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### Adv 1

**Advantage 1 is Practitioners**, or “NPs”**:**

**The FTC challenges State-Level SOP restrictions but fails due to state action immunity. That cements the “physician-only” model.**

**McMichael 20** Internally quoting the Udalova and MEPS data sets. Benjamin McMichael – Faculty, University of Alabama School of Law. McMichael earned a BS in Mathematical Economics from Wake Forest University and a JD and PhD in law and economics from Vanderbilt University. Before joining the faculty at Alabama, Benjamin served as a law clerk to Judge Carolyn Dineen King on the United States Court of Appeals for the Fifth Circuit. Benjamin’s research is interdisciplinary, relying on empirical methods developed in the social sciences—particularly economics—to generate new insight into the ways in which the law influences the provision of healthcare - “Occupational Licensing and the Opioid Crisis” 54 U.C. Davis L. Rev. 887 - December, 2020 – some footnotes included for context and elaboration – but no text omitted other than the OG Table of Contents after the opening abstract - #E&F - <https://lawreview.law.ucdavis.edu/issues/54/2/articles/files/54->

This example illustrates the importance of access **to healthcare providers** **in addition** to access to health insurance. 5 **And** access to providers is **far from given**, with many areas of the country experiencing **shortages of healthcare providers** that experts **expect to worsen** over the next decade. 6 The New York Times example also highlights both **a viable policy option** to address these shortages - the increased use of NPs to provide care - and **an important obstacle** **to implementing this** policy - **restrictive laws**.

NPs are registered nurses who have undergone additional training to provide healthcare services historically provided by physicians. 7 They represent the principal source of care in many geographic areas 8 and are more likely than physicians to practice in **rural** and **underserved communities**. **9 This** makes the 200,600 practicing NPs a natural option to address **chronic**, **critical**, and **worsening** **physician shortages** across the country. 10 While NPs provide healthcare services across the country, their ability to do so is not equal in all areas. **State scope-of-practice** ("**SOP**") laws - a subset of the occupational licensing laws that govern NPs and many other professionals - determine what services [\*891] NPs may provide and the conditions under which they may provide those services.

States often justify SOP laws as necessary to ensure patient safety by preventing unqualified individuals from providing care. 11 Though these laws can further this goal, excessively restrictive SOP laws undermine the ability of NPs to care for patients. **Prior work** has shown that eliminating restrictive SOP laws and allowing NPs to practice **independent**ly **of physicians** can facilitate **access to care**, 12 **improve** the **quality** of care, 13 **reduce** the use of intensive medical procedures, **14** and reduce the price of some healthcare services. 15 Based on this evidence, the Obama and Trump administrations along with the National Academy of Medicine and other organizations have urged states to relax their SOP laws. 16 A minority of states have responded by granting NPs the authority to practice independently, but the ongoing debate and [\*892] political battle over SOP laws has only intensified over the last decade. 17 Physician organizations, in particular, vigorously oppose the relaxation of these laws and have been successful in discouraging states from granting NPs independence. 18

**9** See Peter I. Buerhaus, Catherine M. DesRoches, Robert Dittus & Karen Donelan, Practice Characteristics of Primary Care Nurse Practitioners and Physicians, 63 NURSING OUTLOOK 144, 144-50 (2015) [hereinafter Practice Characteristics] (finding that NPs are more likely to care for Medicaid patients, vulnerable populations, and rural populations); Grant R. Martsolf, Hilary Barnes, Michael R. Richards, Kristin N. Ray, Heather M. Brom & Matthew D. McHugh, Employment of Advanced Practice Clinicians in Physician Practices, 178 JAMA INTERNAL MED. 988, 988-89 (2018) (finding that NPs are likely to be employed in **primary care)**.

**10** Occupational Employment and Wages, May 2019, 29-1171 Nurse Practitioners, U.S. BUREAU LAB STAT., https://www.bls.gov/oes/current/oes291171.htm (last visited Nov. 11, 2020) [https://perma.cc/5A4C-9H7S].

**11** See Morris M. Kleiner, Enhancing Quality or Restricting Competition: The Case of Licensing Public School Teachers, 5 U. ST. THOMAS J.L. & PUB. POL’Y 1, 3, 8 (2011) (“The general rationale for licensing is the health and safety of consumers. Beyond that, the quality of service delivery . . . [is] sometimes invoked.”).

**12** Benjamin J. McMichael, Beyond Physicians: The Effect of Licensing and Liability Laws on the Supply of Nurse Practitioners and Physician Assistants, 15 J. EMPIRICAL L. STUD. 732, 764-65 (2018) [hereinafter Beyond Physicians]; Jeffrey Traczynski & Victoria Udalova, Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes, 58 J. HEALTH ECON. 90, 103-04 (2018); see also John A. Graves, Pranita Mishra, Robert S. Dittus, Ravi Parikh, Jennifer Perloff & Peter I. Buerhaus, Role of Geography and Nurse Practitioner Scope-of-Practice in Efforts to Expand Primary Care System Capacity, 54 MED. CARE 81, 83-88 (2016).

**13** Traczynski & Udalova, supra note 12, at 97

**14** See, e.g., Sara Markowitz, E. Kathleen Adams, Mary Jane Lewitt & Anne L. Dunlop, Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?, 55 J. HEALTH ECON. 201, 209-16 (2017) (showing **a reduced probability** of **intensive procedures** related to pregnancies in states that allow nurse practitioners to practice with no barriers).

When opposing NP independence, physician groups often argue that requiring physician supervision promotes patient safety and the delivery of high-quality care. 19 Although existing clinical evidence undermines these claims, 20 physician groups have recently emphasized the troubling possibility that allowing NPs to practice independently will increase opioid prescriptions. 21 The reasoning offered is straightforward: If NPs can prescribe opioids without physician supervision, then they will inappropriately overprescribe opioids and deepen the ongoing opioid crisis. 22 This Article engages with the debate [\*893] over NP SOP laws by empirically analyzing the impact these laws have on opioid prescriptions. Given the severity of the ongoing opioid crisis, the claim that allowing NP independence will deepen that crisis by increasing opioid prescriptions warrants careful consideration. On one hand, allowing NPs to practice independently can address critical access-to-care issues and improve the healthcare system in other important ways. On the other hand, restricting the practices of NPs may be justified despite these benefits if doing so avoids exacerbating the opioid crisis. This Article provides critical new evidence on the effect that NP SOP laws have on opioid prescriptions. Specifically, I analyze a dataset of approximately 1.5 billion individual opioid prescriptions, which represent approximately 90% of all opioid prescriptions filled at outpatient pharmacies between 2011 and 2018. This dataset provides unprecedented insight into the ongoing opioid epidemic and the role of healthcare providers in that epidemic. Because this dataset covers nearly the universe of opioid prescriptions in the United States over eight years and is organized at the individual-prescription level, I am able to develop more complete and more granular evidence on the role of NP SOP laws in opioid prescriptions than has previously been possible. The analysis reveals that allowing NPs to practice independently reduces the quantity of opioids prescribed across all physicians and NPs by approximately 4.4%. 23 In contrast to physician groups' claims, the evidence developed here suggests that relaxing NP SOP laws reduces opioid prescriptions. Thus, this Article demonstrates that, rather than exacerbating the opioid crisis, granting NPs independence is a valid policy option for addressing that crisis. These results can inform the ongoing debates over both NP SOP laws and the opioid epidemic more generally, and this Article uses this evidence to recontextualize the debate over SOP laws and offer specific policy recommendations. In addition to joining various scholars and [\*894] organizations in urging states to reform their SOP laws, this Article engages with potential federal policy options that can both address the dire healthcare provider shortages across the country while ameliorating the opioid crisis. Federal options, such as the ones discussed below, will become increasingly relevant as state legislation has proven difficult to obtain in certain states. 24 This Article proceeds in four parts. Part I details the contributions that NPs make to the healthcare system and the ways SOP laws impact their ability to do so. 25 Part II provides context for the empirical analysis that is the focus of the Article by detailing the progression of the opioid crisis. 26 Part III discusses the empirical methodology and reports the results of the empirical analysis. 27 Part IV engages with the policy implications stemming from the results of that analysis, 28 and a brief conclusion follows.

I. REGULATING HEALTHCARE PROVIDERS

Historically, physicians have delivered most of the healthcare in the United States. While other providers, such as registered nurses, have always played important roles in healthcare, physicians have been responsible for directing most care delivery. Physician dominance, however, has begun to recede as NPs and other types of healthcare providers are providing "[a] growing share of health care services." 29 And **this trend will likely continue** because the growth rate of NPs outstrips that of physicians, 30 which only **adds urgency** to resolving the debate over NP SOP laws. To provide context to that debate, this Part [\*895] begins by discussing the role of NPs in the healthcare system before outlining the contours of the debate over the SOP laws that regulate NPs.

A. Nurse Practitioners and the Laws that Govern Them

To qualify as an NP, an individual must first become a registered nurse, which often involves completing a bachelor's degree in nursing. 31 Most registered nurses practice for several years before returning to complete a master's or doctoral degree to become an NP. 32 Their training involves clinical and didactic courses that prepare future NPs to diagnose and treat patients, order and interpret tests, and prescribe medication. 33 Following their training, NPs practice in a wide variety of medical settings, but over 60% choose to provide some form of primary care. 34 With this training, NPs provide care alongside physicians across the country, 35 but where they choose to practice and which patients they choose to care for often differs substantially from the choices made by physicians. Relative to physicians, NPs more often choose to practice in primary care and to care for underserved populations, including Medicaid patients. 36 They also provide care in rural or underserved areas to a [\*896] greater extent than physicians. 37 The predilection of NPs to practice in isolated areas and care for patients who have difficulty accessing care is particularly important in an era of worsening physician shortages. For example, the Association of American Medical Colleges estimates that, by 2032, the United States will face a physician shortage of between 46,900 and 121,900. 38 Such a shortage has implications for the country generally, but it will impact rural areas to a greater degree. Recent estimates suggest that the number of physicians practicing in these areas could decline by 23% by 2030. 39 With approximately 200,600 NPs delivering care in 2019 40 NPs can alleviate physician shortages in rural and other areas. Indeed, NPs outnumber primary care physicians, 41 practice in convenient locations like retail and urgent care clinics, 42 and represent the principal source of healthcare in many parts of the country. 43 However, the ability of NPs to function as the principal source of healthcare depends heavily on the SOP laws in place. Prior work has [\*897] classified NP SOP laws in slightly different ways. 44 Each classification system has advantages and disadvantages, but I adopt a classification scheme based on two recent studies that that focus on specific statutory and regulatory language. 45 Where necessary, I updated the classifications based on more recent statutory and regulatory information. This approach to classification eliminates the risk of mis-classification that can occur by relying on inconsistent secondary sources. It also isolates the specific statutes and regulations that policymakers may change to achieve specific results in their healthcare systems. 46 Using these statutes and regulations, I classify each state in each year as either allowing NPs to practice independently or restricting the practices of NPs. To be classified as allowing "independent practice," a state must (1) have no requirement that physicians supervise NPs and (2) grant NPs full prescriptive authority, i.e., allow NPs to prescribe the same range of medications as physicians. 47 States that either require physician supervision of NPs or restrict their prescriptive authority fall into the "restricted practice" category. [\*898] Figure 1 provides an overview of NP SOP laws during the time period analyzed here. In 2011, fourteen states allowed NPs to practice independently, and thirty-seven states restricted the practices of NPs. 48 Of the thirty-seven states restricting NP practice, fourteen changed their laws prior to the end of 2018 to allow NPs to practice independently. 49 Figure 1 separately highlights each of the states that always allowed NPs to practice independently, always restricted NP practice, and changed from restricted to independent practice. As Figure 1 illustrates, the trend among states decidedly favors NP independence, with half of all states that currently allow independent practice adopting a law to that effect in the last decade. This trend has not emerged without opposition, however, and the debate between opponents of relaxing NP SOP laws and advocates of greater NP autonomy has become quite heated. The next subpart engages with this [\*899] ongoing debating, tracing the contours of each side's arguments and the evidence that supports their arguments.

B. The Scope-of-Practice Debate

As NPs have assumed greater roles in the delivery of care, some groups have objected to liberalizing the SOP laws that govern NPs to allow them to provide more services and practice with greater autonomy. Principal among the opponents of relaxing NP SOP laws are physician groups, with the American Medical Association ("**AMA"**) offering some of the strongest resistance to granting NPs greater independence. 50 Advocates of greater NP autonomy include nursing groups, policy think tanks of various political orientations, the National Academy of Medicine, and the Obama and Trump administrations. 51 Opponents of greater NP autonomy often emphasize the greater education completed by physicians and argue that NPs cannot provide safe or high-quality care without physician supervision. 52 Proponents often respond that NPs deliver care of similar quality as physicians and that allowing greater NP autonomy lowers the cost of care and improves access to care. 53 This Part engages with each of these sets of arguments in turn.

1. Independent Nurse Practitioners and the Quality of Care

Perhaps the most contentious point in the debate over NP SOP laws concerns the ability of NPs to deliver high-quality care without physician oversight. Opponents of NP independence generally argue that, **without physician supervision**, NPs cannot safely care for patients. For example, the California Medical Association has stated that it "opposes any attempts to remove physician oversight over [NPs] and believes that doing so would put the health and safety of patients at risk." 54 Some groups frame their arguments about quality of care in [\*900] terms of the different levels of education completed by NPs and physicians. 55 These arguments require the additional inferential step that more education is required to provide the type of care delivered by NPs, but they are effectively equivalent to statements that unsupervised NPs cannot safely care for patients. 56 Advocates of greater NP autonomy respond to these arguments by pointing to the available evidence that demonstrates NPs generally deliver care of comparable quality to that delivered by physicians. 57 Multiple studies have investigated the ability of NPs to deliver high-quality care, often comparing NP-supplied care to physician-supplied care. 58 A recent comprehensive analysis compared the quality of care delivered to Medicare beneficiaries by NPs and physicians and found that physicians perform better on certain quality measures and NPs perform better on other measures. 59 Related work has found no meaningful differences between NPs and physicians in caring for HIV [\*901] patients, 60 managing diabetes, 61 providing primary care, 62 prescribing medications, 63 or providing critical care. 64 Reviewing the evidence, the National Academy of Medicine concluded "that access to **quality care** can be **greatly expanded** by increasing the use of ... [NPs] in primary, chronic, and transitional care." 65 Opponents of broader NP SOP laws have criticized this evidence as irrelevant because these studies are often "performed in a setting of physician oversight and collaboration." 66 They argue that "using data from studies of nurse practitioners working under physician supervision to demand independent practice is a flawed practice, as there is no proof that nurse practitioner care without physician oversight is either safe or effective." 67 However, studies that have explicitly examined the role of relaxing NP SOP laws - as opposed to the role of NPs generally - in promoting the delivery of high-quality care have concluded that NP independence either improves or has little effect on the quality of care delivered. A 2017 study found that NP "independence had no statistically significant effect on any of the three [clinically verified indicators of [\*902] healthcare quality] studied." 68 In contrast to claims that NP SOP laws are necessary for the protection of patients, 69 this study "did not substantiate the use of [SOP] restrictions for the sole purpose of consumer protection." 70 A separate study "cast[] further doubt on the theory that state regulations limiting NPs practice are associated with quality of care." 71 Examining **patient-reported** quality across **many years** of a nationally **representative dataset**, a recent study found that NP independence increases the probability that patients report being in **excellent health.** **72** Another study found that NP independence had no effect on infant mortality rates, an important indicator of healthcare quality. 73 Overall, existing evidence does not support the contention that unsupervised NPs provide unsafe or low-quality care. To be sure, physician groups are correct in their assertion that NPs are not trained to provide the same range of services as physicians - NPs do not perform surgery, for example. Within the scope of their training, however, the evidence demonstrates that NPs perform similarly to physicians.

