. In contrast, “medicinal cannabis would be extremely inexpensive,” at rates which are supposedly 100 times less than the costs of these traditional treatment options. In addition to the prospective cost

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129 See 21 C.F.R. § 328.10 (West 2012).
131 21 C.F.R. §1308.12 (West 2012).
133 21 C.F.R. §1308.12 (West 2012).
136 Supra n. 9 at 52-53.
137 Id. at 69-70.
138 Supra n. 18 at 563.
139 Supra n. 84 at 102 (“[s]treet marijuana today costs $200-$400 an ounce, but the prohibition tariff accounts for most of that. A reasonable estimate of the cost of cannabis as a medicine is
efficacy, the push to legalize marijuana relates to the ineffectiveness or side-effects of common pain relievers for certain patients.\textsuperscript{140} For instance, painkillers such as COX-2 inhibitors, non-steroidal anti-inflammatory drugs (NSAIDs), and barbiturate-based medications are often attributed with cardiovascular and gastric distress (commonly in the form of ulcers), as well as increased incidence of liver toxicity.\textsuperscript{141} One such NSAID, Zomax\textsuperscript{®} (zomepirac), was placed on the market even though it was known as a potential carcinogen, and was not removed from commerce, even when patients began dying from anaphylactic reactions.\textsuperscript{142} An explanation for this occurrence may be found in the rationale that such substances could replace narcotic analgesics.\textsuperscript{143} 

NSAIDs dominate both the prescription and over-the-counter markets in terms of volume, yet opioid analgesics constitute the most effective remedies in the realm of pain management.\textsuperscript{144} An explanation for this phenomenon is likely that, “[u]nlike peripherally acting drugs, opioids relieve pain by acting directly on the central nervous system, binding with the receptors that are involved in the transmission of pain signals to the brain.”\textsuperscript{145} While effective, opioid analgesics are linked to widespread misuse and addiction.\textsuperscript{146} In addition to its addictive characteristics “[f]or a variety of reasons, patients respond variably to opioids and tend to develop tolerance to them after extended use.”\textsuperscript{147} Of course, as with opioids, “[m]arijuana’s analgesic potency may not be universally acceptable to all patients.”\textsuperscript{148} Others also may prefer the side-effects $10 to $20 an ounce, or about 25 cents per marijuana cigarette. As an example consider the following[\ldots] [b]oth the marijuana cigarette and an 8 mg ondansetron pill (cost $20) are effective in most cases for the nausea and vomiting of cancer chemotherapy (although many patients find cannabis to be more useful). Thus cannabis would be nearly 100 times less expensive than the best present treatment for the symptom.”).

\textsuperscript{140} See supra n. 3 at 56-57.
\textsuperscript{141} Id. at 56.
\textsuperscript{142} Id. at 57.
\textsuperscript{143} See id. at 56-57.
\textsuperscript{144} Id. at 56.
\textsuperscript{145} Id.
\textsuperscript{146} Id. at 61-63 (discussing the addictive qualities and abuse of OxyContin\textsuperscript{®} (oxycodone hydrochloride), Percocet\textsuperscript{®}, Percodan\textsuperscript{®}, Vicodin\textsuperscript{®}, and Lortab\textsuperscript{®}); see also Peter J. Cohen, Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology, 2009 Utah L. Rev. 35, 37-39 (2009).
\textsuperscript{147} Id. at 61.
\textsuperscript{148} See supra n. 9 at 74-75.
associated with traditional treatment remedies to the psychological ones associated with marijuana consumption. However, as noted, “marijuana is far less addictive than the opioids and there is no documented evidence of death.” Given these primary setbacks to opioids in treatment, it is unclear why the CSA prohibits marijuana as an alternative.

**Marijuana Substitutes**

Marijuana’s continued occupancy as a Schedule I controlled substance may be due to the availability of synthetic products meant to mimic marijuana’s effects, which have existed since 1986. Many patients and physicians, as well as the National Institute of Health, agree that the effects of synthetic substances cannot match additional medical benefits received through the direct inhalation of marijuana. Dronabinol (synthetic THC) products such as Marinol and Sativex™ present examples of this phenomenon. Forms of Dronabinol that must be taken orally are unhelpful to patients suffering from nausea. Additionally, Marinol reportedly can render a patient “virtually unconscious” with one dose. In response to this problem GW Pharma introduced Sativex™, an oral spray that is meant to mimic the levels of THC found in smoked marijuana, and “[s]everal published studies support the efficacy of Sativex™ in ameliorating the symptoms of neuropathic pain and spasticity.” Although it is argued that such findings could lead to the ultimate replacement of marijuana as a treatment option, as of

149 See supra n. 9 at 75 (“Side effects were mild and self-limited; however, two of the thirty-four subjects dropped out of the investigation because of unpleasant symptoms”).

