## 1

#### Interpretation: medicines is a generic bare plural. The aff may not defend that member nations of the World Trade Organization reduce intellectual property protections for a subset of medicines.

Nebel 19 Jake Nebel [Jake Nebel is an assistant professor of philosophy at the University of Southern California and executive director of Victory Briefs.] , 8-12-2019, "Genericity on the Standardized Tests Resolution," Briefly, https://www.vbriefly.com/2019/08/12/genericity-on-the-standardized-tests-resolution/ SM

Both distinctions are important. Generic resolutions can’t be affirmed by specifying particular instances. But, since generics tolerate exceptions, plan-inclusive counterplans (PICs) do not negate generic resolutions. Bare plurals are typically used to express generic generalizations. But there are two important things to keep in mind. First, generic generalizations are also often expressed via other means (e.g., definite singulars, indefinite singulars, and bare singulars). Second, and more importantly for present purposes, bare plurals can also be used to express existential generalizations. For example, “Birds are singing outside my window” is true just in case there are some birds singing outside my window; it doesn’t require birds in general to be singing outside my window. So, what about “colleges and universities,” “standardized tests,” and “undergraduate admissions decisions”? Are they generic or existential bare plurals? On other topics I have taken great pains to point out that their bare plurals are generic—because, well, they are. On this topic, though, I think the answer is a bit more nuanced. Let’s see why. 1.1 “Colleges and Universities” “Colleges and universities” is a generic bare plural. I don’t think this claim should require any argument, when you think about it, but here are a few reasons. First, ask yourself, honestly, whether the following speech sounds good to you: “Eight colleges and universities—namely, those in the Ivy League—ought not consider standardized tests in undergraduate admissions decisions. Maybe other colleges and universities ought to consider them, but not the Ivies. Therefore, in the United States, colleges and universities ought not consider standardized tests in undergraduate admissions decisions.” That is obviously not a valid argument: the conclusion does not follow. Anyone who sincerely believes that it is valid argument is, to be charitable, deeply confused. But the inference above would be good if “colleges and universities” in the resolution were existential. By way of contrast: “Eight birds are singing outside my window. Maybe lots of birds aren’t singing outside my window, but eight birds are. Therefore, birds are singing outside my window.” Since the bare plural “birds” in the conclusion gets an existential reading, the conclusion follows from the premise that eight birds are singing outside my window: “eight” entails “some.” If the resolution were existential with respect to “colleges and universities,” then the Ivy League argument above would be a valid inference. Since it’s not a valid inference, “colleges and universities” must be a generic bare plural. Second, “colleges and universities” fails the upward-entailment test for existential uses of bare plurals. Consider the sentence, “Lima beans are on my plate.” This sentence expresses an existential statement that is true just in case there are some lima beans on my plate. One test of this is that it entails the more general sentence, “Beans are on my plate.” Now consider the sentence, “Colleges and universities ought not consider the SAT.” (To isolate “colleges and universities,” I’ve eliminated the other bare plurals in the resolution; it cannot plausibly be generic in the isolated case but existential in the resolution.) This sentence does not entail the more general statement that educational institutions ought not consider the SAT. This shows that “colleges and universities” is generic, because it fails the upward-entailment test for existential bare plurals. Third, “colleges and universities” fails the adverb of quantification test for existential bare plurals. Consider the sentence, “Dogs are barking outside my window.” This sentence expresses an existential statement that is true just in case there are some dogs barking outside my window. One test of this appeals to the drastic change of meaning caused by inserting any adverb of quantification (e.g., always, sometimes, generally, often, seldom, never, ever). You cannot add any such adverb into the sentence without drastically changing its meaning. To apply this test to the resolution, let’s again isolate the bare plural subject: “Colleges and universities ought not consider the SAT.” Adding generally (“Colleges and universities generally ought not consider the SAT”) or ever (“Colleges and universities ought not ever consider the SAT”) result in comparatively minor changes of meaning. (Note that this test doesn’t require there to be no change of meaning and doesn’t have to work for every adverb of quantification.) This strongly suggests what we already know: that “colleges and universities” is generic rather than existential in the resolution. Fourth, it is extremely unlikely that the topic committee would have written the resolution with the existential interpretation of “colleges and universities” in mind. If they intended the existential interpretation, they would have added explicit existential quantifiers like “some.” No such addition would be necessary or expected for the generic interpretation since generics lack explicit quantifiers by default. The topic committee’s likely intentions are not decisive, but they strongly suggest that the generic interpretation is correct, since it’s prima facie unlikely that a committee charged with writing a sentence to be debated would be so badly mistaken about what their sentence means (which they would be if they intended the existential interpretation). The committee, moreover, does not write resolutions for the 0.1 percent of debaters who debate on the national circuit; they write resolutions, at least in large part, to be debated by the vast majority of students on the vast majority of circuits, who would take the resolution to be (pretty obviously, I’d imagine) generic with respect to “colleges and universities,” given its face-value meaning and standard expectations about what LD resolutions tend to mean.