**72** Traczynski & Udalova, supra note 12, at 98, 99 tbl.7.

2. Scope-of-Practice Laws and the Cost of Healthcare

Though healthcare quality tends to receive the most attention from experts within the SOP law debate, concerns over the cost of care predominate among the patients who are most affected. Indeed, the health policy conversation over the last two decades has focused heavily [\*903] on the ability of patients to obtain affordable care. 74 Advocates of greater NP autonomy have argued that removing restrictive SOP laws will facilitate the use of lower cost providers and ultimately reduce costs within that system. For example, Kathleen Adams and Sara Markowitz have explained that "achieving productivity gains is one way to reduce cost pressures throughout the health-care system" and that such gains can be realized "by using lower-cost sources of labor to achieve the same or better outcomes." 75 The "high payment rates for physicians in the United States" makes the increased use of NPs a particularly appealing strategy for cost-reduction. 76 Recent research has demonstrated that abrogating restrictive SOP laws can reduce costs within the healthcare system to the benefit of patients and the public. A study by Morris Kleiner and others found that granting NPs independence reduces the price of a common medical examination by between 3% and 16%. 77 A separate economic evaluation estimated that liberalizing SOP laws would save approximately $ 543 million annually in emergency department visits alone. 78 Though specific to certified nurse midwives instead of NPs, a recent study found that eliminating restrictive SOP laws for nurse midwives would save $ 101 million by reducing reliance on more intensive forms of care during birth. 79 Other studies have found that payments in connection with Medicare beneficiaries cared for by NPs were between 11% and 29% lower than those cared for by physicians, 80 the savings achieved by using retail health clinics in lieu of emergency departments are higher when NPs have more independence, 81 and Medicaid costs either decrease or remain flat when NPs are granted more autonomy. 82 On the other side of the debate, opponents of NP independence can point to some evidence that NPs and SOP laws allowing them to practice independently may increase healthcare costs. In a recent report, the [\*904] Medicare Payment Advisory Commission ("MedPAC") highlighted several studies finding that NPs tend to increase costs. 83 One study found that NPs utilized more healthcare resources in caring for patients than physicians, suggesting that more extensive use of NPs may increase costs. 84 A separate study found that NPs order more medical imaging services than physicians in primary care settings. 85 Medical imaging, such as magnetic resonance imaging ("MRI") and computed tomography ("CT") scans can be expensive, so this study suggests that NP independence may increase costs over time. More recent work that examines a larger population contradicts these results, however. Examining data on Medicare and commercial insurance claims, a 2017 study found that NP independence does not result in more medical imaging and does not increase healthcare costs. 86 Similarly, research conducted by economists at the Federal Trade Commission ("FTC") revealed no evidence that relaxing NP SOP laws increases healthcare costs or prices. 87 Overall, a growing body of research suggests that allowing NPs to practice independently can reduce costs and the prices patients must pay for care, while only a few studies have found evidence to the contrary. 88

3. Nurse Practitioners and Access to Healthcare

Turning to the debate over the role of SOP laws in access to healthcare, the evidence more heavily favors advocates of greater NP autonomy than it does in either the cost or quality debates. Advocates of greater NP autonomy have argued that "by unnecessarily limiting the tasks that qualified [NPs] can perform, SOP restrictions exacerbate [healthcare provider] shortages and limit access to care." 89 An Obama administration report noted that "easing scope of practice laws for APRNs represents **a viable means** of increasing access to certain primary care services," 90 and the evidence generally supports this conclusion. For example, one study concluded that states with less restrictive SOP laws "overall had more geographically accessible" NPs. 91 Similarly, a 2018 study found that relaxing SOP laws increases access to healthcare generally but has the largest positive effect in counties that have the least access to healthcare. 92 This evidence suggests that "restrictive licensing laws limit the growth in the supply of [NPs] who could deliver care in communities with relatively few practicing physicians." 93 Extending this evidence to more specific measures of healthcare access, a third study concluded that granting NPs more autonomy increases the likelihood that individuals receive a routine check-up, have access to a usual source of care, and can obtain an appointment with a provider. 94 NP independence also reduces the use of emergency departments for conditions that can be addressed in less intensive (and less expensive) settings, as patients can more easily access a healthcare provider when NPs can practice independently. 95 [\*906] The response to the argument that allowing NPs greater autonomy increases access to healthcare by opponents of NP independence often does not focus explicitly on healthcare access. While not every study has found that relaxing SOP laws increases access to healthcare providers, 96 the existing evidence generally supports this conclusion. 97 Opponents, therefore, typically offer only indirect arguments on the access issue. In opposing a bill that would relaxing California's SOP laws, the president of the California Medical Association offered an example of a common argument: "We must ensure that every American, regardless of age or economic status, has access to a trained physician who can provide the highest level of care. Expanding access to care should not come at the expense of patient safety and we will not support unequal standards of care... ." 98 In other words, expanding access to NP-supplied care does not amount to expanding access to care generally because NPs provide inferior care. Though framed as an access-to-care argument, this contention is more accurately characterized as an argument about the quality of care provided by NPs, which as addressed above, appears to be equal in basic practice areas.

4. The State of the Scope-of-Practice Debate

The debate over NP SOP laws is not new, and multiple national organizations - both governmental and non-governmental - have weighed in on this debate after conducting extensive reviews of the available evidence. Perhaps the most relevant organization to opine on SOP laws to date has been the National Academy of Medicine (formerly, the Institute of Medicine). The Academy criticized restrictive SOP laws, noting that "what nurse practitioners are able to do once they graduate varies widely for reasons that are related not to their ability, education or training, or safety concerns, but to the political decisions of the state in which they work." 99 Calling for an end to restrictive SOP laws, the Academy clearly stated that NPs "should practice to the full extent of their education and training." 100

[\*907] Researchers at the FTC reached a similar conclusion, albeit for somewhat different reasons. The FTC has no authority to enforce **federal** antitrust laws against states that restrict the practices of NPs with SOP laws because these laws fit squarely within **the state-action immunity articulated** in **Parker** v. Brown. 101 However, FTC researchers applied the economic principles that underlie those antitrust laws and concluded that restrictive SOP laws "deny[] health care consumers the benefits of greater competition." 102 They further concluded that the harms to healthcare services markets - higher prices and decreased access to care - associated with restrictive SOP laws were not offset by any attendant benefits. 103 Consistent with these conclusions, the FTC has **regularly opposed** state laws that restrict the practices of NPs and supported the passage of bills that relax the **SOP laws**. 104

**COVID highlights the pivotal role of SOP laws in addressing shortages that are classist and racist in nature**

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When COVID-19 first came ashore in the United States, it quickly became apparent that the virus would bring to light **racial health disparities** that have long pervaded the healthcare industry.

It didn’t take long for the virus, which can become more harmful when an individual has comorbidities, to show itself more harshly among certain populations. Across the country, more Black patients have suffered from COVID-19 and in worse forms, according to Centers for Disease Control & Prevention (CDC) data.

In the agency’s weekly report ending on July 11, 2020, CDC said there were 227.1 COVID-19 hospitalizations per 100,000 non-Hispanic Black patients, compared to only 49 COVID-19 hospitalizations per 100,000 white patients.

For non-Hispanic American Indian or Alaska Native patients, that rate came in at 273 hospitalizations per 100,000 patients, and 224.2 hospitalizations per 100,000 Latinx patients.

Across the industry, leaders were largely unanimous in saying that these health disparities are not new in the age of coronavirus; instead, coronavirus has shown an unflattering spotlight on health disparities that were already there.

“Sadly, the health disparities that are making the news today aren't new and they're not specific to COVID-19,” said Sophia Thomas, DNP, APRN, FNP-BC, PPCNP-BC, FNAP, FAANP, the president of the American Association of Nurse Practitioners (AANP).

For Thomas, health inequity has been a long-standing issue. **N**urse **p**ractitioner**s** and those working within the AANP specifically have been sounding the alarm on healthcare disparities for years, she said. The current climate with COVID-19 has provided a tangible example of how health inequities ultimately manifest.

Health inequities start with the social determinants of health, Thomas explained, and how those social risk factors limit an individual’s ability to achieve wellness. Because traditionally underserved populations, like Black, Hispanic, and Indigenous populations, must contend with **structural and cultural limitations** to care and other resources, they adversely experience social determinants of health.

“When you think about long-term health outcomes and assisting in staving off short-term health complications, providers need to consider things such as poverty, economic stability, safe and accessible housing, and food security,” Thomas, a practicing nurse practitioner herself, told PatientEngagementHIT.

“We talk about food deserts, dependable transportation, and then probably most importantly from our aspect, training and education that provides a pathway for all patients to have greater access to primary care.”

Again, this isn’t a new trend, Thomas acknowledged. Decades of institutional inequities have set the stage for a health equity crisis to come to bear like it has during the COVID-19 pandemic.

“Really, the CDC's recent racial and ethnicity data are proof positive that health systems, policy makers, healthcare providers all need to work together now more than ever to stop the COVID-19 impact on communities of color,” Thomas explained.

And it’s **nurse practitioners** who can play a pivotal role in that, she asserted.

“What makes us unique is that we have a foundation in nursing and with that we also have a **holistic approach** to patient care,” Thomas stated.

“So when we, for example, tell a patient she has diabetes and give her a prescription for her medication, we're not just prescribing medication and saying ‘follow up with us in three months.’ We're making sure that she can afford that medication. We're discussing with her at that time some diet and lifestyle changes.”

And it’s that very discussion that Thomas said truly makes a different in **self-management** for a chronic illness and can ultimately tame those comorbidities that have manifested themselves during the COVID-19 outbreak.

Delivering that care management across every community, especially traditionally underserved ones disproportionately experiencing social determinants of health, will be the first step to addressing health equity, at least on a micro scale.

“The most important thing is listening. But with that, before we start the office visit or discussing the reason why patients are there, we may just do a little bit of small talk to get to know them to hear about their life,” Thomas advised, outlining what an encounter that addressing social determinants of health with a nurse practitioner can look like.

“In hearing the stories, they key us into possible issues that may happen,” Thomas said.

During the coronavirus pandemic specifically, Thomas has been taking advantage of the widespread use of telemedicine to understand the social circumstances in which her patients live. Telemedicine lets Thomas see her patients’ housing situations, or during a conversation about nutrition Thomas can prompt her patients to show her their pantries, if they are interested and engaged.

And perhaps most important, nurse practitioners are poised to **establish trust** with their patients, something that is essential for discussing sensitive topics like social needs and is important when working with traditionally marginalized communities.

“We call on our nursing foundation of compassion and empathy to build a relationship with patients and their family members,” Thomas explained. “Surveys year after year show that nurses are listed as one of the most trusted professions.”

Patients will tell Thomas things they have never felt comfortable admitting to their doctors, she shared, underscoring the important role nurses play in being a **trusted confidante** for underserved patients.

But nurse practitioners can’t accomplish these goals without some support. Importantly, Thomas said nurse practitioners need **expanded scope of practice** regulations in order to fulfill their potential while treating patients.

“There are 77 million Americans that live in communities that don't have adequate access to primary health care, and about 80 percent of rural America is actually designated as medically underserved,” Thomas said.

At the same time, the 10 states with the best health outcomes also have the most flexible scope of practice laws for nurse practitioners, Thomas said, citing the US News and World Reports rankings. In the 10 states with the worst health outcomes, **n**urse **p**ractitioners face the strictest scope of practice laws.

When **access** to quality care is at the crux of health inequities, Thomas said this is a huge issue.

**That access is key to patients ability to make their own medical choices**

**Hudson 15** Dr. Janella Nicole Hudson is now with The Centers for American Indian and Alaska Native Health at The Colorado School of Public Health. Specifically, the author is a postdoctoral fellow in the department of Health Behavior and Outcomes at the Moffitt Cancer Center where Janella contributes to the study of doctor-patient communication with adolescent and young adult cancer patients. The author also serves as the Program Manager for Education and Research at The Academy of Communication in Healthcare. Janella’s research examines health communication processes with diverse medically underserved groups, including black patients, to produce culturally tailored educational interventions. Janella’s research features expertise in Qualitative Social Research, Communication and Media. The methodology for this paper studied a cohort consisting solely of those that identified as black patients. The cohort was predominately “low income” – which the authors define as having an annual income of less than $30,000.00 per year. The cohort was predominately those that identified as “black women”. The paper is a follow-up to a larger principal study by Dr. Louis Penner of Wayne State University. In that parent study, 98.5% of participants identified as black. This paper was written while the author held an MA and was the author’s dissertation paper for obtaining a PhD. "Agency And Resistance Strategies Among Black Primary Care Patients" (2015). Wayne State University Dissertations. Paper 1340. Submitted to the Graduate School of Wayne State University, Detroit, Michigan in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY - #CutWithRJ – One modification – that is not highlighted in the card and doesn’t alter the reading of this evidence – adds the word “century” because it appears to have been left out of editing - <http://digitalcommons.wayne.edu/cgi/viewcontent.cgi?article=2339&context=oa_dissertations>

Despite their benevolent intentions, Pauley (2011) asserts that providers are ultimately gatekeepers, with the power to influence the course of the interaction. As such, negotiations within clinical interactions are not always easy. Physicians may have expert power, but **increasingly savvy patients** (who increasingly access the Internet and other sources to secure information) **complicate the negotiation for power.** In addition, physicians should attempt to address the power disparity by improving the patient's bargaining position with efforts such as increased display of personal vulnerability (Pauley, 2011).

Indeed, clinical communication represents the struggle for dominance between the physician and patient. Roter and McNeilis (2003) assert:

The medical dialogue is the fundamental instrument through which the battle over paradigms is being waged; the patient problems will be anchored in either a biomedical and disease context or a broader and more integrated illness context that incorporates the patient perspective. In other words, the nature of the patient's problems will be established and the visit's agenda and therapeutic course will be determined by whatever wins out (p. 122).

Mishler (2003) further expands upon **this** idea and offers recommendations for a change in clinical communication. Referring to the discourse of medicine, which is most often characterized by a physician-dominated interview, Mishler urges practitioners to develop alternative practices that "interrupt the voice of medicine" and give priority to hearing patients' narratives and contextualized explanations of illness that use everyday language" (p.437). Such an approach centralizes the needs of the patient as opposed to allowing the physician to dominate the encounter with a biomedical approach to identifying and treating illness.

