BUDDING SUPPORT: HOW PROFESSIONAL ATHLETES CAN COMBAT OPIOID ABUSE BY ADVOCATING FOR THE FEDERAL LEGALIZATION OF MARIJUANA

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I. INTRODUCTION

The misuse of prescription opioids has been increasingly recognized as one of the United States' "most significant public health problems."[1] This is because opioid abuse can lead to substance use disorders, physical impairment, mental impairment, and even death.[2] Professional athletes in particular face the risk of opioid misuse due to their constant injuries leading to chronic pain. One proposed alternative to combat painkiller abuse is medical marijuana.

Despite the growing acceptance of marijuana use for medical purposes, it remains federally illegal. Professional athletes are particularly affected by this prohibition, and many have expressed their frustration with restrictions and their support for its legalization. As more states legalize medical marijuana, a patchwork of state laws has left groups, including professional sports teams, with little guidance on how to regulate marijuana within their drug policies. This Comment will explore the effects of the Federal Controlled Substances Act ("CSA")[3], evolving views on marijuana as a medicine for chronic pain, how professional athletes, in particular, are affected by the opioid epidemic, and

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1 Linda B. Cottler et al., *Injury, Pain and Prescription Opioid Use Among National Football League (NFL) Players*, 116 DRUG & ALCOHOL DEPENDENCE 188, 188 (2011); *see* NAT'L INST. ON DRUG ABUSE, MISUSE OF PRESCRIPTION DRUGS RSCH. REP. 3 (2020).

2 Cottler, *supra* note 1, at 188.

3 21 U.S.C. § 801 *et seq.*

how these athletes can advocate for a federal solution in rescheduling marijuana within the CSA.

Part II of this Comment provides an overview of current federal and state marijuana regulations, evolving views on marijuana as medicine, pain medication abuse in professional athletes, and professional sports leagues' current marijuana policies. Part III analyzes current and expected barriers blocking the federal legalization of marijuana. Lastly, Part IV poses solutions for the advancement of medical marijuana use legalization, particularly for professional athletes to treat injuries. This Comment concludes that, while marijuana is increasingly being recognized as a medicine and being legalized by the states, marijuana remains federally illegal and professional athletes provide a unique and public example of why a federal solution is necessary.

In this Comment, I will argue that the unnervingly high rate of painkiller abuse among current and retired professional athletes provides a strong argument favoring the federal legalization of medical marijuana. I will pose that these celebrity athletes are in a unique position and, as a result, should advocate for the legalization of medical marijuana while pushing for further research, deliberation, and action by the federal government.

II. BACKGROUND

A. *The Controlled Substances Act*

The CSA was enacted in 1970 with the goal of classifying and regulating various controlled substances in the United States.[4] Congress recognized that many controlled substances have accepted medical purposes and are "necessary to maintain the health and general welfare of the American people."[5] Congress sought to regulate the "illegal importation, manufacture, distribution, and possession and improper use of controlled substances," because they have a "substantial and detrimental effect on the health and general welfare of the American people."[6]

[4] *See* Michael Gabay, *The Federal Controlled Substances Act: Schedules and Pharmacy Registration*, 48 HOSP. PHARMACY 473, 473–74 (2013).

[5] 21 U.S.C. § 801(1).

[6] 21 U.S.C. § 801(2).

The CSA was passed as part of a greater initiative during President Richard Nixon's term to strictly regulate the use, distribution, and trade of controlled substances in the "War on Drugs."[7] Nixon infamously stated that drug abuse was "public enemy number one" in the United States.[8] Although the goal of the CSA was to regulate dangerous drugs, many question whether there was an underlying political motive discriminating against "hippies" and "blacks."[9] Marijuana particularly comes under scrutiny in debates over whether Congress had an ulterior motive in passing the CSA.[10] John Ehrlichman, Nixon's domestic policy adviser, in a 1994 interview expressed the motives of the Nixon administration:

> The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.[11]

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[7] *War on Drugs*, HISTORY.COM (Dec. 17, 2019), https://www.history.com/topics/crime/the-war-on-drugs.

[8] *Id.*

[9] *See* DAN BAUM, LEGALIZE IT ALL: HOW TO WIN THE WAR ON DRUGS (2016); *see also* Erik Sherman, *Nixon's Drug War, An Excuse To Lock Up Blacks And Protesters, Continues*, FORBES (Mar. 23, 2016, 6:00 AM), https://www.forbes.com/sites/eriksherman/2016/03/23/nixons-drug-war-an-excuse-to-lock-up-blacks-and-protesters-continues/?sh=5838a7c642c8; John Hudak, *How Racism and Bias Criminalized Marijuana*, WASH. POST (Apr. 28, 2016), https://www.washingtonpost.com/news/in-theory/wp/2016/04/28/how-racism-and-bias-criminalized-marijuana/.

[10] *See* Amy Nordrum, *Why is Marijuana a Schedule I Drug?*, INT'L BUS. TIMES (Feb. 19, 2015, 1:33 PM), https://www.ibtimes.com/why-marijuana-schedule-i-drug-1821426.

[11] BAUM, *supra* note 9.

Marijuana was "temporarily" placed on Schedule I when the CSA was enacted, though remained subject to review.[12] "[T]he National Commission on Marihuana and Drug Abuse issued a series of reports" acknowledging that marijuana was not a serious threat to the public health and recommending that federal law permit possession of small amounts.[13] Despite the Commission's advice, many Americans and politicians were fearful of the drug's negative effect on society; ultimately, marijuana was kept on Schedule I.[14]

"Under the CSA, substances are categorized into five schedules" based on their medical "benefit and their potential to result in abuse."[15] The most restrictive is Schedule I.[16] Schedule I substances have "no currently accepted medical use in treatment" and pose a high potential for abuse.[17] "[H]eroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ('Ecstasy')" are all listed as Schedule I substances.[18] Schedule II substances also pose a high risk for abuse; however, Schedule II substances have "a currently accepted medical use."[19] A currently accepted medical use is required for a drug to be placed on a schedule lower than Schedule I.[20] The CSA does not define "medical use," but the "Drug Enforcement Administration ["DEA"] has developed criteria that must be met to establish accepted medical use."[21] The following factors must be met: "the drug's chemistry must be known and reproducible, there must be adequate safety studies, there must be adequate and well-controlled studies proving efficacy, the drug must be accepted by qualified experts, and the

12 Nordrum, *supra* note 10.

13 Nordrum, *supra* note 10; *see also* U.S. NAT'L COMM'N ON MARIHUANA & DRUG ABUSE, MARIHUANA: A SIGNAL OF MISUNDERSTANDING (1972).

14 Nordrum, *supra* note 10.

15 Alice Mead, *Legal and Regulatory Issues Governing Cannabis and Cannabis-Derived Products in the United States*, 10 FRONTIERS PLANT SCI. 1, 2 (2019).

16 *Id.*

17 21 U.S.C. § 812(b)(1).

18 *Controlled Substance Schedules*, U.S. DEP'T JUST. DRUG ENF'T ADMIN. DIVERSON CONTROL DIV. [hereinafter DEA], https://www.deadiversion.usdoj.gov/schedules/ (last visited July 6, 2022).

19 21 U.S.C. § 812(b)(2).

20 *See* 21 U.S.C. § 812(b)(2)–(5).

21 Mead, *supra* note 15, at 2–3.

scientific evidence must be widely available."[22] A substance may be placed in Schedule II if it has a currently accepted medical use, with severe restrictions.[23] Schedule II substances include opioids such as hydromorphone, methadone, meperidine, oxycodone, fentanyl, morphine, opium, codeine, and hydrocodone.[24] Examples of Schedule II stimulants include amphetamine (Adderall), methamphetamine, and methylphenidate (Ritalin).[25] Schedules III, IV, and V substances have a currently accepted medical use and fewer abuse potential findings.[26] Examples include Xanax, Tylenol with codeine, and anabolic steroids such as Depo-Testosterone.[27]

Reforming the CSA requires a rather comprehensive process. To reduce restrictions on a controlled substance, an interested person, the DEA, or the Department of Health and Human Services ("HHS")/Food and Drug Administration ("FDA") may initiate an action to reschedule a drug.[28] Rescheduling under federal law is conducted through an administrative process where the FDA conducts a full assessment of the substance's abuse potential, the DEA publishes a proposed rule in the Federal Register, and the DEA responds to public comments or objections before publishing a Final Rule rescheduling the substance.[29] The Attorney General has delegated the responsibility to transfer a substance between schedules to the Acting Administrator of the DEA.[30] Congress may also schedule, reschedule, or deschedule a substance by enacting a law.[31]

Around the time that the National Commission on Marihuana and Drug Abuse issued its report on marijuana guidance, an organization known as the National Organization for the Reform

22 Mead, *supra* note 15, at 3.

23 21 U.S.C. § 812(b)(2).