#### It applies to medicines:

#### Upward entailment test – spec fails the upward entailment test because saying that nations ought to reduce IPP for one medicine does not entail that those nations ought to reduce IPP for all medicines

#### Adverb test – adding “usually” to the res doesn’t substantially change its meaning because a reduction is universal and permanent

#### Vote neg:

#### Semantics outweigh:

#### T is a constitutive rule of the activity and a basic aff burden – they agreed to debate the topic when they came here

#### Jurisdiction – you can’t vote aff if they haven’t affirmed the resolution

#### It’s the only stasis point we know before the round so it controls the internal link to engagement – there’s no way to use ground if debaters aren’t prepared to defend it

#### Limits – there are countless affs accounting for thousands of medicines – unlimited topics incentivize obscure affs that negs won’t have prep on – limits are key to reciprocal prep burden – potential abuse doesn’t justify foregoing the topic and 1AR theory checks PICs. 1] Aff Limits are worse: a) specification forces the neg to bad pics that don't clash and produce stale debates. b]  infinite prep means that the aff can check back against pics while the neg won't have case-specific offense

#### No offense - either PICs are abusive and spikes and theory checks and you don't need spec OR PICs aren't abusive and you don't need spec. Potential abuse doesn't justify aff abuse - just cause the neg couldread PICs or aprioris doesn't mean the aff gets to be abusive themselves

#### There are over 20,000 affs

FDA 11/18 [(U.S. Food and Drug Administration, federal agency of the Department of Health and Human Service) “Fact Sheet: FDA at a Glance,” 11/18/2020] JL

There are over 20,000 prescription drug products approved for marketing.

FDA oversees over 6,500 different medical device product categories.

There are over 1,600 FDA-approved animal drug products.

There are about 300 FDA-licensed biologics products.

#### Ground – spec guts core generics like innovation that rely on reducing IP for all medicines because individual medicines don’t affect the pharmaceutical industry broadly – also means there is no universal DA to spec affs

#### TVA solves – read as an advantage to whole rez

## 2

#### Interpretation – Marijuana isn’t a Medicine

Mosley 20, Mark. "Medical Marijuana Is a Dangerous Lie." Emergency Medicine News 42.8 (2020): 2-3. (Dr. Mark Mosley is an emergency medicine physician in Wichita, Kansas and is affiliated with Wesley Healthcare Center. He received his medical degree from University of Oklahoma College of Medicine and has been in practice for more than 20 years.)//Elmer

**Marijuana is not a medical drug.** It is a **slang term for** a **plant of the Cannabis family that contains more than 60 different cannabinoid substances and more than 80 biologically active compounds**. Using the term marijuana in place of THC would be like using willow tree in place of acetylsalicylic acid, the active ingredient in aspirin.

#### FDA and CDC definitions prove.

CDC ’18 (CDC; Centers for Disease Control and Prevention; 3-7-2018; “**Is marijuana medicine**?”; CDC; <https://www.cdc.gov/marijuana/faqs/is-marijuana-medicine.html>; Accessed: 9-4-2021; AU)

The marijuana plant has chemicals that may help symptoms for some health problems. More and more states are making it legal to use the plant as medicine for certain conditions. But there isn’t **enough research** to show that the whole plant works to treat or cure these conditions. Also, the U.S. Food and Drug Administration (FDA) **has not recognized** or **approved** the marijuana plant **as medicine**. Because marijuana is often smoked, it can damage your lungs and cardiovascular system (e.g., heart and blood vessels). These and other damaging effects on the brain and body could make marijuana more harmful than helpful as a medicine. Another problem with marijuana as a medicine is that the ingredients aren’t exactly the same from plant to plant. There’s no way to know what kind and how much of a chemical you’re getting.

#### Violation – the resolution calls for reductions on IP protections for medicines, but the aff prevents future patents for cannabis-derived products.

#### Vote neg for limits and ground. Expanding the definition of “medicine” to anything that could be used in a medical setting floods the neg with cases to prep for – everything from new methods of chemo to upgrading stethoscopes becomes topical.

#### At best – they’re extra-T since Cannabis isn’t intrinsically medicinal, it just has medicinal uses so they would reduce Recreational Marijuana patents too which isn’t topical and explodes limits.

#### T ow 1ar theory – it’s a prior question to enagement with the aff bcs u chose not to to be topical which makes it lexically prior and ow all ur shells. Also incoherent bcs we cant eval between abuse if urs happened first. Neg flex – aff has infinite prep time and judge bias 2ar.