Mishler's assertion shows the importance of attending to **surrounding context.** While physicians may be primarily concerned with attending to the biomedical and technical aspects of the patient's illness, they must also allow room for the patient's "knowledge." All too often, the expert knowledge of practitioners and scholars is given the designation of trusted knowledge, while patient knowledge is given little credence (Airhihenbuwa, 2000). In order to centralize patient needs, physicians must allow for the emergence of the voice of the life world during clinical interactions. This approach promotes the enactment of patient agency, which might manifest in several ways. Such an "interruption" of the voice of medicine (Mishler, 2003) allows the patient and the physician to connect through collaborative discourse. This ultimately empowers the patients to take control of their health plans, actively supporting or resisting suggested treatment plans as they attempt to identify the best contextual fit.

Mishler's recommendation represents an ideal in contemporary healthcare that has resulted from a lengthy evolution in patient-physician literature. Whereas greater patient power is promoted in **contemporary** patient-physician **literature,** ***previous literature*** features an extensive history of a physician-dominated ideal.

**The Patient Role**

In keeping with the ever-evolving nature of the health care system, conceptualizations of the ideal roles for patients and physicians **have evolved over time.** For many years, the physicians were expected to exert professional dominance during the clinical interaction and patients were expected to take a submissive role (i.e., paternalism) (Roter & McNeiHs, 2003). In twenty-first (century) health care settings, however, patients are encouraged to assume a greater degree of participation during the clinical interaction (i.e., consumerism). The evolution of the patient and physician roles has provided a platform **for a dyad shift in power**, setting up a "battlefield" where wars over power and paradigms are waged (Rotter & McNeilis, 2003).

**The status quo denies *the option* of health access and pathologizes black patients as passive and incompetent**

**Hudson 15** Dr. Janella Nicole Hudson is now with The Centers for American Indian and Alaska Native Health at The Colorado School of Public Health. Specifically, the author is a postdoctoral fellow in the department of Health Behavior and Outcomes at the Moffitt Cancer Center where Janella contributes to the study of doctor-patient communication with adolescent and young adult cancer patients. The author also serves as the Program Manager for Education and Research at The Academy of Communication in Healthcare. Janella’s research examines health communication processes with diverse medically underserved groups, including black patients, to produce culturally tailored educational interventions. Janella’s research features expertise in Qualitative Social Research, Communication and Media. The methodology for this paper studied a cohort consisting solely of those that identified as black patients. The cohort was predominately “low income” – which the authors define as having an annual income of less than $30,000.00 per year. The cohort was predominately those that identified as “black women”. The paper is a follow-up to a larger principal study by Dr. Louis Penner of Wayne State University. In that parent study, 98.5% of participants identified as black. This paper was written while the author held an MA and was the author’s dissertation paper for obtaining a PhD. "Agency And Resistance Strategies Among Black Primary Care Patients" (2015). Wayne State University Dissertations. Paper 1340. Submitted to the Graduate School of Wayne State University, Detroit, Michigan in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY - #CutWithRJ - <http://digitalcommons.wayne.edu/cgi/viewcontent.cgi?article=2339&context=oa_dissertations>

Discussion of Goal and Agenda Setting/Management. Participants' demonstrations of **patient agency** throughout the diagnosis and treatment sequences of the interaction signal a clear intent to participate and partner with the physician. ***Previous*** literature has examined how the process of setting the agenda during the medical visit often disadvantages the patient, as the physician often chooses a patient problem to discuss without fully exploring the patient's full spectrum of concerns (Marvel, 1999). Manny and Ray (2002) for example, describe a pattern of agenda setting that often consists of the physician initiating the opening sequence with a name exchange/check, brief pleasantry and a first topic initiator. As the interaction continues, the authors note that the inherent power imbalance within the dyad becomes evident as the physician assumes his prerogative to speak first and then manages the agenda for the duration of the interaction. **Our findings,** **however**, demonstrate that participants were comfortable **exerting their agency** in order to influence the unfolding of the interaction and shepherd the physician back to their previously identified topics of interest as needed. This vigilance and focus is understandable when interpreted within the larger context of the interactions. Several participants reported not having received medical care for an extended period of time, and as a result, several health issues that required treatment had accumulated. Participants were aware of the time constraints of the medical visit and therefore worked strategically to ensure that all of their needs could be addressed during the interaction.

In addition to setting the agenda, participants demonstrated **a clear desire for partnership with their physician** when reviewing treatment plans and determining their suitability. While literature shows that not all patients want to participate in decision making (Levinson, Kao, Kuby, & Thisted, 2005) and that physicians often underestimate black patients' desire for partnership during the interaction (Street & Haidet, 2011), our findings clearly show that some patients desire partnership from their physicians when reviewing, discussing and deciding upon diagnosis and treatment.

Participants in our study consistently pressed physicians for additional information and details concerning their decision-making during clinical interactions, and these findings mirror some findings in existing literature. Cooper-Patrick et al. (1999) reported that black patients rated their medical visits as less participatory when compared with white patients. However, participants in our study assumed a more active role when discussing **diagnoses and treatments**, often in response to a minimal education and explanation on the part of the physician. The vigilance that participants demonstrated during these interactions is justified as participants identified instances of misinformation and inadequate understanding of patients' health concerns. Our findings show that black primary care patients can actively participate and partner with the physician during the clinical action, and perhaps are more motivated to do so when the attempting to optimize the visit's outcomes.

It should be noted that all of our participants, who consist of low-income, black patients with a history of discrimination, **demonstrated agency** during interactions with physicians. The nature of these interactions, coupled with participants' explanations of how information, services and **resources were often badly needed**, show that these patients were proficient in demonstrating "active" or agentive behaviors in order to obtain health resources. In fact, it is safe to assume that these patients were already active, or already equipped to exercise their agency when interacting with the physician. This is compelling, **given that much of** patient-centered **literature does not reflect this population in this way.** These findings show that these marginalized patients are capable (without prior prompting) of demonstrating active behaviors, and as a result of having to endure constraints in access to healthcare and health services, they may become more proficient or likely to exercise their agency.

**NPs are a foundational element of care reform – rejecting nursing cements patient barriers, physician negligence, and failing healthcare – expanded autonomy is a critical enabler of imagining a better system**

**Trotter 21** (LaTonya J. Trotter, Associate Professor in the Department of Bioethics and Humanities at the University of Washington, “The Invisible Work of Nurse Practitioners,” Spring 2021, https://www.aft.org/hc/spring2021/trotter)//NRG

Today, the NP as physician substitute is a fairly well-known story, at least within healthcare policy circles. What is less often considered is whether or not the problem they are addressing is only or even primarily about physician scarcity. Not everyone struggles to find a doctor; those with the least profitable conditions and the fewest resources are far more likely to have difficulty. As a consequence, NPs are more likely to treat populations whose care is often socially as well as medically complicated: people who are poor, are uninsured, receive Medicaid, and/or qualify for Medicare due to a disability.14 Far from being a simple substitute, **NPs systematically care for different patients than physicians**.

While some may believe NPs are best suited to provide “routine” care, the reality is that by becoming the provider to the socially marginal and medically vulnerable, NPs are often managing the most complicated patients. And the available evidence suggests they are up to the challenge. Fifty years of research on the safety and effectiveness of NP-led care supports the conclusion that their patients do at least as well as those who see physicians.15 This evidence suggests a possibility that few health policy experts have considered. Perhaps the utility of NPs is found not in their similarity to physicians, but in their **difference from them**. And maybe, just maybe, the problems NPs are a solution to have less to do with physician scarcity than with deeper questions of social inequality and **how we choose to care** for our most vulnerable citizens. These are the questions I brought with me as I spent two and a half years following a group of providers at a place I call Forest Grove Elder Services (a pseudonym).16

Forest Grove is best understood as a nursing home diversion program. All of its patients were eligible for nursing home care due to various physical or cognitive needs. In order to avoid institutional care, the Grove provides a comprehensive set of services that includes, but goes well beyond, medical care. In addition to primary care, the Grove provides physical and occupational **therapy**, **recreation**al activities, and **social work** services. It also coordinates and manages the care its patients receive **outside its walls**, from specialist appointments to rehabilitation services. A dedicated fleet of accessible vans ferry patients to and from the Grove, as well as to these outside services.

From a funding perspective, what is unique about the Grove is the way it tries to manage costs. The state authorized the use of Medicare and Medicaid dollars to pay for these enhanced services as an experiment to test if providing comprehensive, community-based care could save money through averted hospitalizations and nursing home placement. But in the time I spent at the Grove, I found that what was truly unique about the organization is the way its NPs make this model work. Like many healthcare organizations, the Grove employs both physicians and NPs to provide medical care. However, what makes the Grove different from other collaborative environments is that its NPs are the formal leaders of the healthcare team. What it meant for NPs to lead was not just about decision making, but about **fundamentally reshaping** how care happens.

More Than Medicine When I first met Michelle, she had been an NP for almost 20 years. But she had been a nurse for longer still. Like most NPs, she started her career as a registered nurse (RN); her first job was at the hospital bedside. She had already amassed over two decades of experience before she went back to school to become an NP. Maybe that is why when I spent time with Michelle, it became impossible to think of her as a substitute physician. To watch Michelle was to watch a nurse at work. “Ms. Payne. Can you think of anyone else who could come by a few times a day?” Ms. Payne was 86 years old. Like most of the Grove’s patients, she lived with a litany of complaints: diabetes, rheumatoid arthritis, congestive heart failure. Yet none of these were why she was sitting in Michelle’s office on that day. In two weeks, Ms. Payne was scheduled to have cataract surgery to improve her increasingly cloudy vision. Michelle’s aim was to make sure Ms. Payne was prepared for the operation. Cataract removal is a low-risk outpatient procedure. The surgery was not the problem. The problem was what would happen afterward. I sat in the corner, trying to be unobtrusive in a room that seemed full with three people. I listened as Michelle reviewed the surgeon’s postoperative instructions. Ms. Payne would need to apply a series of prescription eye drops—four times a day for four weeks—to control inflammation, prevent infection, and minimize complications. There is nothing remarkable about their application. One would simply stretch an arm upward, tilt one’s head skyward, arch the arm over a selected eye, grip the bottle with a personal selection of fingers, and then squeeze with the right amount of pressure. These coordinated steps, however, require a set of abilities that not everyone possesses. Ms. Payne had rheumatoid arthritis, a condition that not only inflames the joints but also often deforms them. This condition had left her hands curled in on themselves like talons. As Michelle described how often the drops would need to be applied, all three of us looked at these hands, our eyes filling with doubt. In everyday life, when we cannot administer our own medication, parents, children, or even a good friend might be enlisted to assist. This practice is both common and legal as long as it is done for free, which explains why Michelle asked Ms. Payne whether she could think of anyone who might help. Anyone would have sufficed. However, when payment enters the equation, the universe of anyone shrinks considerably. In most states, only physicians and nurses can administer medication outside of an institution. This includes prescription eye drops. Justifying the expense of paying for an RN to visit Ms. Payne four times a day, every day, for four weeks, might not have been impossible, but it certainly would not have been easy. Yet, sending her home after surgery with no plan for applying the eye drops bordered on medical malpractice. Over the next two weeks, I watched as Michelle “knit together” a range of resources on Ms. Payne’s behalf. She called the surgeon to see if a simpler regimen might work on weekends. She asked an RN colleague to meet separately with Ms. Payne to go ask if she were sure that no one could assist her, even once a day. A cousin? A neighbor? Someone from her church? The nurse reminded Ms. Payne, gently but firmly, that not wanting to ask is not the same thing as being unable to ask. With the RN’s help, Michelle eventually crafted a plan that is one part neighbor, one part modified regime, and one part approval for some nursing visits on weekends. Arriving at this complex calculus took more than a little time and a great deal of work. The surgeon performed the technical miracle of curing the patient; Michelle performed a miracle of her own in helping to ensure the best possible outcome. With Ms. Payne’s eyesight improved, the odds are good that she will be able to stay in her own home for some time to come.

Among elder care professionals, there is a saying: “The best long-term care insurance is a daughter.” Even with Medicare and Medicaid paying for services, **navigating bureaucracies**, **coordinating care**, and knitting together **complex information** is someone’s full-time job. Yet, for many, these idealized daughters are in short supply. Few families have access to a physically healthy adult whose time is not taken up by **work** in the paid **labor** market or by **unpaid responsibilities** such as caring for dependent children. Moreover, this work is not unskilled; an adult’s availability does not necessarily signal possession of the knowledge or expertise to do what needs to be done. To categorize this as the work of daughters reveals it as the kind of invisible work that money cannot always buy, and for which insurers rarely reimburse.17 But if this work happens within the reimbursed medical visit, there is a greater chance that it might occur. The **NPs** I spent time with **did this kind of work** as part of the medical exam, making it not just an adjunct to medical work, but a **transformation** of it. And when they did it well, there was a good chance that their patients would experience fewer complications—and that the state would incur fewer costs.

The Hard Work of Being an NP “The NPs do all the hard work.” That was Joanne’s assessment. Joanne was one of the RNs who supported the work of the NPs within the clinic. In spending time with Joanne, I learned that she was currently taking classes for a master’s degree in business. She did not want to do the work of an RN for the rest of her life. “Why business?” I asked. “Why not become an NP of some kind?” She answered from the perspective of someone who had spent several years making her own observations of what the NPs spent their time doing. Because, she explained, it was hard work. And after being a nurse for almost a decade, she was ready for something a little less hard. When I asked what made the work hard, she responded, “Let’s say you’re Mr. Smith. And you’re in the hospital right now. And the hospital calls one of our doctors [to get his medical history]. Chances are, they don’t know Mr. Smith like an NP knows Mr. Smith: his family situation, including his financial situation; what’s going on; what hospital work we’ve done in the past; what has worked for him in the past.” Joanne marshaled her own data to back up this claim. “You pull a physician note [from the medical record], and it’s empty. Not empty, but there’s nothing in there but, you know, a few words.… But you have the NP notes going much deeper into what is found. You find the situation and the conditions of daily living because they’re coming in from their nursing background when you access all those things that you’re adding to the problem.” From Joanne’s perspective, the hard work that the NPs performed gave them a better relationship with their patients, which in turn gave them a better understanding of their clinical care. I pondered Joanne’s words for some time. To speak of relationship is usually to invoke the intangible world of emotions. Yet when Joanne illustrated this term, she did not describe an affective tie between NP and patient, but one born of deep, layered knowledge. Moreover, she was explicit in calling out the action required to cultivate that knowledge. For Joanne, this was not the result of an emotional attachment; it was the result of hard work. As I spent more time in the clinic, I began to understand how the NPs’ work might improve patient care. One afternoon, I sat with Michelle as she met with Mr. George. His weight had gone up by seven pounds in less than two weeks. This was of particular concern to Michelle because Mr. George had congestive heart failure. Rapid weight gain from fluid retention is one of the classic signs that something is amiss. It could be a worsening of his heart; it could be a change in his diet; it could be a problem with his medication. What Michelle knew for sure was that if Mr. George retained too much fluid, he might find himself struggling to breathe.