150 See id. at 37.

151 See supra n. 38 at 275; see Garner supra n. 18 at 562.

152 Id. at 275-85; Garner, supra n. 18 at 562.

153 See supra n. 9 at 95.


156 Supra n. 9 at 97.

157 See id. at 98-99.

158 Id. at 99 (2009) (“In view of the scientific data presented above, it is quite possible that Sativex™ will be approved by the FDA in the next few years… since its rate of absorption is similar to that of smoked marijuana”).

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January, 2012, Sativex™ had not been approved for use in the United States. Finally, Dronabinol-infused products cost more than marijuana, which arguably restricts its application as a mass-market pain management therapy.

**Tripartite Standard of Analysis**

Marijuana’s potential use, in individualized pain management implicates a patient’s right to be free from pain under medical supervision. Fundamental or important rights are subject to a tri-level standard of analysis rooted in the Due Process Clauses of the 5th and 14th Amendments to the United States Constitution, which are applied separately, depending on whether the actor involved is a state or the federal government. A traditional reading of the Fifth Amendment's Due Process Clause shows it to protect the people of the United States from deprivation of life, liberty, or property, without due process of law. However, “[t]he Due Process Clause guarantees more than fair process, and the ‘liberty’ it protects includes more than the absence of physical restraint.” “[T]he guaranties of due process, though having their roots in Magna Carta’s ‘per legem terrae’ and considered as procedural safeguards ‘against executive usurpation and tyranny,’ have in this country ‘become bulwarks also against arbitrary legislation.’” That being said state and federal courts have refused to grant “fundamental right” status to a healthy environment, the right to refuse medical treatment, to direct the course

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160 *Supra* n. 9 at 99.

161 *See supra* pp. 12-22.

162 *See* U.S. Const. amend. V and XIV.

163 *See* U.S. Const. amend. V.

164 *See Raich v. Gonzales*, 500 F.3d 850, 861-62 (9th Cir. 2007) citing Washington v. Glucksberg, 521 U.S. 702, 719 (1997); *see also Planned Parenthood of S.E. Penn. v. Casey*, 505 U.S. 833, 847 (1992) (“It is tempting, as a means of curbing the discretion of federal judges, to suppose that liberty encompasses no more than those rights already guaranteed to the individual against federal interference by the express provisions of the first eight Amendments to the Constitution. But of course this Court has never accepted that view.” (internal citations omitted)).

of one’s treatment, the healing arts, medical use of marijuana, and self harm.\textsuperscript{166} However, lower courts have recognized the fundamental right to the choice of medical care.\textsuperscript{167}

A heightened level of review -strict scrutiny- applies when legislation that burdens a group’s exercise of a fundamental right “is so far from being commensurate with the individual interest” as to be arbitrary or pointless.\textsuperscript{168} Under strict scrutiny the fundamental nature of the right must be established through a showing that 1) the right or liberty is objectively “deeply rooted” in this nation’s history (as seen in our nation’s history, legal traditions, and practices); and 2) the right must be “carefully” described by those seeking its recognition.\textsuperscript{169} If the existence of the right is established, the court will test whether the regulation presents a substantial,\textsuperscript{170} severe, or significant\textsuperscript{171} obstacle to the exercise of that right; and, if so, the law will be found unconstitutional. The next tier involves what has been termed intermediate scrutiny.\textsuperscript{172} On occasion intermediate scrutiny has been applied to review a law that affects an important, though not constitutional, right.\textsuperscript{173} Under intermediate scrutiny the government must show that the challenged legislative enactment served important governmental objectives and is substantially related to the achievement of those objectives.\textsuperscript{174} In contrast, if a court declines to recognize a right as fundamental or important, then the law at issue will be subject only to rational basis scrutiny.\textsuperscript{175} The rational basis test requires that the petitioner prove that the government’s restriction bears no rational relationship to a legitimate state interest.\textsuperscript{176}

\begin{thebibliography}{99}
\bibitem{166} JAMES A. KUSHNER, \textit{GOVERNMENT DISCRIMINATION: EQUAL PROTECTION LAW AND LITIGATION} §6:25 Equal Protection Standards in Specific Cases (2011).
\bibitem{167} \textit{Id.}
\bibitem{169} See \textit{id.} at 721.
\bibitem{170} \textit{Casey, supra} n. 165 at 877.
\bibitem{174} \textit{Id.}
\bibitem{175} \textit{Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach}, 495 F.3d 695, 712 (D.C. Cir. 2007).
\bibitem{176} \textit{Id.} at 712 (citing: \textit{Washington v. Glucksberg}, 521 U.S. 702 (1997)).
\end{thebibliography}
A Fundamental Right

The fundamental right at issue here must be couched an area of constitutional jurisprudence that has not been entirely settled. In Raich v. Gonzales, the Ninth Circuit recognized that marijuana could be subject to “emerging awareness” model that the Supreme Court used in Lawrence v. Texas, but ultimately found that medical marijuana had not yet garnered enough support to be recognized. Although the Ninth Circuit agreed that medical and conventional wisdom recognized the use of marijuana for medical purposes, it maintained that such recognition had not yet reached the point where marijuana use could be considered a fundamental right. Thus, the right must be couched somewhere other than the emerging awareness doctrine.