## 3

#### 1] Interpretation - Reduce means permanent reduction – it’s distinct from “waive” or “suspend.”

**Reynolds 59** (Judge (In the Matter of Doris A. Montesani, Petitioner, v. Arthur Levitt, as Comptroller of the State of New York, et al., Respondents [NO NUMBER IN ORIGINAL] Supreme Court of New York, Appellate Division, Third Department 9 A.D.2d 51; 189 N.Y.S.2d 695; 1959 N.Y. App. Div. LEXIS 7391 August 13, 1959, lexis)

Section 83's counterpart with regard to nondisability pensioners, section 84, prescribes a reduction only if the pensioner should again take a public job. The disability pensioner is penalized if he takes any type of employment. The reason for the difference, of course, is that in one case the only reason pension benefits are available is because the pensioner is considered incapable of gainful employment, while in the other he has fully completed his "tour" and is considered as having earned his reward with almost no strings attached. It would be manifestly unfair to the ordinary retiree to accord the disability retiree the benefits of the System to which they both belong when the latter is otherwise capable of earning a living and had not fulfilled his service obligation. If it were to be held that withholdings under section 83 were payable whenever the pensioner died or stopped his other employment the whole purpose of the provision would be defeated, i.e., the System might just as well have continued payments during the other employment since it must later pay it anyway.  [\*\*\*13] The section says "reduced", does not say that monthly payments shall be temporarily suspended; it says that the pension itself shall be reduced. The plain dictionary meaning of the word is to diminish, lower or degrade. The word "reduce" seems adequately to indicate permanency.

#### It’s temporary – we read blue

**Meredith 21**. [(Sam Meredith is a Correspondent at CNBC in London, covering international politics, energy and business news) “Rich countries are refusing to waive the rights on Covid vaccines as global cases hit record levels,” CNBC, April 22, 2021. <https://www.cnbc.com/2021/04/22/covid-rich-countries-are-refusing-to-waive-ip-rights-on-vaccines.html>] TDI

LONDON — The U.S., Canada and U.K. are among some of the high-income countries actively **blocking a patent-waiver proposal** designed to **boost the global production of Covid-19 vaccines.** It comes as coronavirus cases worldwide surge to their highest level so far and the World Health Organization has repeatedly admonished a “**shocking imbalance” in the distribution of vaccines amid the pandemic.** Members of the World Trade Organization will meet virtually in Geneva, Switzerland on Thursday to hold informal talks on whether to temporarily waive intellectual property and patent rights on Covid vaccines and treatments. The landmark proposal, which was jointly submitted by India and South Africa in October, has been backed by more than 100 mostly developing countries. It aims to facilitate the manufacture of treatments locally and boost the global vaccination campaign. Six months on, the proposal continues to be **stonewalled by a small number of governments** — including the U.S., EU, U.K., Switzerland, Japan, Norway, Canada, Australia and Brazil. “In this Covid-19 pandemic, we are once again **faced with issues of scarcity**, which can be addressed through diversification of manufacturing and supply capacity and ensuring the **temporary waiver of relevant intellectual property**,” Dr. Maria Guevara, international medical secretary at Medecins Sans Frontieres, said in a statement on Wednesday. “It is about saving lives at the end, not protecting systems.” The **urgency and importance of waiving certain intellectual property rights amid the pandemic have been underscored** by the WHO, health experts, civil society groups, trade unions, former world leaders, international medical charities, Nobel laureates and human rights organizations. Why does it matter? The waiver, if adopted at the General Council, the WTO’s highest-level decision-making body, could **help countries around the world overcome legal barriers** preventing them from producing their own Covid vaccines and treatments. Advocates of the proposal have conceded the waiver is not a “silver bullet,” but argue that **removing barriers** toward the development, production and approval of vaccines is **vital in the fight to prevent, treat and contain the coronavirus.**

#### Plan Text in a Vacuum is a useless guideline since words are contextually defined based on function – the only basis for determining Topicality should be if the implementation of the Plan as per their 1AC solvency evidence follows the directional meaning of the Topic’s intent – anything else allows the 1AR to re-contextualize what the Plan says forcing the 1NC to predict infinite 1AR spin since they’re not tied to their evidence.

#### 3] Vote neg for limits and neg ground – re-instatement under any infinite number of conditions doubles aff ground – every plan becomes either temporary or permanent – you cherry-pick the best criteria and I must prep every aff while they avoid core topic discussions like reduction-based DAs which decks generics like Pharma Innovation and Bio-Tech.

#### 5] TVA solves – permanently reduce weed patents.

#### 6] Paradigm Issues –

#### a] Topicality is Drop the Debater – it’s a fundamental baseline for debate-ability.

#### b] Use Competing Interps – 1] Topicality is a yes/no question, you can’t be reasonably topical and 2] Reasonability invites arbitrary judge intervention and a race to the bottom of questionable argumentation.

#### c] No RVI’s - 1] Forces the 1NC to go all-in on Theory which kills substance education, 2] Encourages Baiting since the 1AC will purposely be abusive, and 3] Illogical – you shouldn’t win for not being abusive.

#### Reject 1AR theory- A] 7-6 time skew means it’s endlessly aff biased B] I don’t have a 3nr which allows for endless extrapolation C] 1AR theory is skewed to the aff because they have a 2ar judge psychology warrant.