This was the kind of **slow-moving emergency** that Michelle faced on a daily basis. Because it was not just age that defined her patients; it was medical frailty. All of Michelle’s patients had multiple chronic conditions like diabetes, arthritis, and hypertension—as well as an array of physical and cognitive impairments that interfered with daily life. Her job as their primary care provider was not just to provide medical care, but to manage the full range of services upon which her patients depended. Mr. George saw a regular cardiologist for his heart failure. But if the problem could be treated without that level of care—and cost—it was Michelle’s job to make it happen. As Michelle met with Mr. George, I recognized a technique that I had often seen her employ. When she wanted to understand a problem, either from a patient, family member, or colleague, she asked questions that did not reveal her own suppositions. Instead, she let the person to whom she was speaking give their own rendering of the facts. I watched as Michelle spent half an hour listening to Mr. George describe how he took his medications and when. She was meticulous in her questioning. Because Mr. George was not conversant with the names of the medications he took, she showed him pictures of each of his pills as she asked him when he took them. When Michelle got to one of his last medications, he said, “This one I take halfways.” She stopped and asked, “What do you mean by halfways?” In the conversation that followed, Michelle learned that Mr. George was only taking half of this pill; he was concerned about side effects and believed he felt better when he took less of it. He did not know that the pill he was taking less of was one of the medications that helped him manage his heart failure.

The case of Mr. George could be described as an issue of noncompliance or patient education—the kind of nonmedical problem you had to be neither an NP nor a physician to solve. But the nature of the problem was only apparent in hindsight. Michelle not only had to ask the right questions, she had to listen. If she had simply inquired, “Are you taking your medications?,” Mr. George may have reported—honestly, from his perspective—that he was. If she had sent him directly to the cardiologist, Mr. George might have had his medications changed or increased without addressing his underlying concern of side effects—the concern that had motivated him to modify his medications without understanding the risks. It was listening, conversation, and medical knowledge that led Michelle to the right conclusion and the best plan of action. What Joanne had described as “the hard work” of being an NP did not just make Mr. George feel listened to or cared for, it was a crucial part of keeping him medically stable and independent. When Michelle did this work well, she not only helped Mr. George but also saved his insurer from paying for a more expensive trip to the cardiologist. But their conversation would have benefits beyond any single exam. Michelle’s questions were open-ended. Therefore, along with hearing what she might have thought was important, she heard information that was important to Mr. George. He had his own ideas about how each of his medications made him feel. He asked questions of his own about why he was taking certain pills or why the pharmacy had switched him from a brand name to a generic version. And as they talked, Michelle learned just a little bit more about Mr. George. Such as how he reasoned about which pills to take and when. That despite not knowing which pills were for which condition, he was otherwise willing and compliant with taking them. She learned more about his relationship with a neighbor who came over to help him put groceries away and brought him dinner on Sundays. In addition to learning why he was retaining fluid, she learned more about his support network and personal resources. If she needed to help him address a different issue, she would have new information to draw from to make that happen.

The Nursing Model of Care “The **nursing model** is much more **holistic** [than the medical model]. You’re looking at the whole person. Yes, disease is part of the person, but so is their **environment**, so is their **mentation**, their **spirit**, so is their **social environment**. So I think instinctually, we all—nurses—that’s how we look at some things.” These were the words of Norah, an NP who worked alongside Michelle. These words were in response to a question I had asked about how NPs differed from physicians. For Norah, it was nursing’s **whole-person orientation** that allowed them to “hear things,” and to **“identify needs”** that a physician would not necessarily notice. Norah was quick to make sure I did not misunderstand her. “Look,” she said. “There’s a lot of things that [the physicians] understand way better than I do.” However, for Norah, recognizing the physician’s expertise did not take away from her own. “NPs have really taken on that kind of responsibility,” she told me. “It’s the nature of the profession.” When I watched NPs like Michelle and Norah at work, I came to understand how that different responsibility looked in action. And why it mattered for patients.

A **Crisis of Care** Nurse practitioners were originally created to address the problem of **physician scarcity**. When the issue is defined as a numbers problem, leveraging a more quickly trained provider seems both a creative and practical response. However, to watch NPs at work is to discover that the numbers are not the whole story. Because the Grove’s patients were not getting “less skilled physicians.” They were getting differently skilled—and highly skilled—nurses. This distinction is not just about semantics or even much-deserved recognition: it is about making visible the true problems we face in healthcare.

Because we are not simply facing a crisis of cost or personnel; we are facing a crisis of **care**. For the Grove’s patients, the work of knitting together **information**, **resources**, and **systems** was not a luxury, it was a **necessity**. Certainly, not all NPs care for patients as ill as those the Grove served. But in becoming the primary care providers for people who are **poor**, **disabled**, or otherwise **medically marginalized**, NPs across the country are often asked to meet a fairly high bar of expertise. Moreover, while the expertise required includes that of medicine, it often goes beyond it. Because what ails patients like Ms. Payne and Mr. George is as much about **inequality as illness**. A lifetime of poverty and racial discrimination are known causes of poor health.18 These social conditions not only make it difficult to **access** quality **healthcare**, there is good evidence that they literally age the body and directly produce illness. The **NPs** who listen, advocate, and coordinate will not solve these problems. Nonetheless, they can and do serve as **on-the-ground lifelines** for patients navigating the interwoven terrain of **organizational**, **medical**, and **social problems** that all too often go **unnamed** and **unaddressed**.

This crisis, however, goes beyond the exam room. Because the **scarcity** at work **is less about providers than policy**. We should not forget that the creation of the NP is only one of many possible responses to the crises we face. Despite being organized as a private system, healthcare’s largest payer in the United States is the government.19 Given this reality, what might have happened if we, as a nation, had matched the weight of our financial investment with a **cohesive, national healthcare policy**? What if, when faced with the growing evidence that health disparities were caused by social inequality, we had invested in **social policies** to ameliorate the **worst excesses** of poverty? Or used the full weight of the law to **eradicate entrenched** forms of racial **discrimination**? **These are paths we did not take**. Instead, **we unraveled the national safety net**, leaving individual providers to knit together the last threads of what remained.

Many have argued that the pandemic has exposed the cracks in our healthcare system. I hope it also shines light on the workers who are often called upon—and feel a calling within themselves—to span those cracks. In the hours I spent watching NPs like Michelle and Norah at work, I came to the conclusion that it is often nurses who are left with the **invisible work** of holding healthcare together. Before, during, and after the pandemic, nurses do not only the **visible work** of patient care but also the **invisible work** of shoring up a healthcare system that is crumbling under the weight of social inequality. As of the writing of this article in the first months of 2021, most of the executive orders that expanded NP practice autonomy have already been rescinded, even as the pandemic rages on. NPs like Renee Collins are back to paying physicians for oversight. But her patients in rural Tennessee will never know the difference because Collins is clear in her purpose: “Nurses are not wanting to be doctors.… We are simply wanting to fill the gap for access.”20

**It’s reductive and wrong to think of NPs as a facsimile for physicians and problematic medical structures – the approach of NPs to care is transformatively different**

**Trotter 20** [LaTonya J. Trotter, Assistant Professor of Sociology at Vanderbilt, More Than Medicine : Nurse Practitioners and the Problems They Solve for Patients, Health Care Organizations, and the State 2020]

At the Grove, patients like Ms. Payne, faced with the **interconnected problems** of **aging**, **illness**, and **poverty**, turned to their NPs for a kind of work that was **more than medical care**. And at least some of the time, they found it. This book is an on-the-ground account of how a group of NPs cared for four hundred African American older adults living with poor health and limited economic resources. I followed these NPs as they saw patients, met with colleagues, and spoke with family. What I witnessed was **less a facsimile of physician practices than a transformation of them**. These NPs expanded the walls of the clinic to include **not just medical complaints** but a broad set of ~~indigenous~~ complaints. Patients presented with serious medical problems, such as congestive heart failure and diabetes, but they also brought a broader set of social and economic problems that, for them, were of equal importance. In response, the NPs practiced a professional openness to information and problems that are usually filtered out of the exam room. In response to this openness, patients and their families turned to the clinic as the place to get a diversity of needs met. Through this iterative cycle of openness and turning to, both the **encounter and the work performed** within it **were** **transformed**.

Clinic Work

The proposition that NPs are doing **different work** from physicians is grounded in a **broader** historical **distinction between medicine and nursing**. If physicians are the iconic providers of medical work, nurses are the iconic providers of **care work**. Broadly speaking, care work is defined as labor—paid and unpaid—that cares for members of society who cannot care for themselves because of age, illness, or disability (Duffy 2005; England 1992). While some scholars make further divisions between types of care work, what fundamentally distinguishes care work from other forms of labor is how it is performed and, often, who performs it (Duffy, Albelda, and Hammonds 2013; England 2005).7

Care work is based less on discrete services than on a **general responsiveness to the needs of a person**. In this way, care work is inherently relational. To use an example outside health care, kindergarten teachers are involved not just in educational instruction but in helping their charges eat, visit the toilet, and learn to socialize with one another. Moreover, how the work unfolds depends on the quality of the relationships that form between students, teachers, and parents. These features of the work cannot be separated from the fact that most care workers are women. Care work often overlaps with labor historically performed by women in the domestic sphere. Those who perform such work today continue to be marked by gender and the lower status associated with “women’s work” (Charles and Grusky 2005; England 2010; England, Budig, and Folbre 2002). Despite the gendered devaluation that comes with seeing nursing as care work, nurses continue to claim care as a category and relationship as a feature that distinguishes the practice of nursing from the practice of medicine (Apesoa-Varano 2007, 2016; Evans 1996; Radwin 1996; Tanner et al. 1993).

In this account, I advance the notion of clinic work to illustrate the ways in which the Grove’s NPs brought care work into the medical encounter. I employ this term for two reasons. First, it reflects the reality that the NPs’ work was different in both form and content from the medical work of their physician colleagues. This difference was a consequence not of formal role distinctions but of a very different embodiment of what it meant to address patient complaints. When family disagreements and economic challenges were allowed to enter the clinic as part of the problem of disease management, what “disease management” meant was fundamentally altered. The observation of this difference came not only from me but also from the physicians—the providers best situated to evaluate what medical work was and was not. However, the NPs did address bodily complaints. Moreover, they were held to account by billing paperwork that required their work be made visible as medical work. Because they were doing this work from within the medical visit, this expansive form of clinic work had consequences not only for constructions of NP work but also for changing expectations of the medical encounter.

Second, I use clinic work to underline the ways in which the NPs’ work invoked a different form of relationality—it was in deep relationship with the organization or clinic in which it was located. The Grove’s NPs worked in a context organized around teams. The traditional boundaries one might draw between forms of expertise were less apparent in this organizational context. For patients whose problems were defined as much by poverty as by illness, and whose care was as much a feat of coordination as one of curative treatment, the lines between medical problems, social problems, and organizational problems were not easy to draw. In order to understand the construction of clinic work, I had to account for the ways in which some problems became NP problems while others did not. I discovered that the transformation of the clinic encounter was about neither the rearrangement of tasks nor the renegotiation of turf alone, but rather the working out of much deeper questions about what these problems were, and who was responsible for solving them. The organizational context in which this working out occurred is as much a part of the story as the providers themselves.

Organizational Care Work

Forest Grove Elder Services is not an ordinary outpatient clinic. It is a federally backed policy experiment to evaluate whether a comprehensive care model could ameliorate the state’s economic burdens for long-term care. The pillars of the Grove’s cost savings are coordination and capitation. The team model was its primary strategy for coordinating care. Each team consisted of a mandated mix of providers who worked together not only to provide direct medical, nursing, and supportive care but also to coordinate access to specialists, home care aides, and a host of ancillary services. To pay for this care, the Grove received monthly per capita or per member payments instead of fee-for-service reimbursements. This system provided an incentive to control costs and incentivized preventive over interventionist forms of care. Yet the Grove still operated under the quasi-market logic of all US health care: if its members did not believe they were receiving quality care, they could take their Medicaid and Medicare insurance elsewhere. The Grove had to provide not just cheaper care, but care of sufficient quality to successfully compete with other health care organizations. In some ways, the Grove’s experimental objective was to figure out how to deliver care work under the aegis of medical care. Its mission of intensive management and service coordination necessitated a layered understanding of each patient that required it to be responsive to a broad and variable set of individual needs. Even speaking of its patients as “members” was a nod to the expectation of relationship and responsibility. How does an organization—whose payment structure and regulatory environment still make it primarily accountable for medical work—deliver on the promise of providing the kind of patient-centered relationality required of care work? At the Grove, the answer was through its NPs. One of the unique features of the Grove was that the NP, rather than the physician, was the formal head of the team. What it meant for the NPs to lead, however, was unclear. I observed that NP leadership was often reworked as NP responsibility. The NPs became solely responsible for ensuring that the Grove’s mission of coordination was achieved. Within the expansive category of clinic work, the NPs were expected to deal with a broad set of problems not only as a way of helping their patients but also as a way of managing “difficult patients” for their employer. Doing so was not a simple matter. Various departments inside the Grove had to work together for member care, and the Grove had to communicate with a range of external organizations and family members. Moreover, the work of coordination seemed to generate as many problems as it solved. For the NPs, solving member problems often involved helping them navigate the inefficiencies of the organizations in which they sought care—including those at the Grove. I argue that these NPs were not simply performing an expansive form of work on behalf of their patients; they were also providing an expansive form of organizational care work for their employer. As the NPs put out a range of social and organizational fires in the exam room, they were tasked with the invisible work of caring for the organization as they cared for patients. Clinic work was not in opposition to organizational demands but was partly constructed through the NPs’ responsiveness to them. Problems not solved within the exam room became organizational problems. Patients whose social problems were significant hurdles to medical stability might transition to higher and more expensive forms of care. Members who struggled to navigate the Grove’s inefficiencies might leave the program, expressing their dissatisfaction with the Grove in a way that was visible to the state. The NPs’ performance of organizational care work made them a different kind of provider to patients, as well as a different kind of worker for their employer. I entered the Grove attentive to the work of the NP. My main finding is that their labor became the primary means through which the Grove embodied its own mission of being a caring organization. How these NPs turned a broad set of concerns into clinic concerns reflected the expectations of their colleagues and employer as much as those of patients. I argue that these NPs were doing more than practicing medicine sprinkled with nurse-branded empathy; they were transforming the nature of the work itself.