24 DEA, *supra* note 18.

25 DEA, *supra* note 18.

26 21 U.S.C. § 812(b)(3)–(5).

27 DEA, *supra* note 18.

28 21 U.S.C. § 811(a); 21 C.F.R. § 1308.43(a).

29 Mead, *supra* note 15 at 3.

30 U.S. DEPT. OF JUST., DRUG ENF'T ADMIN., SCHEDULE OF CONTROLLED SUBSTANCES: MAINTAINING MARIJUANA IN SCHEDULE I OF THE CONTROLLED SUBSTANCES ACT (2016) [hereinafter DOJ].

31 Mead, *supra* note 15 at 3.

of Marijuana Laws ("NORML") filed the first petition asking the DEA to reschedule marijuana to a lower tier.[32] The petition was filed in 1972 and aimed to allow physicians to legally prescribe marijuana.[33] DEA Administrative Law Judge, Francis L. Young, heard the case and concluded that "[i]n strict medical terms, marijuana is far safer than many foods we commonly consume . . . [and] one of the safest therapeutically active substances."[34] Young concluded that "the provisions of the [CSA] permit and require the transfer of marijuana from Schedule I to Schedule II," and "[t]he evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people."[35] He also stated that it would be "unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record."[36] Despite the court's conclusion, the petition was ultimately rejected in 1994 by the DEA in court after a twenty-two-year battle.[37] The circuit court reasoned that "only rigorous scientific proof" can satisfy the requirement of a substance having "currently accepted medical use," and that the finding on marijuana did not meet this standard.[38]

Subsequent petitions have been filed and declined by the DEA. In 2011, the governors of Rhode Island and Washington submitted a petition to the DEA to initiate proceedings requesting that marijuana be rescheduled to Schedule II of the CSA.[39] The DEA accepted the petition and submitted the necessary data to HHS requesting a scientific and medical evaluation and

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[32] Nordrum, *supra* note 10.

[33] *Removing Marijuana from the Schedule of Controlled Substances*, DRUG POL'Y ALL., (Jan. 10, 2019), https://drugpolicy.org/resource/removing-marijuana-schedule-controlled-substances.

[34] Marijuana Rescheduling Petition, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Admin. Law Judge, Docket No. 86-22, (Drug Enf't Admin. September 6, 1988) at 58–59. http://www.druglibrary.net/olsen/MEDICAL/YOUNG/ young.html.

[35] *Id.* at 67–68.

[36] *Id.* at 68.

[37] Nordrum, *supra* note 10.

[38] All. for Cannabis Therapeutics v. Drug Enf't Admin., 15 F.3d 1131, 1137 (D.C. Cir. 1994).

[39] DOJ, *supra* note 30.

scheduling recommendation for marijuana.[40] The HHS recommended that Schedule I of the CSA should continue to control marijuana, and the DEA is bound by the HHS' recommendations as to scientific and medical matters.[41] The DEA then set forth its findings in a published report in 2016 and determined that marijuana still meets the criteria for placing a substance in Schedule I of the CSA and therefore did not reschedule the drug.[42]

Ultimately, the DEA found there was not enough evidence to show that marijuana has a currently accepted medical use, and findings still showed that marijuana has a high potential for abuse.[43] This rather recent determination by the DEA indicates that rescheduling marijuana will prove no easy task for future petitioners, as I will discuss below in the case of *Washington v. Barr*.[44]

B. *State Marijuana Laws*

The constitutional issue of state and federal law "butting heads" is certainly relevant in the legalization of marijuana. The CSA contains an anti-preemption clause, stating:

> No provision of this title shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this title and that State law so that the two cannot consistently stand together.[45]

Courts have held that a state law is only preempted by the federal

40 DOJ, *supra* note 30.
41 DOJ, *supra* note 30.
42 DOJ, *supra* note 30.
43 DOJ, *supra* note 30.
44 925 F.3d 109 (2d Cir. 2019).
45 21 U.S.C. § 903.

CSA if it is "physically impossible to comply with both state and federal law" or if the state law "stands as an obstacle to the implementation . . . of the full purposes" of the CSA.[46] Marijuana's classification as a Schedule I substance under the CSA makes its distribution a federal offense.[47] Despite this, many states have taken the initiative to pass laws allowing regulated use.[48]

In 1996, California became the first state to legalize medical marijuana.[49] As of April 2022, thirty-seven states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands have approved medical marijuana programs, and twenty are comprehensive programs.[50] The National Conference of State Legislatures ("NCSL") determines that a program is "comprehensive" if: (1) it provides "protection from criminal penalties for using" marijuana for a medical purpose; (2) it provides access to marijuana "through home cultivation, dispensaries or some other system that is likely to be implemented"; (3) it "allows a variety of strains or products, including those with more than 'low THC'"; (4) it "allows either smoking or vaporization of some kind of" marijuana "products, plant material or extract"; and (5) it is not a limited trial program.[51] Typically, recreational marijuana contains higher tetrahydrocannabinol ("THC") levels than medical marijuana, which is mostly cannabinoid ("CBD").[52] THC is the main psychoactive constituent of the cannabis plant, while CBD has therapeutic effects which may alleviate symptoms.[53] States have increasingly supported the legalization of marijuana, as evidenced by the 2020 election, where five more states voted in favor of

46 Emerald Steel Fabricators, Inc. v. Bureau of Lab. and Indus., 230 P.3d 518, 528–29 (Or. 2010); *see also* Boultinghouse v. Hall, 583 F. Supp. 2d 1145, 1157 (C.D. Cal. 2008); Ter Beek v. City of Wyoming, 823 N.W.2d 864, 871 (Mich. Ct. App. 2012).

47 *State Medical Cannabis Laws*, NAT'L CONF. STATE LEGS. (April 19, 2022), https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx [hereinafter NCSL].

48 *Id.*

49 *Id.*

50 *Id.*

51 *Id.*

52 Marc H., *What's the Difference Between Medical & Recreational Marijuana?*, CANNAMD (July 31, 2019), https://www.cannamd.com/whats-the-difference-between-medical-recreational-marijuana/.

53 *Id.*

legalizing marijuana.[54] Some states, such as New York and Illinois, have gone as far as approving regulations that allow doctors to prescribe medical marijuana as a replacement for opioids in pain treatment.[55]

C. *Evolving Views on Marijuana as Medical Treatment*

While the federal government has not budged in rescheduling marijuana, states increasingly have.[56] A significant promoted use is as a remedy for chronic pain.[57] The increasing legalization of medical marijuana by the states indicates the evolving acceptance of marijuana as a medicine; however, marijuana research results have not proven strong enough to sway the federal government.

A 1999 study highlighted the potential medical use of marijuana, finding: "[s]cientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances."[58] The study also recognized psychological effects, finding: "[t]he psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value."[59] The study concluded that "[t]hose effects are potentially undesirable in some patients and situations and beneficial in others."[60]

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54 Kelly Anne Smith, *These States Passed Provisions to Legalize Marijuana in the 2020 Election*, FORBES (Nov. 4, 2020), https://www.forbes.com/sites/advisor/2020/11/04/these-states-passed-provisions-to-legalize-marijuana-in-the-2020-election/?sh=6e29751d62e3.

55 *New York State Department of Health Announces Opioid Replacement Now a Qualifying Condition for Medical Marijuana*, N.Y. STATE (July 12, 2018), https://www.health.ny.gov/press/releases/2018/2018-07-12_opioid_replacement.htm; *Opioid Alternative Pilot Program*, ILL. DEP'T OF PUB. HEALTH, https://www.dph.illinois.gov/topics-services/prevention-wellness/medical-cannabis/opioid-alternative-pilot-program (last visited May 1, 2022).

56 *See infra*, Section II on State Marijuana Laws.

57 *See* Jayne Leonard, *What are the Best Cannabis Strains for Chronic Pain?*, MEDICALNEWSTODAY, (Aug. 3, 2018), https://www.medicalnewstoday.com/articles/322051.

58 JANET E. JOY, STANLEY J. WATSON, JR., & JOHN A. BENSON, JR., MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE 4 (1999).

59 *Id.* at 108.