#### Infinite abuse claims are wrong- A] Spikes solve-you can just preempt paradigms in the 1AC B] Functional limits- 1nc is only 7 minutes long

## 4

#### CP: Member nations of the World Trade Organization should enter into a prior and binding consultation with the World Health Organization over delaying intellectual property protections for cannabis. Member nations will support the proposal and adopt the results of consultation.

#### WHO says yes – it supports increasing the availability of generics and limiting TRIPS

Hoen 03 [(Ellen T., researcher at the University Medical Centre at the University of Groningen, The Netherlands who has been listed as one of the 50 most influential people in intellectual property by the journal Managing Intellectual Property, PhD from the University of Groningen) “TRIPS, Pharmaceutical Patents and Access to Essential Medicines: Seattle, Doha and Beyond,” Chicago Journal of International Law, 2003] JL

However, subsequent resolutions of the World Health Assembly have strengthened the WHO’s mandate in the trade arena. In 2001, the World Health Assembly adopted two resolutions in particular that had a bearing on the debate over TRIPS [30]. The resolutions addressed:

– the need to strengthen policies to increase the availability of generic drugs;

– and the need to evaluate the impact of TRIPS on access to drugs, local manufacturing capacity, and the development of new drugs

#### Consultation displays strong leadership, authority, and cohesion among member states which are key to WHO legitimacy

Gostin et al 15 [(Lawrence O., Linda D. & Timothy J. O’Neill Professor of Global Health Law at Georgetown University, Faculty Director of the O’Neill Institute for National & Global Health Law, Director of the World Health Organization Collaborating Center on Public Health Law & Human Rights, JD from Duke University) “The Normative Authority of the World Health Organization,” Georgetown University Law Center, 5/2/2015] JL

Members want the WHO to exert leadership, harmonize disparate activities, and set priorities. Yet they resist intrusions into their sovereignty, and want to exert control. In other words, ‘everyone desires coordination, but no one wants to be coordinated.’ States often ardently defend their geostrategic interests. As the Indonesian virus-sharing episode illustrates, the WHO is pulled between power blocs, with North America and Europe (the primary funders) on one side and emerging economies such as Brazil, China, and India on the other. An inherent tension exists between richer ‘net contributor’ states and poorer ‘net recipient’ states, with the former seeking smaller WHO budgets and the latter larger budgets.

Overall, national politics drive self-interest, with states resisting externally imposed obligations for funding and action. Some political leaders express antipathy to, even distrust of, UN institutions, viewing them as bureaucratic and inefficient. In this political environment, it is unsurprising that members fail to act as shareholders. Ebola placed into stark relief the failure of the international community to increase capacities as required by the IHR. Guinea, Liberia and Sierra Leone had some of the world's weakest health systems, with little capacity to either monitor or respond to the Ebola epidemic.20 This caused enormous suffering in West Africa and placed countries throughout the region e and the world e at risk. Member states should recognize that the health of their citizens depends on strengthening others' capacity. The WHO has a central role in creating systems to facilitate and encourage such cooperation.

The WHO cannot succeed unless members act as shareholders, foregoing a measure of sovereignty for the global common good. It is in all states' interests to have a strong global health leader, safeguarding health security, building health systems, and reducing health inequalities. But that will not happen unless members fund the Organization generously, grant it authority and flexibility, and hold it accountable.

#### WHO is critical to disease prevention – it is the only international institution that can disperse information, standardize global public health, and facilitate public-private cooperation

Murtugudde 20 [(Raghu, professor of atmospheric and oceanic science at the University of Maryland, PhD in mechanical engineering from Columbia University) “Why We Need the World Health Organization Now More Than Ever,” Science, 4/19/2020] JL

WHO continues to play an indispensable role during the current COVID-19 outbreak itself. In November 2018, the US National Academies of Sciences, Engineering and Medicine organised a workshop to explore lessons from past influenza outbreaks and so develop recommendations for pandemic preparedness for 2030. The salient findings serve well to underscore the critical role of WHO for humankind.

The world’s influenza burden has only increased in the last two decades, a period in which there have also been 30 new zoonotic diseases. A warming world with increasing humidity, lost habitats and industrial livestock/poultry farming has many opportunities for pathogens to move from animals and birds to humans. Increasing global connectivity simply catalyses this process, as much as it catalyses economic growth.

WHO coordinates health research, clinical trials, drug safety, vaccine development, surveillance, virus sharing, etc. The importance of WHO’s work on immunisation across the globe, especially with HIV, can hardly be overstated. It has a rich track record of collaborating with private-sector organisations to advance research and development of health solutions and improving their access in the global south.

It discharges its duties while maintaining a dynamic equilibrium between such diverse and powerful forces as national securities, economic interests, human rights and ethics. COVID-19 has highlighted how political calculations can hamper data-sharing and mitigation efforts within and across national borders, and WHO often simply becomes a convenient political scapegoat in such situations.

International Health Regulations, a 2005 agreement between 196 countries to work together for global health security, focuses on detection, assessment and reporting of public health events, and also includes non-pharmaceutical interventions such as travel and trade restrictions. WHO coordinates and helps build capacity to implement IHR.