Nursing’s Utility under State Retrenchment

In exploring how these NPs solved problems for members and their employing organization, I had to grapple with the larger context in which these problems came into being. Physician scarcity is often treated as a naturally occurring problem inherent to developed countries with high demand for medical care. Yet this scarcity is not simply a consequence of consumer demand; it is a consequence of inequality. Not everyone struggles to find a physician; those with the least lucrative problems and the fewest resources are the most likely to have trouble accessing physician care. Perhaps one might wish that physicians would behave more altruistically. However, I argue that this uneven distribution of workers and work is a consequence of state inaction rather than individual career choices. While the federal government has decried the physician shortage, it has largely taken a noninterventionist approach in addressing it. The state may coax or convince, but if physicians prefer dermatology to pediatrics, it will not compel. This reticence to use state power is not matched by a reticence to provide state funding. In 2015, the federal government provided 14.5 billion dollars to support medical residents working in teaching hospitals (Villagrana 2018). Even the economic disincentives to working in primary care are a function of state inattention. The comparative lucrativeness of specialty care is partly a consequence of unregulated prices. The federal government treats health care as a commodity and largely declines to interfere in the medical marketplace. It becomes impossible to understand the creation of NPs without placing them within the context of what the state has decided not to do. In the years since I began this research, I have often been asked how NPs in the US compare to those in other parts of the world. The simple answer is that there is no other country that uses NPs in quite the same way. Governments that are less reluctant to directly control costs and personnel have less need for this new provider. Some countries, such as Canada, the United Kingdom, and Australia, are in the process of experimenting with NPs. Referencing the US as a model, they are deploying NPs to counter physician shortages in medically underserved areas. However, the NPs’ extensive use and level of practice autonomy is a uniquely US phenomenon because the US is singular in having a ~~hands-off~~ approach to health care while largely financing its provision. In 2013, the federal government financed nearly two-thirds of all US health care (Himmelstein and Woolhandler 2016). In this context, the NP becomes a privatized, professional response to a set of policy problems that the state has declined to address through other means. The pairing of state financing with privatized solutions has come to characterize not just health care policy but the US welfare state more broadly. Since the 1980s, the US has been the chief evangelist and implementor of neoliberal policy reforms (Centeno and Cohen 2012). Most of these reforms have been directed at deregulating money and labor; however, the general tenet of favoring markets over state influence has had a significant impact on social policy. A move toward smaller government has resulted in the downsizing and privatization of state and federal safety-net programs (Morgen 2001; Smith and Lipsky 2009). The socially and economically vulnerable have been the chief casualties of this approach. But there have also been professional ones. Social workers were once the professional ~~foot~~ ~~soldiers~~ of the welfare state. In the early to mid-twentieth century, the robustness of professional social work reflected prevailing ideas about the state’s role in addressing the symptoms and structural causes of poverty. As the government established relief programs and national efforts such as the War on Poverty, it relied on social workers to carry them out (Ehrenreich 1985). However, the use of state power to address inequality has fallen out of favor. Many of the programs that social workers once implemented have languished or disappeared. Those that remain are increasingly privatized, with social work’s purview narrowed to policing client eligibility rather than providing therapeutic assistance or community development (Lipsky 1980; Schram and Silverman 2012; Smith and Lipsky 2009). With little to no state support, social work’s professional decline was all but inevitable. The story of social work’s falling fortunes is more than just an interesting piece of occupational history. Its diminished status reflects the state’s disavowal of any moral obligation to ameliorate social inequality. Although individual social workers continue to fight on behalf of their clients (Aronson and Smith 2010; Fabricant, Burghardt, and Epstein 2016), social work is in danger of becoming a disciplining agent of the state rather than the agent of social change its pioneers envisioned it to be (Schram and Silverman 2012; Soss, Fording, and Schram 2011). How this shift occurred is a question best addressed by historical analysis. But the logic of its reproduction can be understood through attention to the work that social workers do, and don’t do, within the multidisciplinary environment of a health care organization. The Grove was not unusual in employing NPs, but it was unusual in employing social workers. Social workers are a rarity in outpatient care because, usually, there is no payer for their work in this setting. At the Grove, social worker inclusion was required by the federal regulations that governed the program. Their presence raised an important question: How did the clinic encounter, rather than the social work encounter, come to be the appropriate location for the “sticky” problems of coordination and social precarity? I found that the social workers occupied a marginal position within an organization whose economic solvency was based on the performance of medical work. The logic of medical necessity that set priorities for the Grove’s resources led to an institutional disinvestment in both the social workers and their realm of expertise. The social workers found that what they thought of as real social work had been replaced by labor that was largely in service to state-required paperwork and the regulatory requirements of medical work. Comparing the plights of the Grove’s NPs and its social workers revealed that the appearance of social problems in the exam room was a function not just of NP professional openness within the clinic encounter, but of the lack of resources given to address these problems outside it. The federal government has largely withdrawn itself as a payer for the problems of poverty even as its financing of medical care has soared. I argue that the saliency of the NP is as much a story of welfare state retrenchment as one of economic utility. The hurdles faced by the Grove’s social workers illustrate the limitations of analyzing occupational strategies without placing them within a larger political economy. The NP as policy solution is based on the logic of substitution. Once we start interrogating this logic, a new set of questions arises. As the sociologist Everett Hughes (1970) observed, experts do not just solve our problems; they shape our conceptions of them. The NP might be the kind of solution that rearranges the problem in new ways. Accordingly, the chapters that follow do more than describe the work of a particular category of clinician. They provide a view, from the ground up, of a broader reorganization of medical labor and its relationship to the ever-shifting division between medical problems and social problems. Nurse practitioners are often thought of as filling in for the absent physician. Together, these pages make the case that NPs are just as often filling in for the absent state.

The arguments I make in this book speak to broad changes in health care delivery. Although these arguments are far-reaching in their implications, they are made through the materiality of Forest Grove Elder Services. The first chapters of the book speak directly to the idea of NPs as a policy solution. In part I, I situate the Grove as both a professional and an organizational solution to the problems of health care, old age, and poverty. The Grove and its NPs do not exist in a vacuum; they coexist in a policy environment in which both nursing and health care organizations are seeking to capitalize on state support. I illustrate that the expansion of nursing’s terrain is intertwined with changes in the organization and provision of care for older adults. I then describe the professional resources that these NPs used to construct a notion of clinic work within this expanded terrain. In following the journey of member problems—how they are generated, to whom they are brought, and who fixes them—I reveal organizational logics about the type of expertise the Grove collectively believed resided within the clinic. Part of the work of this section is to reinterpret the clinical encounter as more than a meeting between a medical provider and the patient’s chief complaint, but as an institutionally situated meeting of a range of complaints. I make the case for the NPs’ performance of organizational care work by paying attention to the work they do and contrasting it with the work the physicians do not.

In part II, I demonstrate how the new notion of clinic work effectively reconstructs physician understandings of what constitutes medical work. I begin by looking directly at the relationship between NPs and physicians. The NPs I followed had three distinct views of who physicians were in relationship to their own practice: consultants, captains, or teammates. These three framings led to very different ways of being what each considered a competent NP. I then investigate how the physicians reoriented their own domain of work in the face of the NPs’ view of their role. I pay particular attention to the unease experienced by physicians who found themselves working within NP-led teams, as well as how that unease was managed through actively relocating physician expertise outside the clinic. In doing so, I show that the NPs’ clinic work was a relational concept that required adjustments in how physicians understood their own work.

In part III, I consider how the expansion of clinic work is inextricably tied to the shrinking domain of social work, both as a profession and as an orientation to social problems. Empirically, I ground my analysis in the everyday work of the Grove’s social workers, who are positioned at the margins of an expanding clinic. I situate these observations within a broader view of social work’s precarious professional position. Part of the challenge of claiming expertise for social work is its location in the devalued world of social problems. In this section, I argue that the legitimacy of the NP is related to the delegitimization of social work. The different fates of these two professions do not simply represent a problem of professional strategy; rather, they reflect an unwillingness, in policy and in ideology, to recognize the economic and political character of social problems. I end by questioning professionalization more generally as a privatized response to collective concerns.

Through illustrating these arguments, this book is both a meditation on and an empirical excavation of the possibilities NPs are forging within the confines of the medical encounter. When NPs fill the space that physicians have absented, they are embodying a **different set of possibilities** for what the health care encounter could be. In doing so, they are positioned to make [recognizable] ~~visible~~ not just the scarcity of physician labor but that of **caring labor**. Although sometimes self-conscious of the claim, nursing still relies on care as the bedrock of its professional identity and legitimacy. To care is not empty rhetoric; it is work. And although it is usually seen as ancillary to the main stage of medical interventions, health care organizations have never been more reliant on such work. The Grove’s NPs may have been unique in the wealth of organizational resources available to them as they embodied nursing expertise. However, I believe they are not alone in being asked to solve different problems than their physician colleagues.

#### Only a syndemic approach, centering the interactions between the legal and interpersonal, can inform effective methods of praxis in this context

Brown 20 (Kyrah K. Brown, Department of Kinesiology, University of Texas At Arlington; and Michael Kenneth Lemke, Department of Social Sciences, University of Houston-Downtown; “Syndemic Perspectives to Guide Black Maternal Health Research and Prevention During the COVID-19 Pandemic,” Matern Child Health J. 2020; 24(9): 1093–1098, DOI: 10.1007/s10995-020-02983-7) \*added [black women and birthing people]

Understanding the complex intersection of endemic and COVID-19-specific vulnerabilities and disparities experienced by BWBP [black women and birthing people] requires theoretical frameworks that can overcome the limitations of prevalent epidemiological, biomedical, and public health frameworks (Singer 2013; Mendenhall 2017) and holistically conceptualize the multi-level, interacting, and dynamic nature of the impacts of COVID-19 and corresponding policy changes. Thus, we advocate in this manuscript that is not based upon clinical study or patient data for the proliferation of syndemic perspectives to guide maternal disparities research and prevention during the COVID-19 pandemic. Syndemic perspectives can provide researchers with a theoretical grounding to advance scientific inquiry into the interacting, multi-level, and co-occurring maternal health afflictions that have emerged from dynamic macro-level policies and forces that have led to the clustering of health disparities among pregnant Black women over time. Further, these perspectives can shed light on how these endemic policies, forces, and afflictions, along with novel COVID-19-specific factors and outcomes, may synergistically perpetuate population-level vulnerabilities and exacerbate disparities, with upstream impacts that constitute ‘vicious cycles’. Syndemic-informed research can then lead to holistic, multi-level prevention strategies that simultaneously tackle both endemic and COVID-19-specific factors and outcomes that lead to the clustering of vulnerabilities and disparities over time.

**1ac – plan**

#### The United States federal government should prohibit state action immunity protections for anticompetitive barriers to full practice authority for nurse practitioners.

### Adv 2

#### Advantage 2 is Macro-Abstention

#### A public policy debate about Health Practitioners has at least two functions.

#### In a direct sense – it’s a discussion with value, AND

#### Indirectly – it’s a gateway to broader concerns over any public policy.

#### In the realm of health, malleable change is feasible. Advancing that perspective pivots from approaches that describe the squo toward approaches that prescribe successfully macro-interventions.

Stipp & Smith ‘19

Karen Flint Stipp, MSW, PhD, is associate professor at Illinois State University School of Social Work. Trista Smith - Illinois State University. At the time of this writing, co-author Trista Smith was an MA student at Illinois State University’s School of Social Work and is currently an Adult Protective Service Case Manager at Prairie Council On Aging. This review internally quotes Dayna Bowen Matthew, a leader in public health who focuses on racial disparities in health care. Matthew joined the faculty at the University of Virginia in 2017. She is the author of the book Just Medicine: A Cure for Racial Inequality in American Health Care. Matthew previously served on the University of Colorado law faculty as a professor, vice dean and associate dean of academic affairs - "Review of Just Medicine: A Cure for Racial Inequality in American Health Care by Dayna Bowen Matthew” - Journal of Sociology & Social Welfare - Volume XLVI - Number 4 - December 2019 - #E&F – modified for language that may offend - https://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=4358&context=jssw

Dayna Bowen Matthew focuses on remedies to U.S. health disparities with an attorney’s ~~eye~~ (perspective) for justice deferred. She shows her impatience with a status quo that remains deadly for U.S. racial/ethnic minority groups and draws a line from laws in the Colonial and Industrial Eras to current health disparities. Matthew uses law as her platform to argue for quality of care in a way few writers outside the medical field can. The studies she cites measure quality of care in terms of time with providers, referrals for tests and specialists, and use of best practice interventions. She does not satisfy herself with describing the problem but suggests remedies for the implicit bias and structural exclusions that support differing quality of care for different U.S. racial/ethnic groups. This book takes on the enormous task of addressing both access to and quality of health care, and of providing remedies to the medical and social determinants of health disparities.

Matthew begins by describing Colonial Era laws that restricted access to the social determinants of health, including home, food, employment and education. These laws included Land Grants and Slave Codes that supported commerce through the separation of people from their homes, and that viewed enslaved people as individually expendable and replaceable. In the following era of Industrialization, case law and legislation segregated the spaces where groups of people could live, eat, work and learn. As health care improved in the early 1900s, courts and legislatures also segregated the spaces where people could access care. The Civil Rights Era was ushered in by case law that reinterpreted the constitution’s “equal protection.” The legislature enacted Title VI of the 1964 Civil Rights Act to explicitly prohibit federal exclusions for “race, color or national origin.” Exclusions persisted as change in national attitude was only incrementally ahead of change to the law, and access was hard-won in conflict with local authorities.

In the current era, decades of Civil Rights enforcement have nearly eradicated explicit exclusions. Matthew suggests the dance between attitude and law has likewise eradicated vestiges of malice among professionals. Yet she cites persistent evidence that the U.S. groups experiencing poorer health care today are the same groups restricted from social determinants of health in earlier centuries. The Affordable Care Act expanded access to care, but care remains inequitable. Current courts narrowly interpret Title VI as applicable only to intentional exclusions. Matthew cites laws outside health care that hold individuals and corporations responsible for creating unintentional harm, suggesting health care systems should bear similar responsibility. Although explicit bias is nearly eradicated, disparate rates of morbidity and mortality persist when controlling for health care insurance and other socioeconomic factors. Narrow interpretations of Title VI continue breeding centuries-old disparities, and difficult-to-detect implicit bias remains a health risk for U.S. racial/ethnic minority groups.

Matthew then provides evidence of implicit bias that is nearly invisible to the casual observer, collected from the Implicit Association Test and other measures. If it seems incredible that nearly-invisible mechanisms could have such a negative health effect, recall that the Industrial Era found it incredible that a nearly-invisible mechanism named bacteria could create personal and community disease. When a critical mass of people understood the nearly-invisible problem, medical, social and legal interventions reduced population rates of morbidity and mortality in a generation. Matthew further helps us understand the nearly-invisible with a Biased Care Model of six interacting mechanisms through which implicit bias leads to disparity. Health care providers may be particularly susceptible to implicit bias, because recommendations in any patient encounter are informed by a complex cognitive load. They sort through their knowledge of signs and symptoms, knowledge of etiology and epidemiology, and knowledge of the availability and cost of tests and treatment. This hard-earned knowledge can be unwittingly sullied by the negative images of minority groups that are commonly broadcast by popular culture. Matthew’s model illuminates complex, overlapping pathways from implicit bias to inequitable care.

Matthew follows her presentation of disparity’s causes with medical, social and legal interventions designed to reduce disparate rates of morbidity and mortality, and improve overall population health, in the next generation. She uses Thomas Frieden’s Health Impact Pyramid as a guide to interventions, addressing the Pyramid’s top three tiers: Counseling and education, clinical interventions, and long-lasting protective interventions. The cultural competence in-services many organizations employ have shown little effect, but there are three evidence-based types of intervention that effect change. Stereotype Negation Training, the most effective of the three types, helps intentional professionals replace unconscious negative associations, through prolonged exposure to positive images. Promoting Counter-Stereotypes helps professionals develop heterogeneous impressions of groups through repeated exposures to admired minority individuals and disreputable white individuals. Social and Self-Motivation interventions tap into professionals’ desire for a positive social and self-image, to promote equitable decisions and conduct. All of these, however, presume intentionality and altruism from health care systems. None of them address the lack of structural support for equitable practices.

Matthew recalls theologian Reinhold Niebuhr’s ”serenity prayer,“ a prayer for wisdom and courage to act when things can be changed. With that wisdom and courage, she moves to the Health Impact Pyramid’s fourth tier: The social context of health decisions. She suggests it is again time to summon the courage for broader structural solutions. While Matthew endorses interventions for implicit bias, she calls on health corporations to provide incentives for providers to supply equitable services and care. She calls on courts to apply Title VI regardless of intent when clear evidence exists of disparate services. She calls on legislatures to draft laws that hold health care systems to account for disparate provision of care.