The most relevant recent decision by the Supreme Court in the area of pain management and medical treatment is Washington v. Glucksberg, a case involving physician-assisted suicide. In Glucksberg, the Court cites a variety of fundamental liberties protected by the due process clause, including: the right to marry and to marital privacy, to have children and to direct education and upbringing of one’s children, and to bodily integrity, including abortion. It also holds that other additional rights or liberties may be identified if they are 1) objectively “deeply rooted” in this nation’s history (as seen in our nation’s history legal traditions, and practices); and 2) capable of careful description by those seeking its recognition. As applied to physician-assisted suicide, the Court found that 1) this nation has never historically accepted suicide as legitimate, and 2) that it was subject to abuse through inclusion of more than just competent adults. However, the Court in Glucksberg references its decision in Cruzan v. Dir.,

178 500 F.3d 850, 865-66 (9th Cir. 2007).
179 539 U.S. 558, 578-9 (2003) (“Had those who drew and ratified the Due Process Clauses of the Fifth Amendment or the Fourteenth Amendment known the components of liberty in its manifold possibilities, they might have been more specific. They did not presume to have this insight. They knew times can blind us to certain truths and later generations can see that laws once thought necessary and proper in fact serve only to oppress. As the Constitution endures, persons in every generation can invoke its principles in their own search for greater freedom.”).
180 Raich, supra n. 1 at 865-66 (9th Cir. 2007) (citing Gonzales v. Raich, 545 U.S. 1 (2005)).
182 Glucksberg, supra n. 168 at 720.
183 See id. at 720-21.
184 See id. at 721-36.
Missouri Dept. of Health in which it agreed that a lucid person can refuse life-sustaining treatment. The Court also references Planned Parenthood of S.E. Pennsylvania v. Casey, where it affirmed the right of a woman to choose to have an abortion. Thus, a degree of obscurity remains regarding the scope of the individual right to choose in health-related contexts.

Since its enunciation, the “Glucksberg Doctrine” has been broken down by one scholar into five distinct principles: restraint, narrow description, narrow precedent, history and tradition, and tiered review. Each of these principles is aimed at ensuring the very narrowest tailored description of a right to be recognized by the Supreme Court. In the past the Court has recognized a fundamental right to bodily integrity, the right to decline antipsychotic drug treatment, the right to define one’s own concept of existence, of meaning of the universe and of the mystery of human life, and “the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters… fundamentally affecting a person.” The common thread in these cases involves the individual’s interest in controlling the highly personal realms of healthcare and morality. Yet, the area remains unclear, as evidenced by the D.C. Circuit’s refusal to allow terminally-ill patients access to experimental drugs which have passed Phase I clinical testing in Abigail Alliance for Better Access to Developmental Drugs v.

187 See supra n. 177 at 283.
189 See id.
192 Lawrence v. Texas, 539 U.S. 558, 574 (2003) (“At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State”) (citing Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (1992)).
193 Casey, supra n. 165 at 851-52 (1992) (citing Eisenstadt v. Baird, supra, 405 U.S., at 453, 92 S.Ct., at 1038 (emphasis in original)).
However, it did “not address the broader question of whether access to medicine might ever implicate fundamental rights.”

The D.C. Circuit in Abigail declined to recognize the right of patients to seek the use of experimental medications because to do so would disregard our Nation’s history of regulating the safety of drugs, in general. “Thus, to succeed on its claim of a fundamental right of access for the terminally ill to experimental drugs, the Alliance [would have had to] show not only that there is a tradition of access to drugs that have not yet been proven effective, but also a tradition of access to drugs that have not yet been proven safe.” Of course, that litigation involved not analgesics, but drugs specifically aimed at curing, rather than alleviating, the symptoms of cancer through the use of “experimental cancer drugs [that] ‘have potentially lethal toxicity, with potentially large effects on a patient's remaining quality of life.’” Still, no circuit court has yet acceded to an affirmative access claim in pain management, leaving to debate whether the Supreme Court would in fact recognize the right to access medicine, in whatever form.