60 *Id.*

More recently, in 2017, the National Academies of Sciences, Engineering, and Medicine released a report based on a comprehensive review of 10,700 scientific abstracts from existing research on marijuana health.[61] Conclusions from the report suggest ways to improve marijuana research.[62] One conclusion reads: "There is conclusive or substantial evidence that cannabis or cannabinoids are effective . . . [f]or the treatment of chronic pain in adults . . . [a]s antiemetics in the treatment of chemotherapy-induced nausea and vomiting . . . [and] [f]or improving patient-reported multiple sclerosis spasticity symptoms."[63] Although the DEA concluded in 2016 that there was not enough evidence to show that marijuana has a currently accepted medical use, the 2017 report displays that there already exists "conclusive" evidence to support effective medical treatment through cannabis.[64] Additionally, the report indicates advanced marijuana research is underway.[65] The initiatives taken by a majority of the states to legalize medical marijuana also evidence growing support for its benefits.

States are not the only advocates for medical marijuana and its potential health benefits. Doctors and pharmacists have provided support for the use of medical marijuana to reduce pain and even to treat opioid addiction.[66] One organization, Doctors for Cannabis Regulation ("DFCR"), advocates for the federal legalization of marijuana in order to achieve "improved public health, social justice, and consumer protections."[67] DFCR

61 NAT'L ACADS. OF SCIS., ENG'G, AND MED., THE HEALTH EFFECTS OF CANNABIS AND CANNABINOIDS: THE CURRENT STATE OF EVIDENCE AND RECOMMENDATIONS FOR RESEARCH 31 (2017).

62 *Id.* at 9–12.

63 *Id.* at 13.

64 *Id.*

65 *Id.* at 9 (noting it is "a pivotal time in the world for cannabis policy and research," and recommending clinical trials of marijuana use for medical purposes be conducted).

66 Charles John Gonzalez, Nicole Quackenbush, Sharon Stancliff, *Cannabis as a Substitute for Opioids*, JAMA (July 16, 2019), https://jamanetwork.com/journals/jama/fullarticle/2738280?resultClick=1; Franklin E. Caldera, *Medical Cannibus as an Alternative for Opioids for Chronic Pain: A Case Report*, SAGE (Feb. 12, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7016302/; DOCTORS FOR CANNABIS REGUL., https://dfcr.org/ (last visited Mar. 20, 2022) [hereinafter DFCR].

67 *DFCR Letter to the House in Strong Support of the MORE Act*, DOCTORS FOR CANNABIS REGUL., https://www.dfcr.org/post/dfcr-letter-to-the-house-in-strong-

advocates for science-based regulation and the common good; David L. Nathan, its founder and board president, stated, "[y]ou don't have to be pro-marijuana to oppose its prohibition."[68] DFCR promotes the creation of a legal and regulated system of marijuana to combat the illicit drug trade and ensure public safety.[69] The DFCR is just one group of doctors advocating for marijuana legalization and it is becoming evident that its support is evolving.

The use of marijuana to treat chronic pain is a progressing practice. In 2016, the Centers for Disease Control and Prevention ("CDC") reported that approximately 20.4 percent (50 million) of U.S. adults suffered from chronic pain and eight percent suffered from high-impact chronic pain.[70] The prevalence of chronic pain has led doctors and patients to explore the use of marijuana as a treatment. A 2015 article reviewing existing research on medical marijuana as a treatment for chronic pain found that "several trials had positive results, suggesting that marijuana or cannabinoids may be efficacious" for treating some types of chronic pain conditions.[71] Dr. Kevin P. Hill concluded this article by noting that medical marijuana and cannabinoids have "many potential medical benefits," but "physicians have a responsibility to provide evidence-based guidance" when offering the use of medical marijuana.[72]

support-of-the-more-act (last visited Mar. 4, 2022).

[68] Christopher Ingraham, *More and More Doctors Want to Make Marijuana Legal*, WASH. POST (Apr. 15, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/04/15/more-and-more-doctors-want-to-make-marijuana-legal/.

[69] *Id.*

[70] James Dahlhamer et al., *Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults—United States, 2016*, CDC MMWR 1001, 1003 (Sept. 14, 2018), https://www.cdc.gov/mmwr/volumes/67/wr/mm6736a2.htm; *Prevalence and Profile of High Impact Chronic Pain*, NIH, (Aug. 8, 2018), https://www.nccih.nih.gov/research/research-results/prevalence-and-profile-of-high-impact-chronic-pain (defining "High-impact chronic pain" as "pain that has lasted 3 months or longer and is accompanied by at least one major activity restriction," such as being unable to attend school or work).

[71] Kevin P. Hill, *Medical Marijuana for Treatment of Chronic Pain and Other Medical and Psychiatric Problems*, JAMA 2474 (June 23/30, 2015), https://jamanetwork.com/journals/jama/fullarticle/2338266?resultClick=1.

[72] *Id.* at 2482.

The outstanding issue noted by some doctors is the lack of sufficient research.[73] This is largely due to the federal restrictions severely limiting clinical research on Schedule I controlled substances.[74] Doctors are placed with the burden of weighing the risks and benefits of medical marijuana treatment for each individual patient when deciding on the best course of treatment.[75] They must also keep up with ever-changing and conflicting state and federal laws when recommending marijuana.[76] Until federal restrictions are loosened, sufficient research to make uniform methods of prescribing medical marijuana may not be attainable. Doctors, however, are increasingly opting to prescribe medical marijuana to treat patients where states have allowed it.

The current research on marijuana paints a preliminary path to rescheduling cannabis. The CSA does not require that zero detrimental effects exist for any drug for it to be on Schedule II, III, IV, or V.[77] Many existing Schedule II substances have potential for abuse and detrimental side effects.[78] An argument that marijuana has some detrimental effects should not prevent the acknowledgment and recognition of its beneficial effects. That said, further research is needed to solidify evidence of its benefits that fit the DEA's definition of "accepted medical use" for the CSA.

Also evolving is the accepted use of marijuana as a pain remedy by the FDA itself. In determining whether marijuana has accepted medical use, its potential medical benefits have been the subject of much countervailing opinions and debate. Yet, cannabis has proven medical benefits in particular formulations approved by the FDA.[79] Two THC-based medications, prescribed in pill form, have been approved for the treatment of nausea in cancer patients undergoing chemotherapy and to "stimulate appetite in patients with wasting syndrome due to AIDS."[80] The FDA has also

73 Gonzalez, Quackenbush, & Stancliff, *supra* note 66.

74 Gonzalez, Quackenbush, & Stancliff, *supra* note 66.

75 Gonzalez, Quackenbush, & Stancliff, *supra* note 66.

76 Caldera, *supra* note 66 at 3.

77 *See generally* 21 U.S.C. § 812.

78 Methamphetamine, opioids, etc. all have potential for abuse that can lead to addiction, physical and mental impairment, and death.

79 NATIONAL INSTITUTE ON DRUG ABUSE, MARIJUANA RESEARCH REPORT: IS MARIJUANA SAFE AND EFFECTIVE AS MEDICINE? 1, 23 (2020).

80 *Id.*

approved a CBD-based liquid medication, which is used for the treatment of severe childhood epilepsy, Dravet syndrome, and Lennox-Gastaut syndrome.[81] This federal approval by the FDA for both CBD and THC-based drugs indicates accepted medical use. This acceptance could prove beneficial in the path to federal marijuana legalization to remedy chronic pain for professional athletes.

D. *Painkiller Abuse and Professional Athletes*

As mentioned above, athletes are in a unique position regarding the injuries they face and the need for a remedy to perform and succeed in their careers.[82] The use and abuse of opioids is a serious issue afflicting the United States, and athletes are one group who are heavily affected by this epidemic.[83] Professional athletes inevitably face the risk of physical injury with each day of practice and performance. These constant injuries have contributed to a dire need for pain medication and therapy for many athletes.[84] While painkillers may seem to succeed in numbing pain before or during a game, the everlasting effect of addictive painkillers is often not adequately considered. Many allegations have been made regarding the National Football League's ("NFL") extensive reliance on painkillers to ensure the players are able to participate in the game and thus increase league and team revenues.[85]

In *Dent v. NFL*,[86] former NFL players brought suit in federal court alleging, *inter alia*, that during their years playing in the NFL, they received "copious amounts of opioids, non-steroidal anti-inflammatory medications, and local anesthetics."[87] The plaintiffs claimed that the NFL encouraged them to take pain

81 *Id.* at 24.

82 *See infra*, Part II on evolving views of marijuana.