#### Our argument applies to health provision – but informs lessons that extend beyond it. Discussing proactive public policy broadly hedges against Macro Abstention – an outcome that boosts dangerous outcomes ranging from green violence to intolerance. The impact is large.

**Liu ‘12**

Et al – Eric Liu is the founder of Citizen University. He served as a White House policy adviser for the Clinton Administration and is a member of the commissioned National Task Force on Civic Learning and Democratic Engagement. This Task Force’s report was called “A Crucible Moment – a Call to Action” and was submitted to Eduardo Ochoa – Assistant Secretary for US Department of Education Postsecondary Education; The National Task Force recommendations were the byproduct of a series of five National Roundtables was held between December 2010 and March 2011 involving 134 people representing 61 community colleges, four-year colleges, and universities; 26 civic organizations; 9 private and government funding agencies; 15 higher education associations; and 12 disciplinary societies. Participants in these National Roundtables helped assess the strengths and limitations of current efforts to engage college students in civic learning and made invaluable contributions to the arguments and recommendations presented in A Crucible Moment. Task Force Members include Eric Liu, founder of The Guiding Lights Network; Gale Muller, Vice Chairman of Worldwide Research and Development for Gallup, where he has overseen research on the voices of citizens in more than 130 countries; Eboo Patel, Founder and Executive Director of Interfaith Youth Core (IFYC) and author of the award-winning book Acts of Faith: The Story of an American Muslim, the Struggle for the Soul of a Generation; Kathleen Maas Weigert, Carolyn Farrell, BVM, Professor of Women and Leadership, and Assistant to the Provost for Social Justice Initiatives at Loyola University Chicago; Sylvia Hurtado, Professor and Director of the Higher Education Research Institute at UCLA, where she researches student educational outcomes, campus climates, and diversity in higher education. A National Call to Action – A Crucible Moment: College Learning and Democracy’s Future. Washington, DC: Association of American Colleges and Universities. Available via: www.aacu.org/civic\_learning/crucible/documents/crucible\_508f.pdf‎

**A Crucible Moment** likewise **calls for transformations** necessary for this generation. A daunting one is **to eliminate** persistent **inequalities,** especially those in the United States determined by income and race, in order to secure the country’s economic and civic future. **But the academy must** also **be a vehicle for tackling other pressing issues**—growing **global** economic **inequalities,** climate change and environmental degradation, lack of access to quality health care, economic volatility, **and more**. **To do that requires expanding students’ capacities to be civic problem-solvers** using all their powers of intellect and inventiveness. Sixty-five years after the Truman Commission, the nation faces a different national and global dynamic than in the aftermath of World War II. A Crucible Moment casts its National Call to Action in the context of five trends that shape this historic juncture. Increase in Democratic nations: In 1950, just over 25 percent of countries in the world could be characterized as electoral democracies (Diamond 2011). In 2010, 59 percent of countries could be characterized in this way (Puddington 2011). Moreover, “in 1975 the number of countries that were ‘not free’ exceeded those that were ‘free’ by 50 percent, [but] by 2007 twice as many countries were ‘free’ as were ‘not free’ (Goldstone 2010, 1). According to an official statement released by the Arab Network for the Study of Democracy, the Arab Spring of 2011 brought people in seven countries to the streets united by three notions: freedom, dignity, and justice (Lee 2011). These shifts offer significant opportunities for revitalizing all democracies, both old and new, as modern democracies learn collectively how to recalibrate democratic processes to meet the new demands of a globalized age. Intensified Global Competition: After World War II, the United States competed only with the Soviet Union for global domination as other nations were busy either putting their devastated economies back in order or developing them. Today, powerful new economies exist on every continent. The European Union is challenging US economic domination, and there is a decided tilt toward the Asian markets of China, India, and Japan. In this globalized world, the budgets of many multinational companies are larger than those of many countries, and they are not bound in their practices by any one nation. Dangerous Economic Inequalities: While the United States had been moving toward a diamond-shaped economy with a larger middle class, recent years have seen an increased gulf between rich and poor across US households. Economist Edward N. Wolff notes, for example, that between 2007 and mid 2009 there was “a fairly steep rise in wealth inequality [where] the share of the top 1 percent advanced from 34.6 to 37.1 percent, that of the top 5 percent from 61.8 to 65 percent, and that of the top quintile from 85 to 87.7 percent, while that of second quintile fell from 10.9 to 10 percent, that of the middle quintile from 4 to 3.1 percent, and that of the bottom two quintiles from 0.2 to -0.8 percent” (Wolff 2010, 33). In sum, as of 2009, nearly 90 percent of wealth was concentrated among the top 20 percent of US households, while just over 10 percent of wealth was spread across the remaining 80 percent. One result of this hyper-consolidation of wealth is that for the first time in US history, the younger generation is not on a trajectory to achieve their parents’ economic level. These same economic inequalities are even more dramatic in a global context. According to former UN Humanitarian Relief Coordinator Jan Egeland. “The richest individuals are richer than several of the poorest nations combined—a few billionaires are richer than the poorest two billion people” ( http://ucatlas. ucsc.edu/income.php). Economist Branko Milanovic (2000) has found that the ratio of the average income of the top 5 percent of the world’s population to the bottom 5 percent increased from 78 to 1 in 1988 to 114 to 1 in 1993. In the case of sub-Saharan Africa, a whole region has been left behind: it will account for almost one-third of world poverty in 2015, up from one-fifth in 1990 (United Nations Development Programme 2007). Demographic Diversity: The United States is “the most religiously diverse nation on earth” (Eck 2002, 4), and is more racially diverse than ever. By 2045 communities of color will constitute at least 50 percent nationwide (Roberts 2008), as is already the case in some states. Immigrants now make up 12.5 percent of the US population (Gryn and Larsen 2010). Intensified immigration and refugee populations swirling around the entire globe have resulted in similarly dramatic demographic shifts on almost every continent. Having the capacity to draw on core democratic processes to negotiate the increased diversity will secure a stable future. technological Advances: In 1945, televisions were a rarity and many sections of the country were just getting telephone lines and electricity. The impact of computers and information technology today is reminiscent of the transformation wrought by the Industrial Age: all facets of everyday livingare affected, from communication to health care, from industry to energy, and from educational pedagogies to democratic practices. The Internet— particularly the development of social media to organize groups of people around commonly shared values—influences democratic engagement and activism, as dramatically illustrated by the 2011 Arab Spring and the 2008 US presidential election. While the historical dynamics that shaped the Truman Commission’s findings may differ from today’s political and social environment, a number of stubborn problems that existed then continue to erode the foundation of our democracy. The most pressing of these are unequal access to college and economic lethargy. Although access has increased dramatically, unequal access continues to plague democracy’s ability to thrive. Students are underprepared for college because of what writer and educator Jonathan Kozol (1991) refers to as “the savage inequalities” of the nation’s K–12 system. The poorer the young person, the less likely he or she will go to college. Yet SAT scores, which directly correlate with income, continue to determine many students’ qualifications to attend college. Failure to graduate from high school shuts off college as an option for nearly 30 percent of our nation’s young people; researchers James Heckman and Paul LaFontaine (2007) note that high school graduation rates have leveled or declined over four decades, and the “majority/minority graduation rate differentials are substantial and have not converged over the past 35 years.” In a new foreword to The Drama of Diversity and Democracy: Higher Education and American Commitments, Ramón A. Gutiérrez illustrates Latinos’ attrition along the educational pipeline in the United States. While they are the fastest growing racial minority, surpassing the percentage of African Americans, education is not providing a democratic pathway to economic independence or social mobility. Drawing on research by Armida Ornelas and Daniel Solórzano, Gutiérrez explains that “of every one hundred Latinos who enroll in elementary school, fifty-three will drop out,” and of the forty-seven who graduate from high school, “only twenty-six will pursue some form of postsecondary education” and “only eight will graduate with baccalaureate degrees” (Gutiérrez 2011, xvi). In the face of troubling discrepancies among racial and socioeconomic groups, there is some good news in the longer term regarding the nation’s increasing college graduation rates. In 1940, only 24 percent of the population 25 years and older had completed high school, and just under 5 percent held a bachelor’s degree (Bauman and Graf 2003). Seventy years later, those numbers have progressed dramatically. “Of the 3.2 million youth age 16 to 24 who graduated from high school between January and October 2010, about 2.2 million (68.1 percent) were enrolled in college in October 2010” (Bureau of Labor Statistics 2011). Overall college graduation rates have also improved: the Digest of Education Statistics 2010, for example, reports that for those seeking the bachelor’s degree, the rate of graduation within four years has reached 36.4 percent. Within six years, it jumps to 57.2 percent. For those seeking an associate’s degree, the graduation rate within six years is 27.5 percent (Snyder and Dillow 2011). According to the 2011 Education at a Glance report completed by the Organisation for Economic Co-operation and Development (OECD), the labor force in the United States is among the world’s top five most highly educated. However, OECD’s report explains, “The US is the only country where attainment levels among those just entering the labor market (25–34 year-olds) do not exceed those about to leave the labor market (55–64 yearolds).” As a result, “among 25–34 year-olds, the US ranks 15th among 34 OECD countries in tertiary attainment” (OECD 2011, 2). In other words, the educational attainment level in the United States has remained relatively flat while other countries have rapidly increased and surpassed us. An attainment rate that qualified the United States to be near the top of the world several decades ago is not a guarantee of retaining world leadership educationally. Neither graduation rates nor attainment rates that were sufficient in the past are satisfactory today, when two-thirds of future jobs will require some type of postsecondary credential. There is a strong link between educational level and preparedness for a newly demanding workplace, just as there is a strong link between educational level and other civic indicators, including voting. A high-quality education, workforce preparation, and civic engagement are inextricably linked. A college education—who has access to it, and who completes the degree—affects personal ambitions, the economy, and civic participation. After World War II, the United States invested in higher education as a vehicle to jump-start economic expansion. The community college sector in particular was dramatically expanded to provide people with new access to college and new technical skills. In today’s economy, higher education is once again viewed as a way graduates can achieve greater economic mobility and our lethargic economy can be stimulated. In 1947, with the world in shambles, new structures, alliances, and programs were created in an attempt to avert future catastrophic wars, to reconstruct multiple economies, and to establish common principles of justice and equality. As the Truman Commission demonstrates, political and educational leaders agreed that higher education was needed to educate students for international understanding and cooperation to secure a sustainable future. Although today’s world is more globally integrated financially, culturally, and demographically, it is also fraught with civil and regional wars, clashing values, and environmental challenges wrought by rapacious consumption and carelessness. Citizens who have never examined any of these issues will be left vulnerable in the face of their long-term consequences. How to achieve sustainability—understood in its broadest definition as including strong communities, economic viability, and a healthy planet—is the democratic conundrum of the day. If it is not solved, everyone’s future well-being will be in jeopardy. Meanwhile, students’ economic options are heavily influenced by two long-term trends: the requirement of a college credential for the twenty-firstcentury employment market, and the inadequacy of federal and state funds that could make higher education more widely available. After World War II, the majority of jobs in the United States did not require a college degree, yet many—especially in unionized fields—offered a middle-class living wage and benefits. Today, a college degree is the credential that a high school diploma once was. According to a 2010 report, Projections of Jobs and Education Requirements through 2018, of the 46.8 million new and replacement job openings in 2018, 34 percent will require a bachelor’s degree or better, while 30 percent will require at least some college or a two-year associate’s degree. (Carnevale, Smith, and Strohl 2010, 110). As the report’s authors describe this societal sea change, “…postsecondary education or training has become the threshold requirement for access to middle-class status and earnings in good times and bad. It is no longer the preferred pathway to middle-class jobs—it is, increasingly, the only pathway” (110). This higher educational bar is imposed as colleges and universities continue to cope with the effects of the recession and budget deficits at both state and federal levels. Higher education is often the vehicle that states use to balance their budgets. The sector does well in good times and is hit harder in lean ones. According to a 2011 report issued by the National Conference of State Legislatures, total state support for higher education institutions fell by 1.5 percent in FY 2009. Without federal funding from the American Reinvestment and Renewal Act (ARRA), this decline would have been 3.4 percent. In 2010, twenty-three states decreased state support of public higher education institutions, even after receiving ARRA funds. Eight of these states reported drops in higher education funding exceeding 5 percent (National Conference of State Legislatures 2011). These compounding factors produce our crucible moment today. **The country,** the economy, **and** the **world demand a different kind of expertise** than was required of graduates after World War II. **The** **kind of** **graduates we need at this moment in history** need to possess a strong propensity for wading into an intensely interdependent, pluralist world. They **need to be** agile, creative **problem solvers** who draw their knowledge from multiple perspectives both domestic and global, who approach the world with empathy, and who are ready to act with others to improve the quality of life for all. Another name for these graduates is democratic citizens. In the face of the constellation of forces described in the previous chapter, this crucible moment in US history might look daunting. Certain lessons from the Truman Commission, however, should spur people to action, not paralysis. Despite the ravages of World War II and the resultant worldwide economic devastation, the Commission was ambitious in its scope, calling for bold leadership and investment of public funds and reaffirming the public mission of higher education as a reservoir for progress for the nation and the world. That same visionary leadership is necessary today. The Truman Commission also imagined long-term, systemic change— within both higher education and the nation at large—as an answer to the dire challenges of the day. In a revolutionary stand, the Commission named racial segregation, inequality of any kind, and intolerance as impediments to economic advancement and affronts to democratic values. This twentyfirst-century juncture likewise demands deep structural reforms in higher education and the broader society. As Charles Quigley’s (2011) epigraph to this report states, “Each generation must work…to narrow the gap between the ideals of this nation and the reality of the daily lives of its people.” Today, colleges and universities must once again serve as “the carrier[s] of democratic values, ideals, and process,” but for a new age confronting new challenges (President’s Commission on Higher Education 1947a). **Putting civic learning at the core rather than the periphery** of primary, secondary, and postsecondary education **can have far-reaching positive consequences** for the country and the economy. It can be a powerful counterforce to the civic deficit and a means of replenishing civic capital. That restored capital, in turn, can function as a self-renewing resource for strengthening democracy and re-establishing vitality, opportunity, and development broadly across the socioeconomic spectrum and even beyond national borders. As Martin Luther King Jr. (2011) accurately noted, we are all “tied in a single garment of destiny.” If indeed we seek a democratic society in which the public welfare matters as much as the individual’s welfare, and in which global welfare matters along with national welfare, then education must play its influential part to bring such a society into being. As Ira Harkavy (2011) asserts in the epigraph to this chapter, that will require a commitment to “develop and maintain the particular type of education system conducive to it.” A Crucible Moment posits that the nature of that particular type of education must be determined at the local institutional level in order to construct civic-minded colleges and universities. In Chapter I we argued that such campuses are distinguished by a civic ethos governing campus life; civic literacy as a goal for every graduate; civic inquiry integrated within majors, general education, and technical training; and informed civic action in concert with others as lifelong practice. If Chapter I established the urgency of reinvesting in education for democracy and civic responsibility and Chapter II demonstrated that ambitious action was possible in the face of earlier difficult historical eras, this chapter comprises a National Call to Action: recommendations that can begin to erase the current civic learning shortfall. These recommendations are meant to shift and enhance the national dialogue about civic learning and democratic engagement and to mobilize constituents to take action. Everyone has a role and everyone must act, with participation and deliberation across differences as vibrant democracies require. We invite each constituent group to use this report and its National Call to Action as a guideline to chart a course of action—tailoring, for example, the strategies and tasks to be accomplished, the entities responsible for each effort, the partners to be engaged, the timeline for action, and other particulars—that would most effectively respond in the exigencies of this crucible moment. We encourage readers to expand and refine this report’s recommendations and make them locally relevant by institution, region, issue, and demographics. In Appendix A, we provide a mechanism for doing so in the form of tools to help each participating entity develop its own Civic Investment Plan. Readers are encouraged to **work** collectively **within self-designated spheres to** develop a planfor exactly what they can and will do **to make civic** learning and democratic **engagement a meaningful** national **priority.** As described in the opening pages of this report, the National Call to Action is the product of a broad coalition of people. The idea for bringing such a group together began with the US Department of Education, which commissioned the report, funded it, and nurtured it. From the beginning, the department acknowledged the widespread civic engagement movement that has been working for decades both on and off campus. The design for the project deliberately drew from that expertise and charged leaders in civic renewal efforts to envision the next frontiers of civic learning and democratic engagement in higher education. Assuming that the best solutions would be generated by people responsible for moving from a set of recommendations to purposeful action, the department charged the National Task Force on Civic Learning and Democratic Engagement with making recommendations—to the government and to higher education—that were informed by the expertise and experience of the leaders and essential partners of the civic renewal movement already underway. A staunch partner in promoting civic learning and democratic engagement throughout the process, the department nonetheless made clear that A Crucible Moment was to be the Task Force’s report not the department’s, prepared in dialogue with a very broad community of advisers. Those advisers who were participants in five different national roundtables, and whose names are listed in Appendix C are civic practitioners, scholars, and administrators. They generated what became an evolving set of specific recommendations included in this chapter. The National Task Force continued to refine the recommendations in subsequent drafts. There was consensus among participants that a successful Call to Action would require multiple leaders collaborating from varying constituencies both within and beyond higher education and within and beyond government agencies. The broad swath of recommendations that emerged reflects that consensus. K–12 education is the cornerstone for both functioning democracies and college readiness. As Ira Harkavy (2011) said in his address at the international conference “Reimagining Democratic Societies,” “no effective democratic schooling system, no democratic society. **Higher education has the potential to powerfully contribute to** the democratic **transformation of** schools, communities, and **societies.”** Despite all the investment in improving the level of schooling in the United States, particularly over the past quarter century, far too little attention has been paid to education for democracy in public schools. In their foreword to the report Guardian of Democracy: The Civic Mission of Schools, former Justice Sandra Day O’Connor and former Congressman Lee Hamilton note, “**Knowledge of our system of governance** and our rights and responsibilities as citizens **is not passed along through the gene pool**. **Each generation** of Americans **must be taught** these basics” (2011, 5). The arguments for the civic purpose of K–12 education and the arguments for the civic mission of higher education are similar. **Education for** democratic **engagement is** even **more urgent than it has ever been,** given America’s current diverse populace and global interdependencies. Revealingly, the definition of civic learning put forth in Guardian of Democracy encompasses a continuum across educational levels—in both pedagogy and curricula—that is consistent with an enlarged definition of civic literacies cited in Chapter I of this report, the framework for twenty-first-century civic learning provided in figure 1, and the examples of campus practices featured in Chapter V. Research in 2009 about civic learning in K–12 by Judith Torney-Purta and Britt S. Wilkenfeld echoes findings in higher education. Torney-Purta and Wilkenfeld suggest, for example, that the educational outcomes proceeding from well-constructed civics curricula overlap with the knowledge and skills needed in the workplace. Similarly, their research finds that engaged pedagogies in K–12 that accelerate empowered, student-centered learning also enhance both constructive civic/political participation skills and parallel skills of collaboration, so valuable in the workplace. Finally, they find that classrooms that are civically oriented across multiple kinds of subjects also contribute to students’ motivation to do well and, therefore, to the likelihood that students will stay in school. The Campaign for the Civic Mission of Schools therefore argues there should be three C’s driving reform in K–12 education: college, career, and citizenship (see www.civicmissionofschools.org). Unfortunately, the current public discourse—driven by multiple public, business, and governmental sectors—focuses disproportionately on the first two. The 2011 Educational Testing Services report The Mission of High School voices this concern in a chapter called “A Narrowing of Purpose and Curriculum?” Diane Ravitch is quoted about the grievous consequences to democracy’s health of not setting high expectations across an array of subjects in schools but instead focusing on only a few subjects that are narrowly judged in high stakes testing: “A society that turns its back on the teaching of history encourages mass amnesia, leaving the public ignorant of the important events and ideas of the human past and eroding the civic intelligence needed for the future. A democratic society that fails to teach the younger generation the principles of self-government puts these principles at risk” (Barton and Coley 2011, 25–26). The omission of civic goals for education occurs even in the face of evidence that civic engagement contributes to academic success. As reported by the Center for Information and Research on Civic Learning and Engagement (CIRCLE), “Longitudinal studies show that young people who serve their community and join civic associations succeed in school and in life better than their peers who do not engage” (Levine 2011, 15). Parallel findings across K–12 and postsecondary education suggest that (1) comprehensive civic goals need to be included in standards to be assessed at state and national levels; (2) civic development for teachers in schools needs to be supported; and (3) schools of education need to integrate civic learning and democratic engagement into the curricula that prepare our nation’s teachers. Recognizing the need for a reinvestment in civic learning, thoughtful K–12 educators and leaders have developed a framework that accords with the vision and argument of this report (see particularly the Campaign for the Civic Mission of Schools 2011a, 2011b, www.civicmissionofschools.org/site/ resources/civiccompetencies.html, and Guardians of Democracy). The timing is right, then, to form sturdy bridges to civic learning and democratic engagement across students’ lifelong learning trajectories. Without K–12 education laying the foundations for civic responsibility and developing students’ understandings of democracy’s history and principles, any hopes of raising national civic literacy and civic agency are likely to be undermined, both for college students and, even more so, for high school graduates who may never enroll in college.