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194 495 F.3d 695, 701 (D.C. Cir. 2007).
195 Abigail, 495 F.3d at 701.
196 Id. at 703.
197 Id.
198 Id. at 700.
199 Id. at 726 n. 18 (“See, e.g., Mitchell v. Clayton, 995 F.2d 772, 775 (7th Cir.1993) (“most federal courts have held that a patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider’’); N.Y. State Ophthalmological Soc’y v. Bowen, 854 F.2d 1379, 1389 (D.C.Cir.1988) (“We disagree that the constitutional right to privacy comprehensively protects all choices made by patients and their physicians or subjects to ‘strict scrutiny’ all government interference with choice of medical treatment. There is no basis under current privacy case law for extending such stringent protection to every decision bearing, however indirectly, on a person's health and physical well-being.”), cert. denied, 490 U.S. 1098, 109 S.Ct. 2448, 104 L.Ed.2d 1003 (1989); Carnohan v. United States, 616 F.2d 1120, 1122 (9th Cir.1980) (“Constitutional rights of privacy and personal liberty do not give individuals the right to obtain [the cancer drug] laetrile free of the lawful exercise of government police power.”); Rutherford v. United States, 616 F.2d 455, 457 (10th Cir.1980) (“[T]he patient[s] ... selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health. The premarketing requirement of the [FDCA], 21 U.S.C. § 355, is an exercise of Congressional authority to limit the patient's choice of medication. This is clear under the [Supreme Court's] decisions ....”), on remand from 442 U.S. 544, 99 S.Ct. 2470, 61 L.Ed.2d 68 (1979), cert. denied, 449 U.S. 937, 101 S.Ct. 336, 66 L.Ed.2d 160 (1980); see also Sammon v. N.J. Bd. of Med. Exam'rs, 66 F.3d 639, 645 n. 10 (3d Cir.1995); United States v. Burzynski Cancer Research Inst., 819 F.2d 1301, 1313-14 (5th Cir.1987); cf. Lambert v. Yellowley, 272 U.S. 581, 588, 590, 596-97, 47 S.Ct. 210, 71 L.Ed. 422 (1926) (where Congress determined, in
Careful Description of the Right to be recognized

The mere existence of a right is not constitutionally dispositive as to the law being challenged. The right to be protected must be carefully described by those seeking its recognition. Scholars have defined the right to employ marijuana in medical treatment as: the right to controversial medical treatment, the right to medical autonomy through the pursuance of adequate healthcare decisions, the right to live, the right to die with dignity, the right to avoid pain, and the right to bodily integrity. While some of these rights have been recognized in other contexts, none have led to the allowance of marijuana as a treatment option in the context of pain management, generally because those rights, as enunciated, were not sufficiently narrowly-tailored to achieve that purpose.

implementing Prohibition, that “practicing physicians differ about the value of malt, vinous and spirituous liquors for medicinal purposes, [and] that the preponderating opinion is against their use for such purposes,” the Court rejected a physician's claim of a constitutional right to “use ... such medicines and medical treatment as in his opinion are best calculated to effect [his patients'] cure and establish their health,” holding that “there is no right to practice medicine which is not subordinate ... to the power of Congress to make laws necessary and proper.... High medical authority being in conflict as to the medicinal value of spirituous and vinous liquors taken as a beverage, it would, indeed, be strange if Congress lacked the power to determine that the necessities of the liquor problem require a limitation of permissible prescriptions....”); Watson v. Maryland, 218 U.S. 173, 176, 30 S.Ct. 644, 54 L.Ed. 987 (1910) (“It is too well settled to require discussion at this day that the police power of the States extends to the regulation of certain trades and callings, particularly those which closely concern the public health. There is perhaps no profession more properly open to such regulation than that which embraces the practitioners of medicine”).

See Casey, supra n. 165 at 873 (plurality opinion) (“not every law which makes a right more difficult to exercise is, ipso facto, an infringement of that right”).


See supra n. 21.

See supra n. 171 at 1985.

Id.

Id.

Supra n. 155 at 253-54.

See e.g.: Raich, supra n. 1.
New Mexico’s Controlled Substances Act\(^\text{208}\) provides definitional narrowing of the right to be protected through establishing specific conditions or requirements for those wishing to use marijuana. For instance, the Act constricts the general availability of the drug to debilitating conditions such as: cancer, glaucoma, multiple sclerosis, damage to nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, HIV/AIDS, admission to hospice, or “any other medical condition or disease as approved by the Department of Health pursuant to recommendations by the advisory board.”\(^\text{209}\) Thus, because proving a fundamental right relies on the proper and narrow framing of the right at issue, it is helpful to identify the “ideal plaintiff” who might at some later date challenge the statute. In New Mexico, a hypothetical challenger of the federal CSA is a pain patient who qualifies for medicinal use under New Mexico’s compassionate use provision.