83 Clint Fletcher, *Sports Injuries and Opioid Addiction: The Connection*, BROAD BREACH RECOVER CTR. (Nov. 13, 2019), https://meadowsmalibu.com/sports-injuries-and-opioid-addiction-the-connection/.

84 *Id.*

85 Michael B. Scallan, *Painkillers for Profit Gains: How the Ninth Circuit's Revival of Dent v. NFL Could Hold the League Liable for Long-Term Injuries Caused by its Administration of Painkillers*, 46 S.U. L. REV. 325, 332 (2019).

86 Dent v. NFL, 902 F.3d 1109, 1115 (9th Cir. 2018).

87 *Id.*

medications without prescriptions, that they were handed pills in "small manila envelopes that often had no directions or labeling" and were told to take whatever was in the envelopes.[88] The players further alleged that the NFL never warned them about "potential side effects, long-term risks, interactions with other drugs, or the likelihood of addiction," constituting a lack of informed consent.[89] Lastly, the plaintiffs claimed that as a result of their use (which led to overuse) of these pain medications, retired players suffer from "permanent orthopedic injuries, drug addictions, heart problems, nerve damage, and renal failure."[90] The case has been to the Ninth Circuit Court of Appeals twice, and in February 2021, the district court denied the NFL's motion to dismiss and recommended that the case either proceed to trial or summary judgment, to avoid "a third dismissal and overindulgence in judicial notice."[91]

Dent is just one of many cases where NFL players have alleged misconduct by the NFL in providing painkillers without informing the players of the serious side effects and future consequences.[92] Whether lawsuits are brought or not, current and former players who speak out have made the outstanding issue of painkiller addiction and abuse evident. A study conducted by researchers at Washington University in St. Louis School of Medicine, which surveyed 644 former NFL players, concluded that "retired NFL players misuse opioid pain medications at a rate more than four

88 *Id.*

89 *Id.*

90 *Id.* The NFL argued in defense that the players' claims were preempted by § 301 of the Labor-Management Relations Act. The Ninth Circuit Court of Appeals held that the claims brought against the NFL by retired players neither arose from collective bargaining agreements nor required their interpretation, and therefore, "the players' claims regarding the league's alleged violation of federal and state laws governing controlled substances were not preempted by § 301." The Ninth Circuit declined to inquire into the merits of the case and remanded to the district court.

91 Dent v. NFL, No. C 14-02324 WHA, 2021 U.S. Dist. LEXIS 31568, at *22 (N.D. Cal. Feb. 19, 2021).

92 *See* Ed Sherman, *Mike Ditka, 1985 Bears Players Detail Team's Excessive Painkiller Use*, CHICAGO TRIBUNE (Jan. 17, 2015), https://www.chicagotribune.com/sports/bears/chi-1985-bears-pain-killers-real-sports-20150117-story.html; *see also* Andrew Withers, *Painkillers, Concussions, Injuries, Oh My: NFL 'Player Safety', as Explained by Megatron*, DETROIT METRO TIMES, (July 7, 2016), https://www.metrotimes.com/the-scene/archives/2016/07/07/painkillers-concussions-injuries-oh-my-nfl-player-safety-as-explained-by-megatron.

times that of the general population."[93] The study stated that "new evidence suggests that is occurring because players misused the painkillers during their NFL careers."[94] When the players were asked about their prescription painkiller use while playing in the NFL, forty-eight percent said they never used the drugs while playing, while fifty-two percent of the retired players said they had used prescription pain medication.[95] Of the players who said they used prescription painkillers while playing in the NFL, seventy-one percent admitted to misusing the drugs—fifteen percent admitted to misusing prescription pain medications within the past thirty days of the survey.[96] Notably, the study found that "retired players who misused prescription painkillers while playing in the NFL were three times more likely to misuse the drugs today than those who used the pills only as prescribed while playing."[97] Furthermore, the "[p]revalence of current opioid use was seven percent—three times the rate of the general population."[98]

This study brought to light some concealed concerns within the league. Dr. Eric Strain, Drug and Alcohol Dependence Editor-in-Chief and Director of the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins Center for Substance Abuse Treatment and Research, found the results "important" and "valuable."[99] He stressed his concern with athletes' ease of access to painkillers: "People will often continue to use drugs for reasons that are different than the reasons that they started using them."[100] Dr. Strain's concern is that these athletes "start using these

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93 John Barr, *Painkiller Misuse Numbs NFL Pain*, ESPN http://www.espn.com/espn/eticket/story?page=110128/PainkillersNews&redirected=true (Last Visited Jul. 6, 2022). "Misuse" is defined as someone using more painkillers than prescribed, using them without a prescription or obtaining painkillers from a nonmedical source.

94 *Id.* The study is the first of painkiller use and misuse by former NFL players. Directed by Linda Cottler, a professor of epidemiology in Washington University's Department of Psychiatry, the study was commissioned by ESPN, with additional funding provided by the National Institute on Drug Abuse, a division of the U.S. Department of Health and Human Services.

95 Cottler, *supra* note 1.

96 Cottler, *supra* note 1, at 190–91.

97 Barr, *supra* note 93.

98 Cottler, *supra* note 1, at 188.

99 Barr, *supra* note 93.

100 Barr, *supra* note 93.

[prescription] drugs for pain-relieving purposes but then . . . find that [they are] unable to function without the use of these drugs."[101]

An example illustrating Dr. Strain's concern is Dan Johnson, a former NFL player who played tight end for the Miami Dolphins in the mid-1980s.[102] Johnson "said he became addicted to painkillers after two back surgeries that were necessary because of injuries he suffered as an NFL player."[103] Johnson reported that he took nearly one thousand painkillers per month to overcome the pain from injuries he sustained while playing in the NFL.[104] In fact, Johnson broke so many bones during his time in the NFL that his teammates referred to him as the "King of Pain."[105] Most concerning though is how Johnson acquired his painkillers—through the internet, via overseas shipments, or through acquaintances.[106] Johnson admits he was addicted to painkillers and has also revealed that a few times his addiction led him to contemplate suicide.[107] Fortunately, Johnson was able to end "his addiction with the help of Suboxone, a narcotic used to treat opioid dependence."[108]

Johnson's method of medication acquisition is not unique among NFL players. A Washington University study found that sixty-three percent of the retired players using prescription pain pills during their time in the NFL had obtained these medications from a nonmedical source at least once.[109] In fact, many players have admitted that "it was commonplace for the players to get prescription painkillers from sources outside of NFL locker rooms, either from unscrupulous doctors or drug dealers," and one former player stated these drugs were taken just before game time.[110] The study showed that not only were former NFL players experiencing moderate to severe pain daily, but these players were

101 Barr, *supra* note 93.

102 *See generally* Dan Johnsson, PRO FOOTBALL REFERENCE, https://www.pro-football-reference.com/players/J/JohnDa02.htm (last visited Mar. 20, 2022).

103 Barr, *supra* note 93.

104 Barr, *supra* note 93.

105 Barr, *supra* note 93.

106 Barr, *supra* note 93.

107 Barr, *supra* note 93.

108 Barr, *supra* note 93.

109 Cottler, *supra* note 1, at 190–91.

110 Barr, *supra* note 93.

also using and misusing painkillers given by their team doctors without prescriptions when they complained of pain.[111]

Misuse of pain medication does not end with the NFL. Numerous National Hockey League ("NHL") players have spoken out about the lack of education given to professional athletes regarding the risks of using pain medications to treat brutal hockey injuries.[112] Former NHL player Ryan Kesler spoke out about pain medication abuse in the NHL, opening up about his misuse of an anti-inflammatory drug, Toradol, for his chronic hip pain.[113] Toradol is not approved for long-term use,[114] yet Kesler revealed that he needed to take it in order to get through each game.[115] Kesler has developed chronic inflammatory diseases which his doctor says were likely triggered by his Toradol use.[116] Kesler said that he was unaware of any of the possible side effects while taking the drug, exemplifying, as Rick Westhead of TSN worries, that the NHL trainers and doctors have not focused enough on educating the players on what medications they are given.[117] NHL players are expected to be tough and push through each game; as a result, many use pain medications before every game in order to perform.[118]

One distressing example of the NHL's easy path to addiction is the story of Derek Boogaard. Boogaard was a star enforcer in the NHL, having played for the New York Rangers and Minnesota Wild.[119] He "was widely regarded as the toughest man in the

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111 Barr, *supra* note 93.