#### Of course “Fiat is not Real” – The Aff doesn’t believe we just magically shifted NP policy.

#### Rather, our solvency hinges on what we are not. Skepticism over capacity to insta-change Macro Policy risks inverting the error. Energies re-channel towards intensely local priorities. That locks-in the worst versions of the squo. None of this is inevitable – provided theorization begins with constructing civic engagement around Macro Public Policy.

D’Arcy ‘14

Stephen D’Arcy - Associate Professor in the Department of Philosophy at Huron University College. The author’s published research mainly addresses practical ethics and the author teaches courses in moral and political philosophy. From the article: “The Rise of the Post-New Left Political Vocabulary - The Public Autonomy Project: The ethics and politics of popular self-organization – Modified for potentially objectionable language - January 27, 2014 - <http://publicautonomy.org/2014/01/27/the-rise-of-the-post-new-left-political-vocabulary/>

A Shift in Priorities *from* Ultimate Victory to Challenging Everyday Impacts. The older vocabulary looked at capitalism, racism, and sexism (for example) as social systems or institutions that could and probably would be defeated, once and for all, in the foreseeable future. Accordingly, activists of that era defined and described their movements as struggles for “socialism,” “black liberation,” or “women’s liberation.” By contrast, the new vocabulary tends to suspend judgment on (without denying) the prospects for ultimate victory, and to focus its attention on challenging everyday impacts of capitalism, racialization and gender, in the here and now. This prioritization of resistance to everyday impacts infuses, not only the way activists today talk, but also how they choose what to do. For example, what is happening in this meeting, today, is emphasized much more, because it is not seen merely in instrumental terms as a means to destroy systems of domination. The meeting itself is generating impacts that have to be challenged as they arise. Addressing problems of “process,” which once would have been seen as a “distraction” from an urgent liberation struggle, is now seen as part and parcel of what the Left is for.

A Shift of Focus from Analyzing System Dynamics to Analyzing Interpersonal Dynamics. The old vocabulary assumed that political analysis should study large-scale, often transnational social systems and structures, centuries in the making, e.g., systems of oppression and exploitation. In contrast, the new vocabulary assumes that race and gender and other forms of privilege are enacted in everyday, interpersonal interactions. This is key to the concept of “privilege.” It is likened to “an invisible backpack” of advantages or monopolized benefits that some receive and others are denied. Privileged persons gain these benefits whether or not they even know or acknowledge it. Thus, whereas activists in the late 60s and 70s were keen to use history and political economy to develop a sophisticated analysis of the historical process, centuries-long, that established European colonial domination of much of the world, the new vocabulary both reflects and encourages a change of focus, toward how racism (for example) is enacted or reproduced in the everyday interactions of white people with racialized people, as individuals or in groups. The analysis of the power dynamics of these everyday interpersonal interactions has tended to gain in prominence and sophistication, in parallel to the relative de-emphasis of the importance of political economy and critical sociology within the activist Left.

A Shift in Emphasis from Commonality (Among Social Groups) to Specificity. The vocabulary of the 60s and 70s grew out of and contributed in turn to the construction of broad-based popular movements, in which hundreds of thousands and sometimes millions of people participated. By contrast, the vocabulary of today’s activists emerged in a completely different, and arguably much less favourable context. One symptom of this is a change in emphasis from the search for commonalities that could be the basis for building alliances and expanding the base of support for militant mass movements, to grappling with the barriers to joint organizing and common struggle. In brief, the old vocabulary emerged in a context where opportunities to encourage solidarity and collaboration were actively sought, whereas the new vocabulary emerged out of the frustration of failed efforts to bridge gaps between people and organizations that reflected real differences. There is a certain optimism in the idea of “consciousness-raising,” or the concept of “the people,” that seems naive and unconvincing to many of today’s activists. The shift from “consciousness-raising” to “calling out,” for instance, reflects (and encourages) a loss of confidence in the capacity of people to learn about, understand and oppose forms of inequality that do not adversely impact them as individuals. These doubts are, in turn, elaborated in terms of positionality and privilege.

Taken together, these three shifts go a long way toward explaining the transformation of the way activists talk, which has been noticeable at least since the 1990s. But is this a turn in the right direction? Or has the activist Left gone badly astray? As we try to assess both the gains and the losses of this change, it is necessary to acknowledge two fundamental, and incontrovertible facts: First, it is true that the vocabulary, and the practice, of the Left in the 1960s and 70s had several serious problems. There is no denying the fact that their movements were vastly more potent, and drew in vastly more people from all walks of life, than any political organizing that happens on the Left today, with the possible exception of the Occupy movement during its height. And yet, many people entered and participated in those movements in spite of serious concerns about the persistence, within movement activities, of sexist behaviours and attitudes, forms of machismo that were at once misogynist and homophobic, and ways in which (in some organizations and struggles) college-educated, middle-income white people tended to dominate the proceedings and set the agendas. To the extent that the movement was plagued by problems of this kind, the 60s New Left’s practice belied the radicalism of is official rhetoric, and made its universalistic claims about the “unity” of “the people” ring hollow. It seems clear that the attentiveness in today’s Left activist subcultures to interpersonal dynamics within the movement reflects a genuine learning process. It is a step toward beginning to address problems that were, in effect, glossed over and ignored by phrases like “the people” and a complacent view of the prospects for building genuine “solidarity” and “alliances.”

Second, however, it is also true that the series of shifts from the old vocabulary to the new one has entailed certain losses. In particular, the relative de-*emphasizing* of system-level causation, in favour of a new emphasis on the importance of individual action or inaction, tends to ~~weaken~~ (hamper) the integration of everyday Left discourse with the theoretical analysis of systems like capitalism and colonialism. It is true that, in exchange, we have a vocabulary that better enables us to focus on class privilege and settler privilege. But if we are to defeat colonialism and capitalism, we cannot do so one person at a time, or one interaction or relationship at a time. The systems themselves have to be named, understood, attacked and overthrown. This issue is, obviously, closely connected to the loss of a focus on liberation. A liberation focus and a systems focus share a common understanding: that the purpose of the Left is to defeat systems of exploitation and oppression. Challenging immediate impacts is important, but not enough. It is necessary, but by no means sufficient. Moreover, the *way* we challenge everyday impacts should be informed by our understanding that they are not produced simply by individual actions, but by the operation of large-scale systems. The Left needs a vocabulary, and a self-understanding, that highlights and foregrounds the importance of constructing and expanding anti-systemic movements that aim to defeat systems of oppressive and exploitative power. It is hard not to think that the older vocabulary better expresses this insight, even as it obstructs our access to other critical insights that are also indispensable.

#### Our Macro Abstention arg Is not the trope of a rules-based framework.

#### To the contrary, our position is consistent with many approaches.

#### As such, the role of the ballot is that the Aff should lose if our plan is bad – and not because other agendas may also good. Aff and Neg approaches may *differ* – but we should set a high bar for declaring the two *mutually exclusive*.

Carson ‘9

Rob Carson is currently an Associate Professor of English – since 2008 - at Hobart and William Smith Colleges. This paper was accepted to conform with the PhD requirements for the degree of doctor of Philosophy Graduate Department of English University from The University of Toronto. At the time of the writing, the author held an MA, Philosophy, Queen's University - DIGESTING THE THIRD: RECONFIGURING BINARIES IN SHAKESPEARE AND EARLY MODERN THOUGHT – https://tspace.library.utoronto.ca/bitstream/1807/17736/1/Carson\_Robert\_B\_200906\_PhD\_thesis.pdf

There are two kinds of binaries that are of particular interest (and particular concern) to me. The first of these is the kind of binary that results from the logical fallacy traditionally called "false dilemma." This occurs when an argument starts off by presenting two valid alternatives, but then goes on to make the faulty assumption that these two options are the only options available to us. To put this idea another way, there is almost never a problem with simply drawing a binary distinction (which is to say, a contrast between two alternative concepts), but there may well be a problem if this binary distinction is then recast as a dichotomous opposition, as if these two alternatives were diametrical opposites of each other, opposites which, when taken together, exhaust the field of relevant possibilities. (The Latin idiom that logicians use to express this situation is tertium non datur, "the third is not given.") This type of slippage from distinction to dichotomy can sometimes be quite subtle and very often passes unnoticed. A famous instance, I suggest, might be seen in the case of Cartesian dualism. Descartes draws a wholly legitimate distinction between the mind and the body, conceiving of the mind as a thinking and unextended thing and of the body as an extended and unthinking thing (1: 190). However, the appealing tidiness of this chiasmus sets the stage for this valid binary distinction to be recast as an invalid binary opposition, as if mind and bod}' were not just distinct but dichotomous, and tertium non datur. Before we know it, thought and extension shift from being two apparently unrelated concepts to being two diametrically opposed concepts.