Take, for instance, an AIDS patient experiencing wasting syndrome who, upon being arrested, seeks to challenge the CSA. That person’s right would be centered on a desire to use marijuana because it betters his life through the stimulation of chemical receptors in the brain which reduce his physical perception of pain and nausea, and because it stimulates his appetite. This equates to a right to be free from pain, and to seek professional approval to employ marijuana for that purpose. Thus, in arguing against the application of the federal CSA in this realm, the argument for legalization of medical marijuana must be framed in the language of pain, pain management, and medicinal efficacy. The fundamental right at issue is, therefore, the right to be free from pain through the use of controlled substances under the supervision of a physician who believes that the risks of the treatment given are outweighed by the medical benefits of that treatment. This framing of the right bridges the gap between the theories offered by prior scholars, and leaves open the application of medical autonomy for a physician who believes that the risks of medical marijuana outweigh any benefit it might pose for a particular patient.

**Analysis and implications**

The standard enunciated in *Glucksberg* requires that any additional right or liberty to be recognized by a court must be 1) objectively “deeply rooted” in this nation’s history; and 2) capable of careful description by those seeking its recognition.\(^\text{210}\) In the context of medicinal marijuana, the availability and utilization of alternative pain management treatment options is “deeply rooted” in our nation’s history.\(^\text{211}\) Additionally, the right to be protected (to be free from pain through the use of controlled substances under the supervision of a physician who believes that the risks of the treatment given are outweighed by the medical benefits of that treatment) is capable of narrow formulation, given the restrictive nature of FDA scheduling process\(^\text{212}\) and


\(^{210}\) *Glucksberg*, supra n. 168 at 720-1.

\(^{211}\) See supra pp. 2-5.

\(^{212}\) See supra pp. 9-10.
current state rescheduling efforts.\textsuperscript{213} Therefore, at least under the first prong of the \textit{Glucksberg} analysis, the right in itself is “fundamental.” As such, governmental infringement or regulation of the right is subject to strict scrutiny, a balancing analysis which pits the individual liberty interest against the utility of the government’s reason for so burdening it.\textsuperscript{214}

\textit{Glucksberg} and \textit{Abigail Alliance} provide illustrative foils for why the right implicated here ought to be recognized in lieu of the government’s general goal of “providing for uniformity in drug control.”\textsuperscript{215} Those cases involved the right to employ physician-assisted suicide to ease the pain and indignity of long-term suffering\textsuperscript{216} and the right to employ experimental treatments not yet approved by the FDA.\textsuperscript{217} The courts involved in both cases declined to extend fundamental right status to either because there was little to no evidence that either had been recognized throughout the history of the United States.\textsuperscript{218} Additionally, both rights were outweighed by the state’s interest in protecting patients from their own treatment decisions due to the assuredly fatal nature of assisted suicide and potentially toxic alternative cancer-treatment therapies.\textsuperscript{219} In contrast, medicinal use of marijuana in pain management presents a pain-management option that has never proven fatal, but which could actually alter an individual patient’s perception of symptoms associated with a debilitating illness.\textsuperscript{220} Unlike the potentially toxic experimental drugs in \textit{Abigail}, marijuana’s risks and benefits are well documented, thereby allowing physicians and patients to make truly informed decisions for the management of a patient’s symptoms, rather than seeking out an untested last-resort cure. Given these assertions, the CSA’s goal of providing uniformity in drug control through deferential scheduling is not narrowly tailored enough to sufficiently protect an individual’s patient’s right to seek out an alternative pain management remedy.

As a fundamental right, the government’s regulation of the medical substance treatments available to individuals ought to be narrowly tailored to achieve an important governmental interest. However, at least according to the federal CSA, marijuana has no accepted medical use in this country. This presents a dichotomy between the assumedly objective scheduling process and current state-sanctioned medicinal marijuana programs. It also unduly restricts individual

\textsuperscript{213} See supra pp. 10-11.


\textsuperscript{215} See supra n. 38 at 277.

\textsuperscript{216} \textit{Glucksberg}, supra n. 168 at 707.

\textsuperscript{217} \textit{Abigail Alliance}, 495 F.3d 695, 700.

\textsuperscript{218} See supra pp. 26-27.

\textsuperscript{219} Id.

\textsuperscript{220} See supra pp. 12-23.
patient’s access to a potential symptomatic remedy by disallowing marijuana’s use, even though evidence indicates that is has therapeutic efficacy if administered correctly.\textsuperscript{221} The CSA’s scheduling requirements and subsequent processing by the DEA ought to reflect knowledge indisputably grounded in fact. Based on responses to rescheduling petitions, they fail to do so.\textsuperscript{222} Thus, the CSA violates the rights of the people to seek alternative treatment options, such as medical marijuana, if recommended and monitored by a licensed physician in the face of contradicting implications of the benefit or harms caused by a particular course of medical treatment because it fails to recognize a useful alternative treatment option. The CSA is, therefore, not narrowly tailored and fails to pass constitutional muster.