112 *See generally* Greg Wyshynski, *Former Player Ryan Kesler Says There's Lack of Education Across NHL in Risks of Pain Medications*, ESPN (Sept. 26, 2020), https://www.espn.com/nhl/story/_/id/29946533/former-player-ryan-kesler-says-there-lack-education-nhl-risks-pain-medications.

113 *Id.*

114 Dave Stevenson, *Former NHL Players Open Up About the Danger of Pain Medications*, FANSIDED (Oct. 23, 2020), https://puckprose.com/2020/09/23/former-nhl-players-open-up-danger-pain-medications/. (Experts say the drug should not be used for longer than five days.); *See* ROCHE LABRATORIES INC., TORADOL (KETOROLAC TROMETHAMINE TABLETS) 1 (2013), https://www.accessdata.fda.gov/drugsatfdadocs/label/2013/019645s019lbl.pdf.

115 Stevenson, *supra* note 114 ("'I never wanted to hurt the team, so I knew I had to play. To play, you have to take pain killers,' Kesler said.").

116 Wyshynski, *supra* note 112.

117 Wyshynski, *supra* note 112.

118 Wyshynski, *supra* note 112.

119 Stu Hackel, *Derek Boogaard Alarming Example of NHL's Easy Path to*

NHL."[120] Consequently, Boogaard suffered numerous injuries requiring many surgeries resulting in terrible pain.[121] These injuries, coupled with the pressing need to return to the ice and keep fighting, led to a serious painkiller substance abuse disorder and, eventually, his death by drug overdose.[122] A jarring aspect of Boogaard's story is how easy it was for him to find pain medications. He reportedly obtained pain medications including hydrocodone and oxycodone from doctors for teams he did not even play for.[123] Boogaard's story prompted many to question the easy access to addictive drugs in the NHL, however, Kesler's statements reveal that the NHL seems to turn a blind eye to how the players obtain drugs and get themselves back on the ice, indicating their dire need for an alternative remedy.[124]

Unfortunately, these stories are not uncommon in professional athletes. These athletes must show up and perform to compete, but later could become addicted to the pain medications that allowed them to do so. An important question becomes when the players' long-term health will become more imperative than the guarantee that they play in every game. Does marijuana present a better pain-relieving medicine to substitute for these detrimental painkillers? If so, what will stand in the way of reforming the professional leagues' policies and federal law?

Addiction, SPORTS ILLUSTRATED (May 13, 2015), https://www.si.com/nhl/2015/05/13/derek-boogaard-alarming-example-nhl-drug-addiction. "The role of enforcer[] in the NHL is highly controversial. Although it is not an official position in hockey, it is a well-known title for players whose jobs as fighters overshadow their play on the ice." Anne Tjønndal, *NHL Heavyweights: Narratives of Violence and Masculinity in Ice Hockey*, 70 PHYSICAL CULTURE & SPORT STUD. & RSCH. 55, 56 (2016) (citing Dennis Coates et al., *Does Violence in Professional Ice Hockey Pay? Cross Country Evidence from Three Leagues in* R. TODD JEWELL, VIOLENCE AND AGGRESSION IN SPORTING CONTESTS 47 (2012)).

120 Anne Tjønndal, *NHL Heavyweights: Narratives of Violence and Masculinity in Ice Hockey*, 70 PHYSICAL CULTURE & SPORT STUD. & RSCH. 55, 59–60 (2016).

121 Brett Popplewell, *Fall of the Boogeyman*, SPORTSNET (2011), https://www.sportsnet.ca/hockey/nhl/fall-boogeyman-derek-boogaards-final-days/.

122 *Id.*

123 Hackel, *supra* note 119.

124 Wyshynski, *supra* note 112.

E. *Professional Sports Leagues' Marijuana Policies*

As more athletes become plagued by opioid addiction, players have turned to other remedies for their pain. While concurrently the public perception of medical marijuana evolves,[125] some athletes are choosing the use of marijuana as a treatment for their injuries.[126] Athletes face a unique issue that increases their need for marijuana law reform, namely that their job is to perform, and they cannot perform if they are injured or in pain. Medical marijuana could revitalize the way athletes manage their pain before gameday. However, the current federal prohibition of marijuana stands as a roadblock. It is a deterrent to professional sports leagues contemplating permitting the use of marijuana. This is evidenced by each league's substance abuse policies, discussed below.

The "Big Four" professional sports leagues in the United States are the NFL, National Basketball Association ("NBA"), NHL, and Major League Baseball ("MLB").[127] The Big Four's drug policies do not vary substantially, except for their stances on marijuana and punishments for noncompliance.[128] The NHL has long been quite relaxed regarding restrictions and penalties for marijuana use. The NFL and MLB's policies have just recently followed similar patterns in loosening formerly tight restrictions on marijuana, as will be shown below.

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125 Andrew Daniller, *Two-thirds of Americans Support Marijuana Legalization*, PEWRESEARCH, (Nov. 14, 2019), https://www.pewresearch.org/fact-tank/2019/11/14/americans-support-marijuana-legalization/ (stating that the share of U.S. adults who oppose legalization has fallen from fifty-two percent in 2010 to thirty-two percent in 2019.).

126 Emily Kaplan, *Is the NHL the Future of Marijuana in Pro Sports? Why it Could Be*, ESPN (Mar. 7, 2019), https://www.espn.com/nhl/story/_/id/26046596/is-nhl-future-marijuana-pro-sports-why-be.

127 Christopher R. Deubert, I. Glenn Cohen, & Holly Fernandez Lynch, *Comparing Health-Related Policies and Practices in Sports: The NFL and Other Professional Leagues*, 1 HARV. J. OF SPORTS & ENT. L. 1, 14 (2017).

128 *Id.* at 20.

The NFL in 2020 amended its labor agreement to cease the suspension of players who test positive for marijuana.[129] The new policy reduced the time when players are subject to testing "from four months to the two weeks at the start of training camp."[130] Additionally, a new threshold for a positive test was put in place, "raising the allowed amount of THC from 35 nanograms to 150."[131] This indicates that the League tolerates more marijuana found in a player's system than before. The NFL also moved away from a punishment approach and toward providing treatment for those that need it, which is determined by a medical board if the player tests positive during training camp.[132] The 2020 Collective Bargaining Agreement ("CBA") reflected an important shift from punitive to rehabilitative treatment of marijuana use.

MLB formerly listed marijuana on its banned substances list, but only tested players if there was a "reasonable cause" to do so.[133] The punishment for a positive marijuana test was referral to the Treatment Board for an evaluation that could result in a treatment program that may consist of counseling, in- or out-patient treatment, and follow-up testing.[134] A player would be suspended only if they "flagrantly disregard the rules," or were believed to be a "threat" to fellow players' safety.[135] In 2020, MLB removed marijuana from its banned substances list and will no longer punish players for testing positive.[136] The League retains "the right to punish players who break existing marijuana laws, such as possession and distribution, as well as for driving under the

[129] Bill-in-Bangkok, *CBA Nuggets: Marijuana Use by NFL Players in 2020 and Beyond*, SBNATION, (May 10, 2020), https://www.hogshaven.com/2020/5/10/21253409/cba-nuggets-marijuana-use-by-nfl-players-in-2020-and-beyond; *See* NFLPA, Collective Bargaining Agreement (Mar. 5, 2020), https://nflpaweb.blob.core.windows.net/media/Default/NFLPA/CBA2020/NFL-NFLPA_CBA_March_5_2020.pdf.

[130] Bill-in-Bangkok, *supra* note 129.

[131] Bill-in-Bangkok, *supra* note 129.

[132] Bill-in-Bangkok, *supra* note 129.

[133] Kendall Baker, *Where the Major Sports Leagues Stand on Weed*, AXIOS, (Mar. 8, 2019), https://www.axios.com/marijuana-policies-sports-leagues-nhl-nba-nfl-mlb-57d6cc62-2d8c-4215-9609-0b72c0c63785.html.

[134] Deubert, Cohen, & Lynch, *supra,* note 127, at 136.

[135] Kaplan, *supra,* note 126.

[136] MLB Communications (@MLB_PR), TWITTER (Dec. 12, 2019, 11:07 AM), https://twitter.com/MLB_PR/status/1205157274676682752.

influence."[137] This essentially means the players cannot show up to their practices, games, workouts, or meetings high on marijuana.[138] Additionally, club medical personnel are "prohibited from prescribing, dispensing or recommending the use of marijuana or any other cannabinoid" to players or officials.[139] The changes to MLB's policy came after the death of a player who overdosed on opioids, discussed in Section IV.