## Case

### A2 Monopolies

#### 1] Big Pharma patent monopolies have failed – their Thailand example proves – the patents were indefinitely banned.

Reuters 19 Staff. “Thailand to Revoke Foreign Patent Requests on Marijuana.” Reuters, Thomson Reuters, 28 Jan. 2019, www.reuters.com/article/us-thailand-cannabis/thailand-to-revoke-foreign-patent-requests-on-marijuana-idUSKCN1PM1FU. //sid

Thailand on Monday effectively revoked all foreign patent requests for the use of marijuana, after fears foreign firms would dominate a market thrown open last month when the government approved the drug for medical use and research. The junta-appointed parliament in Thailand, a country which until the 1930s had a tradition of using marijuana to relieve pain and fatigue, voted to amend the Narcotic Act of 1979 in December in what it described as “a New Year’s gift to the Thai people”. While countries from Colombia to Canada have legalized marijuana for medical or even recreational use, the drug remains illegal and taboo across much of Southeast Asia. But in Thailand, the main controversy with the legalization involved patent requests by two foreign firms, British giant GW Pharmaceuticals and Japan’s Otsuka Pharmaceutical, filed before the change to the law. Thai civil society groups and researchers feared domination by foreign firms could make it harder for Thai patients to get access to medicines and for Thai researchers to get marijuana extracts. ADVERTISEMENT The military government issued a special executive order on Monday enabling the Department of Intellectual Property to revoke all pending patents that involve cannabis, or remove marijuana from those patents, within 90 days. “The pending patent requests are illegal,” Somchai Sawangkarn, a member of parliament responsible for amending the Narcotic Act told Reuters. “This NCPO order is beneficial for Thai people across the country because it prevents a monopolistic contract,” he said referring to the junta by its official name, the National Council for Peace and Order. Reuters did not have contact details for spokesmen for either of the two foreign firms and the companies did not immediately respond to emailed requests for comment.

#### 2] Barnett has no internal to innovation in medical marijuana – it’s specific to farmers not being able to grow weed to sell, not medical research.

#### 3] No impact to marijuana innovation – we don’t need new types of weed. This doesn’t turn our innovation arguments because our link is that reduction in IP chills innovation for all medicine due to fear of spillover

#### 4] No Uniqueness – Biden wont’ legalize Marijuana at a federal level.

Kane 21 Kris Kane 3-26-2021 "Enjoy Marijuana? Joe Biden Doesn’t Care About You" <https://www.forbes.com/sites/kriskrane/2021/03/26/enjoy-marijuana-joe-biden-doesnt-care-about-you/?sh=4dec240e651d> (Senior Contributor at Forbes on the Weed Industry)//Elmer

This pattern of legalization supporters backpedaling to appease Joe Biden dates back to the campaign itself, where **Biden’s** **campaign** seemingly **sought to roll back years of progress** made by the Democratic Party since President Obama left office. In 2016 the Democratic Party platform included language calling for a “pathway” to legalization. Yet in 2020 **Biden’s campaign rejected** such language, removing any mentions of **meaningful cannabis policy reform** from the platform. When supporters tried to add a legalization plank back into the platform, even co-chair of the Congressional Cannabis Caucus Rep. Barbara Lee (D-CA) voted against it, presumably not to run afoul of the wishes of her party’s standard bearer despite her own strong support for legalization. Of course, none of this should be especially surprising. Joe **Biden’s record on marijuana**, drugs and crime **is** arguably **the worst** and most punitive of any Democratic politician of the past 50 years not named Diane Feinstein. He was an author and **champion** of the 1994 Crime Bill that is largely responsible **for** the current **mass incarceration** crisis in this country, and was the lead sponsor of the RAVE Act, one of the last pieces of draconian drug policy legislation passed by Congress that punished concert venue owners and promoters if drugs were used or sold at their events, even if they had no knowledge or involvement in the drug related activity. This is a politician who in 1974 said, “I don’t think marijuana should be legalized,” repeating that sentiment **as recently as 2010** when he **stated** “**I think legalization is a mistake**.” As Vice President in 2012 Biden had ““serious doubts that decriminalization would have a major impact on the earnings of violent criminal organizations,” and that “on examination you realize there are more problems with legalization than with non-legalization.”

### A2 Opioids

#### 1] Medical marijuana does not solve opioid use. Prefer – they only analyze prescriptions but the problem the 1AC isolates is overuse of illegal drugs.