\textbf{An Important Right}

The Supreme Court has developed an intermediate level of scrutiny that lies “between the extremes of rational basis review and strict scrutiny.”\textsuperscript{223} Intermediate scrutiny has been applied to review a law that affects “an important, though not constitutional, right.”\textsuperscript{224} Under intermediate scrutiny, the government must show that the challenged legislative enactment is substantially related to an important governmental interest.\textsuperscript{225} A variety of subjects have been granted status as important rights including: the right to move about freely,\textsuperscript{226} the right to vote,\textsuperscript{227} the right to equal education,\textsuperscript{228} the right to equal protection from statutes relying on sex as a decision making factor,\textsuperscript{229} and the right to access partial-birth abortion.\textsuperscript{230} The common thread in these decisions is the ability for an individual American to act autonomously in spheres of personal choice. The right at issue, which would allow for the employment of marijuana as an alternative treatment option under proper medicinal supervision, is similar to those rights because it implicates personal autonomy in pain management. Of course, this is not to say that the government can never legislate in such fields, but the law requires it to avoid absolute

\begin{itemize}
\item \textsuperscript{221} See supra pp. 19-23.
\item \textsuperscript{222} See supra n. 53.
\item \textsuperscript{223} Clark v. Jeter, 486 U.S. 456, 461 (1988).
\item \textsuperscript{224} Id. (citing, Coleman, 166 F. 3d. at 431; cf. Plyer, 457 U.S. at 223 (applying, without labeling it as such an intermediate form of scrutiny to review of a law that implicated right to education)).
\item \textsuperscript{225} Id. (citing, Wengler c. Druggists Mut. Ins. Co., 446 U.S. 142 (1980); Craig v. Boren, 429 U.S. 190, 197 (1976)).
\item \textsuperscript{226} See Ramos v. Town of Vernon, 353 F.3d 171 (2nd Cir. 2003).
\item \textsuperscript{227} See Gomillion v. Lightfoot, 364 U.S. 339, 340 (1960).
\item \textsuperscript{228} See Griffin v. County Sch. Bd. of Prince Edward County, 377 U.S. 218, 222 (1964).
\item \textsuperscript{229} See Craig, supra n. 173 at 202.
\item \textsuperscript{230} See Stenberg v. Carhart, 530 U.S. 914 (2000).
\end{itemize}
prohibition or unduly burdening fundamental rights, unless the reasons for such restrictions are substantially related to an important government interest.\footnote{231}{See Mary Helen Wimberly, Rethinking the Substantive Due Process Right to Privacy: Grounding Privacy in the Fourth Amendment, 60 Vand. L. Rev. 283, 313-4 (2007).}

In \textit{Stenberg v. Carhart}, the Supreme Court, in an opinion by Justice Breyer, spent a great deal of time considering the potential risks and benefits associated with a variety of techniques in performing abortion. Specifically, the Court made reference to the fact that partial birth abortion is safer than completing the procedure intra-uterine due to the risk of perforation to a patient’s surrounding organs and tissues.\footnote{233}{Id.} Ultimately, the Court found that the Nebraska law in question unconstitutionally burdened the class at issue, women, in that it discouraged them from employing their right to (partial-birth) abortion at all, due to its failure to provide an exception for the preservation of the health of the mother.\footnote{234}{Id. at 923-32.} Thus, in analyzing the applicability of restrictive statutes on important rights, the Court shows deference to the risks and benefits or side-effects of performing one procedure over another.\footnote{235}{Id. at 923-32.} However, if the prohibition of one such option, of which the court in \textit{Carhart} had many, actually infringes upon the right to choose to exercise the right (to have an abortion) itself, such restrictions must be found unconstitutionally undue.\footnote{236}{See John A. Robertson, \textit{Embryo Culture and the “Culture of Life”: Constitutional Issues in the Embryonic Stem Cell Debate}, 2006 U. CHI. LEGAL F. 1 (2006).} The importance of the governmental interest in regulating the area in which the right resides is overridden by the fundamental nature of said right.

The federal government enjoys sweeping authority in regulating potentially addictive substances,\footnote{237}{See supra pp. 5-11.} much more than it does in regulating the mostly state-based realm of abortion.\footnote{238}{See Carhart, supra n. 230 at 921.} Still, the right to individual protection in pain management is more important than the governmental interest behind the CSA. That interest relates to controlling the trafficking of controlled substances as they move through interstate commerce;\footnote{239}{21 U.S.C.A. § 801(3) (West 2012)} at least, that was the basis upon which the Supreme Court verified Congress’ power to regulate marijuana.\footnote{240}{See Gonzales v. Raich, 545 U.S. 1 (2005).} Thus, as in
Carhart, the risks (and benefits) of providing qualified patients with access to an additional treatment options must be weighed against an absolute prohibition. Like with the risks and benefits inherent to different forms of abortion, so are there risks and benefits incurred by different drug therapies and pain management systems, and in this way, marijuana is no different from those therapies currently in legal use. Thus, the absolute federal prohibition of marijuana, which inarguably discourages patients from employing it as a treatment option, unconstitutionally burdens a class of patients who would otherwise seek to exercise their right to alternative pain management therapies.