The NHL has long offered a less stringent marijuana policy.[140] The NHL's "Substance Abuse Program does not subject the players to random drug testing" for disciplinary purposes.[141] The League does not punish players who test positive for marijuana.[142] Rather, if a player shows abnormally high THC levels, NHL physicians will recommend treatment to those who they determine at their discretion may need to use the drug less.[143]

The NBA's 2017 CBA dissimilarly requires random marijuana testing during the regular season.[144] The punishment for a player's first positive test is to enter a substance abuse program.[145] The second offense is a $25,000 fine.[146] The third offense results in a five-game suspension, with five games added to each subsequent positive test.[147] This makes the NBA the lone league in the Big Four that still punishes players with fines for testing positive for marijuana.

While leagues are slightly relaxing their restrictions on marijuana, players are also increasingly performing in states where marijuana is legal. In 2019, eighty-two percent of the 123 teams of the Big Four played their home games in locations where either

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137 Jeff Passan, *MLB: Players Still Subject to Penalty for Using Pot*, ESPN, (Feb. 28, 2020), https://www.espn.com/mlb/story/_/id/28804440/mlb-players-subject-penalty-using-pot.

138 *Id.*

139 *Id.*

140 Baker, *supra* note 133.

141 Deubert, Cohen, & Lynch, *supra* note 127, at 152.

142 Baker, *supra* note 133.

143 Baker, *supra* note 133.

144 Baker, *supra* note 133.

145 NATIONAL BASKETBALL PLAYERS ASSOCIATION, Article XXXIII, Sec. 8(b)(c)(A), (Jan. 19, 2017), https://cosmic-s3.imgix.net/3c7a0a50-8e11-11e9-875d-3d44e94ae33f-2017-NBA-NBPA-Collective-Bargaining-Agreement.pdf.

146 *Id.* at Article XXXIII, Sec. 8(b)(c)(B).

147 *Id.* at Article XXXIII, Sec. 8(b)(c)(C),(D).

medical or recreational marijuana is legal.[148] That number has likely risen after additional states legalized medical and/or recreational marijuana in 2020.[149] Additionally, teams travel out of state for away games where there are different marijuana laws, making it more difficult for players to continue marijuana treatment and more confusing to know whether they are complying with the law. Take, for example, one NFL team: the New York Giants. The Giants' 2021 schedule consisted of seventeen games, eight home and nine away.[150] The team traveled to Missouri, California, Florida, Louisiana, Illinois, Maryland, Texas, and Pennsylvania.[151] In two of those states, marijuana is legal both recreationally and medically.[152] In five, marijuana is only medically legal, and each state has different medical marijuana programs and restrictions.[153] In one state, marijuana is illegal recreationally and medically.[154] This schedule is just one that exemplifies that these professional teams are increasingly playing home games and traveling to perform in states where medical marijuana is legal. As views on marijuana as a medicine evolve, so could the players' ability to lawfully choose it as a treatment for their chronic pain.

Despite the slight liberation in marijuana policies and the increasing number of states legalizing marijuana, the use of marijuana as a medicine is still restricted by federal law, the CSA. Additionally, leagues do not permit the use of medical marijuana for the treatment of injuries,[155] which is a crucial change needed to mitigate painkiller abuse. The classification of cannabis as a

148 Kaplan, *supra* note 126.

149 *See* NCSL, *supra* note 47.

150 *NY Giants Schedule, 2021*, N.Y. GIANTS, https://www.giants.com/schedule/ (last visited Mar. 20, 2022).

151 *Id.*

152 *See* NCSL, *supra* note 47.

153 *See* NCSL, *supra* note 47.

154 *See* NCSL, *supra* note 47.

155 *But see* Dana Perkins, *What You Need to Know About Sports and CBD, Part 1*, SORSE TECH., (Apr. 30, 2020), https://sorsetech.com/what-you-need-to-know-about-sports-and-cbd-part-1/ (explaining in Major League Soccer ("MLS"), if a substance is banned by the U.S. Anti-Doping Agency or FIFA, it is banned by the League. Following WADA guidelines, use of CBD is allowed in MLS, but THC is not.); *see also* MAJOR LEAGUE SOCCER, https://judiciary.house.gov/sites/democrats.judiciary.house.gov/files/mlsconstitution_0.pdf (last visited Mar. 20, 2022).

Schedule I drug still poses a major barrier to the leagues, as evidenced by the National Basketball Players Association Executive Director Michele Roberts's statement in 2018 when she said the NBA was "'exploring' medical exemptions for NBA players to use medical cannabis [but that] federal law [stood] in the way."[156] Even though a majority of the Big Four Leagues prohibit the use of medical marijuana by their athletes, the leagues seem to have a less stringent stance on painkiller abuse.

III. BARRIERS TO LEGALIZATION

A. *Lack of Research*

As with most legislative reforms, barriers will stand in the path to rescheduling marijuana on the CSA. Politicians, citizens, medical professionals, and researchers have participated in a hot debate on the benefits and concerns of rescheduling cannabis to a lower tier. The main conclusion or recommendation in many research reports on marijuana and its health benefits is two-fold: (1) evidence points to *both* benefits and detriments of its use; and (2) further research is needed to come to more concrete conclusions regarding its accepted medical use.[157] A concern of the federal government is that marijuana remains unproven in terms of safety or efficacy.[158] One of the first studies to research cannabis in-depth, a 1999 Institute of Medicine Report, *Marijuana and Medicine*: *Assessing the Science Base*, explored the history of marijuana use as a medicine, its effects, and its potential.[159] The report described how cannabinoids have shown significant promise in basic experiments on pain, yet the ethical and logistical difficulties of conducting pain experiments on human volunteers

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156 TG Branfalt, *NBA Players Union Boss Says MMJ Access Being Explored for Players*, GANJAPRENEUR (Feb. 20, 2018), https://www.ganjapreneur.com/nba-players-union-boss-says-mmj-access-being-explored-for-players/.

157 *See* Valeriy Zvonarev, Tolulope A. Fatuki, & Polina Tregubenko, *The Public Health Concerns of Marijuana Legalization: An Overview of Current Trends*, CUREUS (Sept 30, 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6837267/.

158 Peter A. Clark, Kevin Capuzzi, and Cameron Fick, *Medical Marijuana: Medical Necessity Versus Political Agenda*, MED. SCI. MONIT 249, 250 (Dec. 1, 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3628147/pdf/medscimonit-17-12-ra249.pdf.

159 *See generally* ALISON MACK & JANET JOY, MARIJUANA AS MEDICINE? THE SCIENCE BEYOND THE CONTROVERSY (2000).

have strained the ability to confirm conclusions on marijuana's clinical pain relief abilities.[160] The report recommended continued research of marijuana as medicine to elaborate potential benefits and thorough epidemiological studies to define suspected risks such as lung cancer from smoking marijuana."[161] Many researchers believe that the debate on the safety of marijuana as a medicine is miscast and that medical use of potent, controlled psychoactive drugs has not led to their abuse.[162] These researchers believe the medical marijuana debate should focus on the promise of future drug development rather than drug control policies.[163]

Although further investigative trials may be necessary to overcome the administrative process, research and data do exist, and it is up to advocates to push for continued research, acceptance, and change.

B. *Risk to Public Health*

The lack of sufficient research is not the only barrier deterring the federal government from rescheduling cannabis in the CSA. The DEA report from 2016 discussed above in Part II, concluding that marijuana shall remain in Schedule I of the CSA, sheds light on the barriers advocates for rescheduling will face.[164] One major concern of the DEA and HHS, which politicians and citizens will likely share, is the risk to the public health associated with marijuana use.[165] The DEA report discusses findings of risks such as the effect on physical and/or psychological functioning of an individual user, driving impairments, car accidents, and impaired neurological function including altered perception, paranoia, delayed response time, and memory deficits.[166]

The HHS reviewed clinical studies testing the hypothesis that marijuana is a gateway drug.[167] Its findings were limited and concluded that: "although many individuals with a drug abuse

160 *Id.* at 79.
161 *Id.* at xii.
162 *Id.*
163 *Id.*
164 *See* DOJ, *supra* note 30.
165 *See* DOJ, *supra* note 30, at 4.
166 *See* DOJ, *supra* note 30, at 43.
167 *See* DOJ, *supra* note 30, at 45.

disorder may have used marijuana as one of their first illicit drugs, this does not mean that individuals initiated with marijuana inherently will go on to become regular users of other illicit drugs."[168] One report published in 2019 conducted a review of the current benefits and adverse effects of marijuana legalization in various states across the United States.[169] Some public health risks studied were: increased use after legalization, use by youths, violent crime rates, fatal car accidents, suicide rates, increased rates of homelessness, and effects of marijuana revenues.[170]

These risks are undoubtedly important; however, they may be less imminent if only medical marijuana is legalized. The issue remains that the CSA does not consider recreational and medical marijuana separately, it just classifies cannabis as a Schedule I drug.[171] Therefore, the DEA needs to reschedule cannabis itself, and then the legislature can set forth regulations for the recreational and medical use of marijuana.