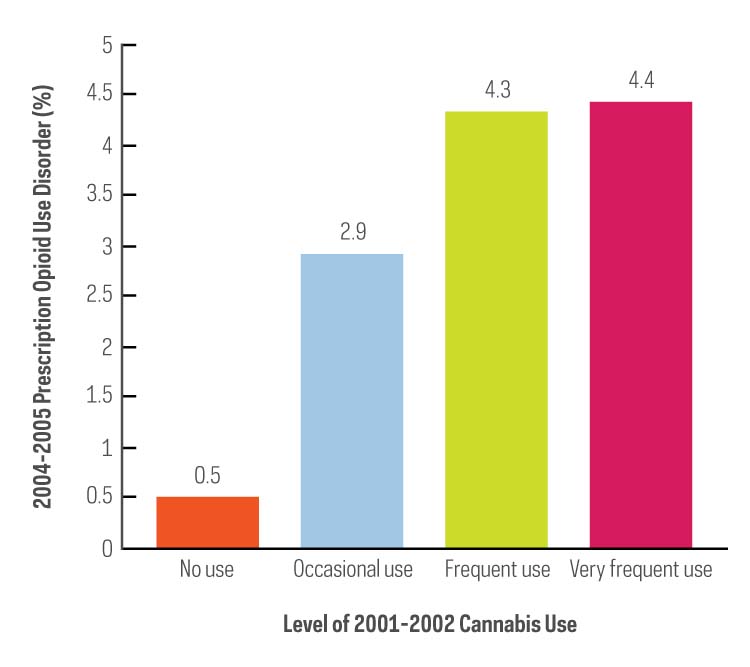
Firozi 20, Paulina. “Analysis | the HEALTH 202: No, Legalizing Medical Marijuana Doesn't Solve the Opioid Crisis.” The Washington Post, WP Company, 17 July 2020, www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/06/11/the-health-202-no-legalizing-medical-marijuana-doesn-t-solve-the-opioid-crisis/5cfe94a61ad2e5122b87c57f/. //sid

Five years ago — as the country’s opioid crisis had just started garnering national attention — a study got a lot of buzz suggesting that opioid overdose deaths were 25 percent lower in states that had given the nod to medical marijuana. At the time, policymakers were starting to search for the best ways to respond to the crisis, and the public was just starting to learn about the so-called “Lazarus drug” Naloxone, which rapidly reverses opioid overdoses. But now, Stanford University researchers have released a new study finding the exact opposite: States that allowed marijuana use for medical purposes actually had 23 percent more deaths from opioid overdoses, when they looked over a longer period of time. “The new work appears to be a cautionary tale about inferring cause and effect — wanting research to show something it can’t because the nation is in the grip of a deadly opioid epidemic or because there is money to be made by offering possible solutions,” my Post colleague [Lenny Bernstein writes](https://www.washingtonpost.com/health/a-cautionary-tale-about-medical-marijuana-and-opioid-deaths/2019/06/10/b8e1c924-8b97-11e9-adf3-f70f78c156e8_story.html?utm_term=.b2438263a99d&itid=lk_inline_manual_10). It was intriguing to think that the problem of opioid overdoses, which have taken more than American 400,000 lives in the past two decades, could have such a simple solution upon which states were already embarking. Thirty-three states plus the District of Columbia [now allow](https://disa.com/map-of-marijuana-legality-by-state) the use of medical marijuana. Last week, New Mexico joined New York, New Jersey and Pennsylvania in [approving it](https://www.washingtonpost.com/national/health-science/medical-pot-laws-no-answer-for-us-opioid-deaths-study-finds/2019/06/10/faf5b0d0-8bb2-11e9-b6f4-033356502dce_story.html?utm_term=.58b00d7ceb19&itid=lk_inline_manual_11) specifically for patients addicted to opioids. (Although not every state is embracing medical marijuana products. Iowa Gov. Kim Reynolds (R) vetoed a bill last month that would have expanded a medical cannabidiol program allowing capsules and extracts, saying the state needs to “proceed cautiously” on changes.) South Bend, Ind., Mayor Pete Buttigieg, who is seeking the Democratic presidential nomination, criticized the veto: The correlation between medical marijuana and lower opioid overdose seemed to be confirmed in a [2014 study](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4392651/) by Johns Hopkins researchers, who found 24.8 percent fewer deaths in the period from 1999 to 2010 after states passed laws legalizing medical marijuana. The Stanford researchers came up with very similar results while looking at the same time period, but the data reversed once they extended the analysis to 2017. “A lot of people interpreted the first study as causal because it’s congenial to their goals,” Chelsea Shover, a postdoctoral fellow in psychiatry who was part of the Stanford research team, told Lenny. “It did not say that one is causing the other.” “I wish it were true,” she added. “I wish that passing medical cannabis [laws] would solve the opioid crisis. But the evidence doesn’t support that.” Shover told Lenny the conflicting results could be related to the fact that only 13 states had medical marijuana laws for the initial study, and many of them were in the West, where the opioid epidemic arrived later. Many more states had approved medical use of marijuana by the end of the study time period, leaving researchers with few states to use for comparison.