Given the burden involved, the final correlation between Carhart and the right at issue relates to whether other available treatment options can, on balance, provide safe and effective relief in light of a patient’s overall condition. There are alternative marijuana-based treatment options available to patients under the CSA, just as there were alternative ways for a woman in Nebraska to seek out and have an abortion. However, the Court’s ruling in Carhart focused specifically on the fact that the availability of alternatives was insufficient if the regulation denied a method that was safer for the mother. As applied to marijuana, there are supported side effects of smoking cannabis that have not yet been legally replicated by marijuana substitutes in the United States and benefits associated with its use as an alternative to an opioid or NSAID. Thus, Congress has unduly burdened a pain or nausea-stricken patient’s right to access to marijuana to alleviate their pain through entirely disallowing its use. The legal and illegal trafficking of controlled substances is already regulated under the Controlled Substances Act, and rescheduling marijuana so that it is available for legitimate medical use would in no way change the functioning of that important governmental interest because recreational misuse of the drug would still be subject to governmental control, just like other controlled substances, under the reformed CSA.

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241 Supra n. 87 at 555 (“[o]ne parent tells the following story of her son’s fight against testicular cancer and the effects of chemotherapy: As a parent I was strongly opposed to marihuana [sic] and other illegal drugs... But we were desperate”).

242 See supra pp. 19-23.

243 See supra n. 235 at 937 (“[w]here a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view, we cannot say that the presence of a different view proves the contrary”).

244 See supra pp. 22-23.

245 See supra pp. 19-23.

246 See supra pp. 5-11.
Irrational Regulation

The last standard of review to be applied looks to whether the law is rationally related to a legitimate government interest.247 A law will typically survive this level of scrutiny unless the plaintiff overcomes the overwhelming burden of proving that the law is wholly irrational.248 The rational basis test requires only that the means employed by the statute be rationally related to legitimate state goals, and not that the means be the best way of achieving that goal.249 “It is conventional constitutional doctrine that where reasonable people disagree the government can adopt one position or the other.”250 That principle, however, assumes a state of affairs in which the government’s choice does not intrude upon a protected liberty.251 Thus, “[i]f marijuana criminalization abridges constitutional guarantees… it must be abandoned.”252

The Supreme Court of Washington in Seeley v. State253 held that the Washington legislature’s decision to classify marijuana as a Schedule I controlled substance did not violate rational basis. Their reasoning relied on the premise that “legislative acts are presumed constitutional… unless proved to be arbitrary or obsolete,”254 and an assumption that the agencies responsible had objectively weighed the evidence relating to marijuana. However, this reasoning was based upon the report filed by the DEA Administrator, Robert C. Bonner, in Alliance for Cannabis Therapeutics v. Drug Enforcement Admin.255 As has been discussed, Mr.


248 Id.


250 Casey, supra n. 165 at 851 (citing e.g., Ferguson v. Skrupa, 372 U.S. 726, 83 S.Ct. 1028, 10 L.Ed.2d 93 (1963); Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955)).

251 Casey, supra n. 165 at 851 (citing West Virginia Bd. of Ed. v. Barnette, 319 U.S. 624, 63 S.Ct. 1178, 87 L.Ed. 1628 (1943) (“Thus, while some people might disagree about whether or not the flag should be saluted, or disagree about the proposition that it may not be defiled, we have ruled that a State may not compel or enforce one view or the other”); Texas v. Johnson, 491 U.S. 397, 109 S.Ct. 2533, 105 L.Ed.2d 342 (1989)).


253 940 P.2d 604, 613-14 (Wash. 1997).

254 Seeley supra n. 249 at 613-14 (citations omitted).

255 Id. at 615 (Wash. 1997) (citing Alliance for Cannabis Therapeutics v. Drug Enforcement Admin 15 F.3d 1131 (D.C.Cir.1994)).
Bonner’s critique is best characterized by his arbitrary conclusion that “there are no adequate, well-controlled scientific studies proving marijuana is effective for anything.” Still, the State maintained that placing marijuana in Schedule I was rationally related to its dual interest in controlling potential drug abuse and assuring efficacy and safety in medicines, asserting that “[i]t is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it.” Given this finding, the Washington Supreme Court declined to interfere with its legislature’s prerogative in issuing scheduling decisions because it was supported by “substantial evidence.”