C. *Existing Cannabis Drugs*

The FDA has approved both CBD and THC-based drugs for certain illnesses,[172] which could prove beneficial for rescheduling; however, it also could pose as a barrier to rescheduling because one may argue that cannabis-based drugs already exist, and the CSA is not hindering patients from receiving treatment. The counterargument would be that the federal prohibition is hindering certain groups who do not currently qualify as patients who may be prescribed cannabis for chronic pain, i.e., athletes. An important innovation would be the creation of a CBD or THC-based drug to help with extensive pain post-injury for athletes. Athletes have used marijuana to treat pain regardless of the consequences of violating their organization's drug abuse policy. If medical marijuana were permitted to be prescribed to treat their pain, the numerous suspensions of players and alternative drug abuse would diminish, and their pain could be remedied. Until the federal government opens its eyes to the increased acceptance

168 *See* DOJ, *supra* note 30, at 45.

169 Zvonarev, Fatuki, & Tregubenko, *supra* note 157.

170 *Id.*

171 *See* 21 U.S.C. § 812.

172 *See infra,* Part II regarding evolving views on marijuana.

of marijuana's benefits to those who experience chronic pain, such as athletes, it will be difficult to permit medical marijuana usage in these professional sports leagues.

D. *Stigma*

It has become evident that there is a stigma surrounding marijuana legalization and its effects on individuals and society. Some former athletes are advocating for marijuana bans to remain in professional sports.[173] This is partly because the drug remains banned by federal law, illegal in some states still, and also because of the impact on the leagues', individual players', and the sports' reputation as stars that children emulate.[174] These professional leagues are in a tough situation because there is a patchwork of laws, which they will need to keep up with if they remove marijuana bans. Between the federal prohibition and state's nuanced stances on marijuana, the leagues face a messy situation. Additionally, the stigma on marijuana will make leagues reluctant to allow the use of marijuana, especially while it is still federally illegal.

While these arguments for marijuana bans are valid, there are options for these leagues. They could specify that they would allow medical marijuana to treat injuries and would not permit recreational use. The benefits of medical marijuana are arguably better than the addiction issues from constant reliance on opioids. Many celebrities and former athletes have expressed their support for medical marijuana for athletes and the elimination of marijuana bans in professional sports.[175] Some believe banning marijuana in professional sports does not serve a logical purpose and argue that it is only tested for political reasons.[176] Another argument is that marijuana is not a performance-enhancing drug and leagues should not penalize its use as harshly.[177] Many athletes

[173] Joseph M Hanna, *It's Time to Get Real about Marijuana and Professional Sports: Part 1*, AMERICAN BAR ASS'N (Feb. 25, 2019), https://www.americanbar.org/groups/litigation/committees/jiop/articles/2019/marijuana-professional-sports/.

[174] *Id.*; *see also* Peter A. Clark, Kevin Capuzzi, and Cameron Fick, *Medical Marijuana: Medical Necessity Versus Political Agenda*, MED. SCI. MONIT, (Dec. 1, 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3628147/pdf/medscimonit-17-12-ra249.pdf.

[175] Hanna, *supra* note 173.

[176] Hanna, *supra* note 173.

[177] Hanna, *supra* note 173.

have retired early after multiple suspensions due to marijuana usage.[178] Further, if marijuana was not a banned substance then athletes could treat their pain and continue to progress in their professional careers. Athletes are a prime example that federal legalization is necessary to get rid of the patchwork of state laws that have emerged. There are already evolving views regarding the stigma surrounding marijuana,[179] and it is up to advocates like the leagues and players to push lawmakers to revise restrictions.

IV. SOLUTIONS

A. *Players Advocating for Marijuana Rescheduling*

Athletes are in a unique situation to make a change in society and the law. This is due to the problems they face. For example, athletes face imminent risk of injury and bigger problems, such as inconsistent state laws on marijuana in the different states they constantly travel to. Additionally, athletes are in the spotlight, which creates an opportunity for very visible testing of differing policies, and an opportunity for athletes to advocate for changes in the law.

Many of the most basic individual constitutional rights were debated and legalized after copious and persistent advocacy.[180] Advocates and scholars have offered marijuana as an alternative to opioids in pain management for injuries suffered by athletes.[181] In 2017, a retired NFL player, along with four other plaintiffs, brought suit against the Attorney General and the DEA in the Southern District of New York, seeking marijuana decriminalization at the federal level.[182] In *Washington v. Barr*, the district court dismissed the case for failure to exhaust administrative remedies, since the plaintiffs did not first request

178 Hanna, *supra* note 173.

179 *See supra*, Part II on evolving views of marijuana.

180 *History of Civil Rights Protests in Sports*, Sports Mgmt. Degree Hub, https://www.sportsmanagementdegreehub.com/history-civil-rights-protests-sports/ (last visited Mar. 20, 2022).

181 *See generally* Annie Bach Yen Nguyen, *The Alternative to Opioids: Marijuana's Ability to Manage Pain Caused by Injuries Sustained in the National Football League*, 19 TEX. REV. ENT. & SPORTS L. 63 (2019).

182 Washington v. Barr, 925 F.3d 109, 113 (2d Cir. 2019).

rescheduling of the substance from the DEA.[183] The Second Circuit Court of Appeals agreed that the plaintiffs must first exhaust administrative remedies, however, the court noted that it was "troubled by" the DEA's history of dilatory proceedings.[184] Accordingly, the court concurred with the district court's ruling, but did not dismiss the case, and rather held it in abeyance and retained jurisdiction to "take whatever action might become appropriate if the DEA does not act with adequate dispatch."[185] Assuming rejection was imminent, the plaintiffs decided not to waste time attempting to petition the DEA and instead petitioned directly to the United States Supreme Court.[186] On October 13, 2020, the Supreme Court denied the petition.[187] The Second Circuit's reference to the DEA's troubled history of dilatory proceedings could spark advocacy. If advocates were to build on this, and encourage the DEA to listen, we could set a straighter path to rescheduling marijuana. Some athletes have already begun to advocate for change.

Although the Supreme Court will not hear the case, it nonetheless serves as an important step in the right direction toward athlete advocacy for change in the law. Numerous other NFL players have advocated for the use of marijuana and cannabinoids for pain treatment in athletes. One of the most notable athlete advocates for marijuana legalization is former Miami Dolphins running back, Ricky Williams. Williams was an All-American, a Heisman trophy winner at the collegiate level, and went on to have a highly successful NFL career.[188] Despite his clear talent, Williams ultimately retired from the NFL after multiple suspensions for violating the League's substance abuse policy when testing positive for marijuana.[189] Williams was using marijuana as

183 *Id.* at 114–15.

184 *Id.* at 113.

185 *Id.*

186 Sheilla Dingus, *Ex-NFLer's Cannabis Decriminalization Lawsuit May Be Heading To The Supreme Court*, ADVOC. FOR FAIRNESS IN SPORTS (Jan. 20, 2020), https://advocacyforfairnessinsports.org/current-litigation/marvin-washington-v-william-barr/ex-nflers-cannabis-decriminalization-lawsuit-may-be-heading-to-the-supreme-court/.

187 Washington v. Barr, No. 20-148, 2020 U.S. LEXIS 4918, at 1 (Oct. 13, 2020).

188 Greg Bishop, *Ricky Williams Takes the High Road*, SPORTS ILLUSTRATED, https://www.si.com/longform/2016/ricky-williams-weed/ (last visited Mar. 20, 2022).