#### 2] Turn – Marijuana increases Opioid Use

HBFF 18 Hazelden Betty Ford Foundation "Marijuana Is Not a Public Health Solution to the Opioid Crisis" <https://www.hazeldenbettyford.org/education/bcr/addiction-research/marijuana-not-solution-to-opioid-crisis> (an addiction treatment and advocacy organization that was created in 2014 with the merger of the Minnesota-based Hazelden Foundation and the Betty Ford Center in Rancho Mirage, California in the United States. The organizations have a long history together.)//Elmer

Studies at the individual level: **Marijuana use increases risk for subsequent opioid use and dependence** The other side to the story regarding marijuana and opioids is how the two substances are related to each other at the individual level. The vast majority of individuals who misuse prescription pain medication and/or heroin initiated their drug use early in their teens, usually beginning with alcohol and marijuana. Biologically, **early initiation of drug use primes** the **brain for enhanced responses to other drugs later in life.** Most recently, **Caputi and Humphreys** (2018) **show** the **heightened risk of prescription opioid misuse among medical marijuana users**. **Using nationally representative data**, they found that medical marijuana users have **twice the risk for prescription opioid misuse** compared with non-users of medical marijuana. Although this study used data collected at one point in time, the findings raise doubts that medical marijuana can be protective against the development of opioid use disorder.



#### 3] No internal between Morell and Quetteville – opioids are not nerve agents, which means no internal to chemical weapons ban erosion or chemical weapons use.

#### 4] Blake 20 is missing an internal between overprescription of opioids and abuse of much worse drugs like carafentanil. They assume a causal relationship, but smoking weed is not the same as shooting heroin.

#### 5] Assign this impact scenario zero risk – their 1AC Morell card isolates one singular Opioid, “Carfentanil” as a “chemical weapon” – your 1AC de Quetteville is about Nerve Agents and Chemical Gas which isn’t the same thing .

#### 6] Medical Marijuana is worse – higher rates of addiction and more of a gateway to worse drugs which turns case

Mosley 20 [Mark Mosley MD, PHD, 10-15-2020, "Viewpoint: Medical Marijuana Is a Dangerous Lie : Emergency Medicine News," LWW, <https://journals.lww.com/em-news/fulltext/2020/08000/viewpoint__medical_marijuana_is_a_dangerous_lie.27.aspx>] srey

The brain has a natural cannabinoid system much like the intrinsic endogenous opioid receptors. Both increase dopamine, which registers as a reward and suppresses negative emotion and suffering. Exogenous opioids and exogenous cannabinoids also increase dopamine but to a much greater extent than endogenous pathways. When stimulated chronically, dopamine becomes down-regulated. Cannabinoids, completely separate from any pain-relieving properties, which initially decreased suffering, anxiety, and negative mood make one hypersensitive to suffering, anxiety, and negative mood. THC is known for its acute immediate effects of slow thinking and difficulty with problem-solving, altered time and sense misperception, and memory difficulties can cause psychosis when used at higher doses. (N Engl J Med. 2014;370[23]:2219; https://bit.ly/3hmxTrM.) Marijuana used chronically is correlated with lower life satisfaction, poorer mental health, poorer relationships, decreased IQ, and low resilience. Mentally ill people in particular tend to self-medicate with marijuana, which paradoxically increases their anxiety and psychosis. It is reported that 20 percent of pregnant women under 24 use marijuana, though its effects on the fetal brain are unknown. (JAMA. 2017;318[24]:2490; https://bit.ly/3hnJoiE.) Other associations include COPD, increased motor vehicular collisions, Cannabis hyperemesis syndrome, childhood overdoses from edibles, a gateway to harder drugs, and decreased school and work performance. Illicitly made marijuana can be laced with K2, fentanyl, and embalming fluid. (N Engl J Med. 2014;370[23]:2219; https://bit.ly/3hmxTrM.) It is true that overdosing on marijuana is rarely life-threatening, unlike opioids, but addiction and mental illness could actually be worse than opioids due to availability.

### A2 Plan/Solvency

#### 1] 1AC Kellner undermines aff solvency – it concedes that shortening patent windows will be compensated by increasing profitability, but the aff scenario is reliant on increasing access by lowering prices

#### 2] The card is not saying that delaying enforcement causes innovation – it just incentivizes finding legal loopholes or shutting down the businesses.

Recut Kellner 21 “Mitigating the Effects of Intellectual Property Colonialism on Budding Cannabis Markets” Hughie Kellner [Hughie Kellner came from the small farm town of Uvalde, Texas and received a bachelor’s degree in Physics from the University of Texas at Austin. Upon graduation from the Indiana University Maurer School of Law, Hughie will deploy his physics degree while prosecuting patents in the Frankfurt am Main, Germany office of Leydig, Voit, & Mayer. After Hughie’s first year at Maurer, he worked for a law firm in Thailand as a Stewart Fellow.] Indiana Journal of Global Legal Studies Vol. 28 #1 (Winter 2021) <https://www.repository.law.indiana.edu/ijgls/vol28/iss1/9/> SM //rehighlighted sid

#### Third, if actors are utilizing technology under such currently unenforceable but soon-to-be enforceable patents, they will have clear notice when they must cease such infringing action, and either close their doors or develop a compliant way of doing business. Thus, actors in the market can establish themselves and then innovate their own means