Abigail again bears mentioning in this context. After the D.C. Circuit determined that no fundamental right existed to access experimental cancer treatments, it held: “we cannot say that the government’s interest does not bear a rational relation to a legitimate state interest.” This was found because “[f]or the terminally ill, as for anyone else, a drug is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefit.” The court concluded: “[a]lthough terminally ill patients desperately need curative treatments…their deaths can certainly be hastened by the use of a potentially toxic drug with no proven therapeutic benefit[:] [t]hus, we must conclude that, prior to distribution of a drug outside of controlled studies, the Government has a rational basis for ensuring that there is a scientifically and medically acceptable level of knowledge about the risks and benefits of such a drug.” In the context of the various medical opinions available as to marijuana’s efficacy, the government cannot assert an interest in protecting patients as it did in Abigail.

256 See Marijuana Scheduling Petition; Denial of Petition; Remand, 57 FR 10499-02 (1992) (emphasis added).

257 Seeley supra n. 249 at 616.


259 Id. at 622.


261 Id. at 712 (citing United States v. Rutherford, 442 U.S. 544, 99 S.Ct. 2470, 61 L.Ed.2d 68 (1979) (which stands for the proposition that a drug is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefits).

262 Id. (citing United States v. Rutherford, 442 U.S. 544, 99 S.Ct. 2470, 61 L.Ed.2d 68 (1979) (which stands for the proposition that a drug is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefits).

263 Id. at 713.
What distinguishes the topic at hand from Seeley and Abigail is the nature of the remedy to be regulated and the effect that marijuana’s prohibition has upon a patient’s right to seek relief from its use. The deference given to the Washington Legislature by the Court in Seeley was inappropriate, because it supplanted its own role by allowing governmental interference with a historically-recognized constitutional guarantee without critically reviewing the evidence supporting the legislature’s decision. What that Court should have employed is the comparative distinction referenced in Abigail, which focuses on the government’s ultimate prerogative to protect seriously-ill individuals from untested and potentially-toxic treatment options. Without that more narrowed analysis, there is no rational basis for the absolute prohibition and subsequent restriction on a seriously ill-person’s right to use medical marijuana.

A putative right to employ medical marijuana as a pain management treatment option has been established through the foregoing discussions relating to heightened levels of constitutional scrutiny. Therefore, prohibitory criminalization of cannabis in any form is repugnant to the general rule that an irrational restriction of a protected liberty is constitutionally void. Further, the contradictory evidence adduced in Seeley and presented above establishes that, contrary to the findings of Mr. Bonner, there is at least some therapeutic efficacy in marijuana use, even if the exact particulars remain debated. Finally, unlike the potentially toxic experimental medications at issue in Abigail, which most would agree the government should prevent from unfettered dissemination to the public; marijuana has never been associated with a death due to overdose or improper use.

States like New Mexico and Tennessee offer an even simpler argument: under Schedule I of the Federal Controlled Substances Act, a drug has “no currently accepted medical use in the United States;” however, the states’ acceptance of medical marijuana as a medical treatment option directly contradicts this implication. An argument is “irrational” when it is “not in accordance with reason and utterly illogical.” The CSA places drugs on Schedule I that

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264 See supra n. 255.

265 See supra n. 263.

266 See supra n. 252.

267 Probably because the lethal dose would require ingestion of 20,000 times the amount of marijuana generally contained in one marijuana cigarette. See supra n. 252 at 65 (2009).

268 Supra n. 75.


have no currently accepted medicinal value in the United States. Given that the purpose of the CSA is to provide uniformity in drug regulation, scheduling ought to be based on objective scientific findings.\textsuperscript{271} Marijuana has a currently accepted use in the United States as is evidenced by the twenty-two State laws decriminalizing its use for medical purposes.\textsuperscript{272} Concluding this line of reasoning is the proposition that marijuana ought not to belong on Schedule I. The statute, proven illogical, is, therefore, irrational, causing the federal CSA to fail under the rational test basis test, which renders the entire structure (and integrity) of the federal CSA unconstitutional.

**Conclusion**

Although current federal law is blind to the efficacy of marijuana as a viable pain-management treatment, the day has come for courts of the United States to recognize the liberty interest inherent in this country’s support of personal autonomy in medical treatment. Patients who suffer from debilitating medical conditions deserve to exercise their right to be free from pain if their decision to use medicinal marijuana is supported by a treating physician, taking into consideration the risks and benefits of its use in the context of that individual patient’s prognosis. Concerns relating to treatment efficacy and detrimental side effects have been ignored. Given the historical support for the employment of alternative treatment, there is a fundamental, important, and recognizable right associated with a patient and doctor’s ability to seek the best course of drug therapy for pain, nausea and other physiological symptoms. Therefore, as applied to patients seeking relief from symptoms of debilitating disease, the government’s prohibition of the substance should be rejected.


\textsuperscript{272} See state statutes *supra* n. 72.