189 *Id.*

a pain-relief alternative that "worked for him in way painkillers did not."[190] Today, Williams owns a line of cannabis-based products and advocates for the NFL to consider marijuana as a potential pain relief alternative to opioids.[191] Williams believes that the stigma surrounding marijuana is a leading reason the NFL has not made progressive changes to its drug policy.[192] Williams is in good company as he is not the only professional athlete advocating for lessened marijuana restrictions. Other major advocates for marijuana use in professional sports include Rob Gronkowski, a current NFL player campaigning for the use of CBD-based products to treat injuries in the NFL,[193] and Al Harrington, a former NBA player whose company markets and produces cannabis products for medical and recreational use.[194] Both Gronkowski and Harrington have found the use of CBD crucial to their injury recoveries.[195]

The road to rescheduling marijuana may not be so jagged if more advocates follow in former NFL player Eugene Monroe's footsteps. Monroe is currently a lead advocate for medical cannabis research and policy reform in the NFL.[196] As expressed on his website, Monroe's desire for marijuana reform stems from the large volume of painkiller addictions among NFL athletes: "I'm calling for the NFL to remove marijuana from the banned substances list; fund medical marijuana research, especially as it relates to CTE [chronic traumatic encephalopathy]; and stop overprescribing addictive and harmful opioids."[197] Monroe urges the NFL to make these changes and persuades others to get

190 *Id.*

191 REAL WELLNESS HERBAL, *Our Story: Transformation Rooted in Flexibility*, https://realwellnessherbal.com/our-story/ (last visited Mar. 6, 2021); Bishop, *supra* note 188.

192 *See generally* Bishop, *supra* note 188.

193 Scott Jenkins, *CBD Has Helped Rob Gronkowski Play Football Again*, SPORTSCASTING (May 21, 2020), https://www.sportscasting.com/cbd-has-helped-rob-gronkowski-play-football-again/.

194 Ben Pickman, *Al Harrington and the Fight for Cannabis Use in the NBA*, SPORTS ILLUSTRATED (Mar. 11, 2020), https://www.si.com/nba/2020/03/11/al-harrington-cannabis-viola-adam-silver-nba.

195 Jenkins, *supra* note 193; Pickman, *supra* note 194.

196 *My Story*, EUGENE MONROE, http://eugenemonroe.com/ (last visited July 6, 2022).

197 *Id.*

involved and spur change by reaching out to key decision-makers.[198]

These players are not the first to argue for policy changes. Professional athletes play a vital role in society and have made a considerable impact on the law in areas such as racial and gender inequality.[199] Athletes often find themselves in the spotlight, which puts them in a unique position to spark reform in the law. If medical marijuana were permitted as medicine for athletes' injuries, the potential to decrease painkiller addiction and overdose rates could be significant.

B. *Big Four Policy Changes*

The road to rescheduling marijuana is not quick, straight, or easy; however, the issue of painkiller substance abuse disorders in professional athletes is imminent and unnerving. A substantial step toward the normalization of marijuana would be for professional sports leagues to modify their drug policies to endorse medical marijuana use for pain in states where medical marijuana is legal. Such endorsements by the Big Four Leagues for the use of medical marijuana to treat pain could potentially decrease the widespread abuse of painkillers. A promising development in this area is evidenced by some sports professionals. The commissioner of the NBA has already stated that he is open to reform and will "follow the science."[200] The commissioner of the NFL similarly stated he would "follow the medicine" and the League would change its position if marijuana can be proven to help.[201] MLB recently made a policy change, which serves as an influential steppingstone to spark movement by

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198 *Id.*

199 *History of Civil Rights Protests in Sports,* SPORTS MGMT. DEGREE HUB, https://www.sportsmanagementdegreehub.com/history-civil-rights-protests-sports/ (last visited Mar. 20, 2022); SI Staff, *The Most Influential People in Title IX History*, SPORTS ILLUSTRATED, (June 22, 2007), https://www.si.com/more-sports/2007/06/22/22-0the-most-influential-people-in-title-ix-history#gid=ci0255c9e5a00024a5&pid=billie-jean-king.

200 Kaplan, *supra* note 126.

201 Mike Florio, *Goodell Says League Would Consider Marijuana as a Concussion Treatment*, NBC SPORTS (Jan. 23, 2014, 4:56 PM), https://profootballtalk.nbcsports.com/2014/01/23/goodell-says-league-would-consider-marijuana-as-a-concussion-treatment/.

other leagues.[202]

Following the death of Los Angeles Angels Pitcher Tyler Skaggs,[203] MLB changed its marijuana and opioid policies.[204] Tyler Skaggs was a twenty-seven-year-old MLB player who died in his hotel room during the 2019 MLB season.[205] Skaggs aspirated while having "a mixture of fentanyl, oxycodone, and alcohol in his system."[206] The Angels' director of communications had provided Skaggs with illegally obtained oxycodone pills.[207] Effective in the 2020 season, MLB removed marijuana from its "drugs of abuse" list and implemented mandatory tests for cocaine and opioids.[208] Players who test positive will be evaluated and prescribed a treatment plan.[209] Those who fail to follow the treatment plan are subject to punishment by the League.[210] Through this new policy, both MLB and the Players Association aim "to protect athletes from lethal and addictive substances."[211] MLB's Chief Legal Officer, Dan Halem, noted: "[t]he opioid epidemic in our country is an issue of significant concern to Major League Baseball. It is our hope that this agreement—which is based on principles of prevention, treatment, awareness and education—will help protect the health and safety of our Players."[212] MLB's drug policy changes

202 Anthony Witrado, *MLB's New Marijuana Policy Could Spark Change In NFL And NBA Policy*, FORBES (Dec. 16, 2019, 11:27 AM), https://www.forbes.com/sites/anthonywitrado/2019/12/16/mlbs-new-marijuana-policy-could-spark-change-in-nfl-and-nba-policy/?sh=3dd997fb42a1.

203 Richard Gonzales, *Autopsy of Los Angeles Angels Pitcher Tyler Skaggs Reveals Opioids And Alcohol*, NPR, (Aug. 30, 2019), https://www.npr.org/2019/08/30/756044573/autopsy-of-los-angeles-angels-pitcher-tyler-skaggs-reveals-opioids-and-alcohol.

204 Paolo Zialcita, *Major League Baseball Drops Marijuana, Adds Opioids, Cocaine To 'Drugs Of Abuse' List*, NPR (Dec. 12, 2019, 4:57 PM), https://www.npr.org/2019/12/12/787550622/major-league-baseball-drops-marijuana-adds-opioids-cocaine-to-drugs-of-abuse-lis.

205 Bill Shaikin & Richard Winton, *Grand Jury Examines Evidence in 2019 Overdose Death of Angels Pitcher Tyler Skaggs*, L.A. TIMES (Mar. 2, 2020, 7:48 PM), https://www.latimes.com/sports/angels/story/2020-03-02/grand-jury-examines-evidence-tyler-skaggs-2019-overdose-death-angels-pitcher.

206 *Id.*

207 *Id.*

208 Zialcita, *supra* note 204.

209 Zialcita, *supra* note 204.

210 Zialcita, *supra* note 204.

211 Zialcita, *supra* note 204.

212 Zialcita, *supra* note 204.

denote the grave concern caused by painkiller addictions, as well as the shrinking concern for marijuana use.

The new MLB policy will also require all players and team staff "to take classes on the 'dangers of opioid pain medications and practical approaches to marijuana' during the next two seasons."[213] Under this policy, marijuana use will be treated equivalent to alcohol use, meaning the "[p]layers caught using cannabis will be referred to a treatment board," but "cannot be punished for failing to participate in a treatment program."[214] The White House Office of National Drug Control Policy applauded the efforts of MLB and the Players Association by praising the recent policy change which now prioritizes treatment over punishment, even further stating its propensity to save lives.[215] Despite the liberating changes to MLB's marijuana policy, the League is not quite advocating for marijuana use as a pain medication. If players can assist in adjusting the stigma and advocating for a change in federal law, the leagues will have a more open door to treat athletes with medical marijuana.

V. CONCLUSION

The opioid epidemic remains an enormous public health issue in the United States. The use of medical marijuana to treat chronic pain is a proposed alternative to these dangerous, addictive opioids. While marijuana legalization is a widely debated topic and will require further research, professional athlete advocacy and professional sports league policy modifications are useful steps that can help educate the public and normalize the acceptance of marijuana as a medicine. It is important to note that athletes are just one of many groups in society that will be benefited by rescheduling marijuana. Rescheduling marijuana could benefit cancer patients, those who suffer from epilepsy, and athletes who suffer painful injuries, but it also could detriment those who misuse the drug. What is imperative to consider is that each controlled substance carries both beneficial and detrimental effects. But at what point is it more unjust and dangerous to

213 Zialcita, *supra* note 204.
214 Zialcita, *supra* note 204.
215 Zialcita, *supra* note 204.

deprive such a large portion of the population of a safer alternative medicine? The road to reform is historically successful by perseverance. Player advocacy coupled with policy changes is a key step in the direction towards combating painkiller misuse by professional athletes.