#### of carrying out business or license it from those who do. This is the exact action patents are meant to incentivize, innovating

#### Framing DA - Their framings of resistance of Medical speheres sustain neoliberal crisis—turns the case necessitates psychological violence

McKeown et al 2017. Dr. M McKeown is Reader in Democratic Mental Health, School of Nursing, University of Central Lancashire. Dr. K Wright is the head of School of Nursing, University of Central Lancashire, Lancashire. Dr. D. Mercer Lecturer, School of Health Sciences, University of Liverpool. “Care planning: a neoliberal three cardtrick.” Volume 24, Special Issue on Care Planning and Co-ordination

Pages 451–460] VR

Listening for a squawk of resistance

Where then is the squawk from beleaguered nurses and other psy-professionals? There are some notable exemplars: the Critical Psychiatry Network, Psychologists Against Austerity, and the Critical Mental Health Nursing Network, amongst a few. Similarly, health and public service trade unions are often vociferous campaigners against cuts, but arguably require a more sophisticated politics of mental health and somewhat less hubris to forge the necessary alliances with survivor and service user activism required to pursue change (McKeown et al. 2014a). Notwithstanding the energies put into various campaigns, or grassroots rumblings of discontent, any collective squawk from mental health nurses seems to be very much muted at present but has great potential to grow into something more powerfully meaningful. Under neoliberalism, Western democracies, their health care services and trade unions face a multiplicity of interconnected legitimacy shortcomings. An inevitable consequence is the precipitation of protest and contemplation of alternative futures. The various crises of legitimation include democratic deficits in the state at national and local levels, a crisis in care and alleged lack of compassion amongst the workforce (Francis 2013), and trade union decline associated with loss of faith in internal democratic structures (Hyman 2007). Bauman (2000) posits a state of liquid modernity that has come to typify the experience of life under mature capitalistic societies. Public services in particular suffer predictably negative consequences of marketization and privatisation, including heightened uncertainties and insecurities for the workforce with subsequent damage in terms of continuity and fragmentation of caring relationships (Randall & McKeown 2013). Mental health services are perennially starved of resources and organised around a medical model that upholds mass compulsion and coerced treatment, precipitating specific criticisms and pro-active consideration of alternatives. Thus bio-psychiatry is subject to a quite particular legitimacy crisis, subject to powerful questioning on its own scientific terms with credible critique of the evidence for treatments such as medication (Moncreiff 2008, Whittaker 2010). The resource squeeze on public services has significantly contributed to a workforce crisis, with disquiet over establishment of safe staffing levels. Such concerns have largely referenced general adult healthcare; with mental health services (perhaps conveniently) neglected in much of the discussion. In some regards this has resulted in the beginnings of a squawk, but arguably the levels and volume of dissent have been insufficient or energies side-tracked into circular debates regarding the calibration or evidencing of staffing profiles. Neoliberal regimes favour elaborate mechanisms for scrutiny and calculation that promulgate a strange admixture of illusory confidence and abject anxieties concerning staffing-levels. The pretence of systematisation fosters a veneer of safety to present to auditors and commissioners whilst a necessity of defensive practice is reinforced in the face of insufficiencies and high turnover of staff. Taken together, these crises have provoked critical thinking to frame alternative forms of care that hold promise to meet Sedgwick’s demand for large-scale responses to mental distress. A number of these, such as Soteria, earlier thinking around Therapeutic Communities and the more recent Open Dialogue, whilst not panaceas, share a common characteristic of privileging democracy, and if at all possible, minimising coercion and medication (Mosher 1999, Seikkula et al. 2011, Spandler 2009, Winship 2013). The notion of user voice has achieved, at least at the level of rhetoric, a certain prominence in policy and practice, with examples of involvement extending beyond direct care into education and research (Lowes & Hulatt 2013, McKeown & Jones 2014, Terry 2012). Somewhat paradoxically, critically minded service users have capitalised on a distinctly consumerist turn in social policy attendant on neoliberal assertions of the primacy of individualism and personal choice. A consumerist framing perhaps explains both the general lack of transformative impact of what passes for standard user involvement initiatives (see Suzanne Hodge 2005, 2009) and the ever present hazard of co-option. Cooke & Kothari (2002) view such participation as akin to a new form of tyranny, too readily incorporated into established systems of governance and control. Yet, whilst not yet revolutionary there are also undoubted contemporaneous successes of more creative and deliberative forms (McKeown et al. 2014b). To some extent this supports the view of commentators such as Clarke (2007) who defy pessimism regarding the possibilities for overthrowing neo-liberal hegemony, highlighting the potential of recalcitrant positioning within the cracks and interstices of public services. Similarly, Saario (2012) has noted the subtle ways in which mental health nurses can resist unwanted aspects of new managerialism. We turn now to consider opportunities for moving beyond a rhetoric of participation and voice towards a logic of democratisation that involves staff and service users in shaping the very ways in which care work is organised. Within such a frame, the very idea of individualised care planning may become redundant, or at least credibly questioned, in a context of more collectivised intervention