I would suggest in response that the reduction of the whole of our experience into the categories of the mental and the physical carries with it certain philosophical casualties. It is not just the idea that mind and body are opposed that concerns me, although I think some very valuable critical work has been done in recent years that undermines this opposition by focusing on the embodiedness of the mind and the ensouledness of the body. What concerns me more is that the Cartesian binary is not exhaustive, especially in the way that it fails to account for the kinds of intersubjective social behaviours that seem to me to be every bit as fundamental to human experience as thought and extension are. When I console my crying son, or teach my daughter how to play a card-game, or flirt with my wife over dinner, or engage in any of the hundreds of forms of enculturated behaviour that we all engage in on a daily basis, are my actions readily explainable as being either mental or physical, or even as some combination of the two? For that matter, when you learned to play a hemiola at the outset of this chapter, was it a mental accomplishment or a physical accomplishment? Does either characterization make sense? Human experience fundamentally involves us performing actions that we learn from one another, and these enculturated social behaviours, so foundational to our understanding of meaning, are bifurcated awkwardly under the Cartesian model. Certainly we have thoughts and certainly we occupy space, but we also just as certainly participate in shared practices with one another, and I would suggest that these intersubjective behaviours make much more sense when they are examined on their own terms than when we try to explain them using the unresponsive and inappropriate categories of the mental and the physical.

Cartesian dualism, of course, provided the template for the more sweeping binary oppositions that would soon come to dominate Enlightenment philosophy — spirit and matter, noumenon and phenomenon, the objective and the subjective, the ideal and the material, and so on — all of them still touchstones of analytic philosophy that seem to me to be false dichotomies in ways that run parallel to one another. Furthermore, despite our best efforts in recent decades to escape from our Cartesian inheritance and to move beyond mind-body dualism, I would suggest that we nevertheless continue to rely quite heavily upon these other derivative Enlightenment binaries. In literary criticism, this reliance is perhaps most perspicuous in our continued subscription to the dichotomy of the material and the ideal, albeit this is now usually recast as an opposition of the material and the ideological, or taken even more broadly, as an opposition of fact and theory.12 Of course, this last opposition is foundational to a great many modern academic disciplines, but perhaps none more so than philosophy, which in the twentieth century saw itself divided into two camps: the analytic idolaters of fact and the Continental idolaters of theory.

My favourite account of this far-reaching philosophical schism is a story recounted by Adam Gopnik. During the five years that he worked as the Parisian correspondent for The New Yorker, Gopnik discovered that French intellectuals were not only unfamiliar with the idea of fact-checking in journalism, but deeply suspicious of the whole enterprise (94-97). The fact-checking department of The New Yorker is, of course, famous for being one of the strongest bastions of positivism in the West. Like most serious American magazines, as a matter of course The New Yorker places follow-up telephone calls to all interview subjects in order to confirm all of the substantive claims that are set to go into print, and Gopnik's French subjects were often baffled by what they imagined to be an unhealthy fetishization of fact. Some felt affronted that they were being asked under cross-examination to confirm the "truth" of the details that they had already presented in the interview (as if such a thing as truth could possibly be imagined to exist in the first place), while others assumed this process of "fact-checking" must be part of an iron-fisted strategy by which the magazine maintained a strong ideological line, and others still were convinced that Gopnik's fellow reporters must be conspiring against him from across the Atlantic and attempting to sabotage his position. Gopnik's moment of insight comes when he imagines how American intellectuals would respond to receiving a follow-up telephone call along these same lines from a "theory checker" at a French magazine. He envisions a call of this sort:

"A what?" “

You know, a theory checker. Just someone to make sure that all your premises agree with your conclusions, that there aren't any obvious errors of logic in your argument, that all your allusions flow together in a coherent stream — that kind of thing." (96)

Is a "theory checker" any less sensible an idea than a "fact checker"? If truth be told, I suspect that almost all of us working in academia would benefit greatly from keeping checkers of both kinds employed full-time on retainer. In any case, I will argue below that the binary assumption that sets fact and theory in dichotomous opposition to each other very much deserves to be called into question. In the first place, fact and theory are surely not polar opposites of each other in the way that good and evil are, since an argument can be both factually and theoretically sound (or for that matter, unsound) at once. Fact and theory can undoubtedly complement each other, not just compete with each other. Furthermore, and more pointedly, I would also suggest that the dyad of fact and theory is not exhaustive, since the kinds of social practices and enculturated behaviours that interest me so much are not adequately explained either in terms of fact alone or in terms of theory alone. (Did learning to play a hemiola, for example, involve learning a fact or learning a theory?) The practical, I suggest, constitutes a digested third in this model that warrants consideration alongside the factual and theoretical.

The second class of binaries that both interests and concerns me is the kind that results from the process of dialectical antithesis. Whereas the problem of false dilemma might be seen to be characteristic of certain strains of dualistic thought, the problem of dialectical antithesis might be seen in turn to be characteristic of certain strains of monistic thought. Here we might cite as representative examples of dialectical antithesis gone awry the binary oppositions of essentialism and anti-essentialism and of realism and anti-realism. The problem in each of these cases stems from the fact that we set out a positively defined position in opposition to a negatively defined position, and negatively defined positions are difficult to make sense of since they are identified only in terms of what they are not rather than what they are. All oppositions that take the form of "x" and "anti-x" are perfectly valid as dichotomies, of course, since by definition the component parts of any such dyad will be mutually exclusive and conjointly exhaustive. What is problematic here, I suggest, is our too-ready acceptance that concepts like "anti-essentialism" and "anti-realism" are coherent in and of themselves in the first place. Few of us would be tempted to divide the world's religions up into the categories of "Christianity" and "anti-Christianity": this is undoubtedly a perfectly valid dichotomy on paper, but in practice we have little reason to classify two religions (say, Islam and Shinto) together in terms of their shared difference from Christianity.

Is it self-evident that anti-essentialism and anti-realism are any more coherent as concepts than "anti-Christianity" is? When we opt to define a concept like anti-essentialism in purely negative terms, our implication is that in spite of the differences between the various strains of anti-essentialist thought, their shared resistance to essentialism is enough in itself to constitute a coherent category, and this is an implication that I suggest we would do well to question. We find similar qualms, of course, in postcolonial theory and in identity politics: critics will often feel a pull in one direction to unite diverse marginalized populations together in order to fight the good fight against oppression; yet at the same time they will feel reluctant to homogenize the rich and varied traits of distinct cultures by gathering them together into a single nondescript "Other" and defining them not on their own terms but only in terms of their alterity. Most of us, I think, would agree that negatively defined reductivist terms like "non-white" and "oriental" are highly problematic, and it is for much the same reason that I, as a committed opponent of both essentialism and realism, am nevertheless reluctant to describe myself as either "anti-essentialist" or "anti-realist." To put this point more succinctly: I hold specific beliefs of my own; I do not merely hold objections to the specific beliefs of others.

In the chapters that follow, I begin with the premise that our most familiar philosophical binaries very often digest a third term, either because they are structured upon dualistic false dichotomies that obscure and efface a third option from our consideration, or because they are the product of monistic dialectical thinking that pits a positively defined principle of "x" against a negatively defined "anti-x" instead of more sensibly contrasting the "x" with a "y" and a "z". Before proceeding further, however, let me take a moment to distinguish between the sort of digested third that I envision and some of the other triadic structures that have found a place in traditional philosophy. First, I should emphasize that the digested thirds that I have in mind are not some sort of middle ground that is located somewhere in between the received binaries. I am thus in no way revisiting the Aristotelian doctrine of the mean, which envisioned virtue as forming the midpoint on a continuum stretched between opposing vices. Instead I imagine these third terms as being wholly distinct from the original binary opposition.14 It might help to imagine the three positions not as if they were on a continuum but instead as if thev were situated in relation to one another more like the legs on a stool: a stool can be rotated so that any one of the three legs might be positioned as if it were "between" the other two when considered from a particular point of view. Or better yet, we might imagine them as if they occupied the three dimensions in spatial geometry (which is to say, as the x, y, and z axes) with each position perpendicular rather than opposed to the other two. This last options appeals to me in particular since it encourages us to imagine that each one-dimensional and linear concept receives breadth and depth from its relationship with the other two perpendicular concepts, an idea that emphasizes that these three dimensions can be viewed as complementary rather than conflicting.

Secondly, I should clarify that the sort of third term that I envision has nothing to do with the notion of synthesis in Hegelian (or more properly, Fichtean) dialectic. The familiar dialectic strategy undoubtedly employs three terms — thesis, antithesis, and synthesis — but this ternary vocabulary, I contend, is misleading, since in effect what we see in a dialectical analysis is a succession of binary oppositions, never an interplay of three ideas at once. Each new synthesis comes into being only by displacing the previous opposition, and so at no point are there three positions in contention with one another; this simultaneous ternary tension is crucial in my conception of a digested third. My own conception, then, has little to do with the Hegelian Aufhebung, or for that matter, with the triadic "moments" that we find Kant employing as he organizes his tables of judgments and of the categories. The thirds that interest me are not the products of binary oppositions any more than depth is the product of height and breadth. When I recover a digested third, I am not developing a new third position from a binary conflict, but identifying something that has existed alongside the binary opposition from the outset, a third option that has been divided or mangled or overlooked because of our inopportune tendency towards binarism.

Finally, I should also clarify that the sort of third I imagine is also quite distinct from the many examples of liminal "undecidables" that are so exciting in Derrida's work: the supplement, the pharmakon. the hymen, the gram, and so on. These "unities of simulacrum," as he explains in Positions, are:

"false" verbal properties (nominal or semantic) that can no longer be included within philosophical (binary) opposition, but which, however, inhabit philosophical opposition, resisting and disorganizing it, without ever constituting a third term, without ever leaving room for a solution in the form of speculative dialectics. (40)

There is undeniably considerable similarity to be found between Derrick's interests and my own, since the purpose of the hemiolic strategy is also to resist and disorganize traditional philosophical binaries by bringing ambiguous and overlooked counter-examples to light. However, where I break from deconstruction is that I see nothing "nominal," "semantic," or in any other way "false" about these digested thirds, nor do I feel that traditional philosophical oppositions are inevitable, as Derrida maintains (Positions 39). More importantly, unlike Derrida, I in fact do make an attempt to recover a "third term" from my problematization of the binary, in the hope that this new ternary structure will help to overcome the problem created by the traditional opposition.

As you might infer from the examples that I have offered thus far, the kind of digested thirds that most interest me typically involve enculturated behaviours, social practices, or other such intersubjective and functional aspects of our experience. My broad contention is that the influential and overarching binary opposition that pits the material against the ideological (as well as the natural against the artificial, the real against the constructed, fact against theory, and so on) is ill-equipped to make sense of the ways in which we interact with one another within the world. This intersubjective functionality, I suggest, is bifurcated awkwardly and inexactly when we attempt to envision it as being either a passive feature of the material world or an active contributor to the process of ideological construction. Instead, my argument — perhaps the central claim of this dissertation — is that we would do better to imagine social functions as constituting a third category unto themselves rather than dividing them up between the categories of the real and the constructed.

#### The competitive venue of debate meshes with our Role of the Ballot. Assigning a win or a loss based on the benefits of the Aff Plan is distinct from seeking to change what our D’Arcy ev describe as inter-personal dynamics that are “happening in this meeting, today”. Those dynamics will hinge on intrinsic motivations, not extrinsic factors like a ballot.

Kohn ‘86

This card internally quotes Edward L. Deci – a Professor of Psychology and Gowen Professor in the Social Sciences at the University of Rochester, and director of its human motivation program. He is well known in psychology for his theories of intrinsic and extrinsic motivation and basic psychological needs. With Richard Ryan, he is the co-founder of self-determination theory (SDT), an influential contemporary motivational theory. Alfie Kohn is a contemporary academic. He holds an M.A. in the social sciences from the University of Chicago. He earned a B.A. from Brown University – where he created his own interdisciplinary course of study. He has published 13 books. He writes, travels to Universities, and speaks widely on human behavior and education. Kohn has been featured on hundreds of TV and radio programs, including the "Today" show and two appearances on "Oprah"; he has been profiled in the Washington Post and the Los Angeles Times, From the Book: No Contest: The Case Against Competition – modified for language that may offend - http://www.scribd.com/doc/153712556/No-Contest-The-Case-Against-Competition-1986-de-Alfie-

The idea that trying to do well and trying to do better than others may work at cross-purposes can be understood in the context of an issue addressed by motivational theorists. We do best at the tasks we enjoy. An outside or extrinsic motivator (money, grades, the trappings of competitive success) simply cannot take the place of an activity we find rewarding in itself. "While extrinsic motivation may affect performance," wrote Margaret Clifford, "performance is dependent upon learning, which in turn is primarily dependent upon intrinsic motivation." More specifically, "a significant performance-increase on a highly complex task will be dependent upon intrinsic motivation."59 In fact, even people who are judged to be high in achievement motivation do not perform well unless extrinsic motivation has been minimized, as several studies have shown.60 Competition works just as any other extrinsic motivator does. As Edward Deci, one of the leading students of this topic, has written, "The reward for extrinsically motivated behavior is something that is separate from and follows the behavior. With competitive activities, the reward is typically 'winning' (that is, ~~beating~~ (defeating) the other person or the other team), so the reward is actually extrinsic to the activity itself."51 This has been corroborated by subjective reports: people who are more competitive regard themselves as being extrinsically motivated.62 Like any other extrinsic motivator, competition cannot produce the kind of results that flow from enjoying the activity itself. But this tells only half the story. As research by Deci and others has shown, the use of extrinsic motivators actually tends to undermine intrinsic motivation and thus adversely affect performance in the long (term) ~~run.~~ The introduction of, say, monetary reward will edge out intrinsic satisfaction; once this reward is withdrawn, the activity may well cease even though no reward at all was necessary for its performance earlier. Money "may work to 'buy off one's intrinsic motivation for an activity. And this decreased motivation appears (from the results of the field experiment) to be more than just a temporary phenomenon."63 Extrinsic motivators, in other words, are not only ineffective but corrosive. They eat away at the kind of motivation that does produce results.

# 2ac

## case

#### If we win macro-abstention we win that the 1ac is already relational

Lowe ‘12

B. Loewe is an organizer and activist. In recent years, B has served as NDLON's Communications Director, supported the Alto Arizona work against SB 1070 and Sheriff Arpaio, and participated in the organizing of the 2010 US Social Forum in Detroit. B.’s been honored to be part of movements for police accountability, food justice, for peace, and for the past ten years, for migrant worker rights. – “An End to Self Care” – Organizing Upgrade – October 15th - Modified for potentially objectionable language - <http://www.organizingupgrade.com/index.php/blogs/b-loewe/item/729-end-to-self-care>

~~Talking~~ (Discussing) about how we sustain ourselves, honor our personal needs, and prioritize our well-being in this brusque and brutal world is a huge advance from movement culture generations before. However, centering that conversation on ‘self-care’ devoid of our place in the collective misses the central point of why we need to care for ourselves. And that is because we must have all of our strength in place to counter the systems which, without our ability to resist and transform, without the self-preservation Audre Lorde describes, would ~~see~~ (have) us destroyed. Yashna Maya Padamsee, in her article Communities of Care, Organizations of Liberation, writes “~~Talking~~ (Discussing) only about self-care when ~~talking~~ (discussing) about healing justice is like only ~~talking~~ (discussing) about recycling and composting when speaking on Environmental Justice. It is a necessary and important individual daily practice- but to truly seek justice for the Environment, or to truly seek Healing for our communities, we need to interrupt and transform systems on a broader level. Speaking in Phoenix, Arizona in 2009 at a rally for migrant rights, Zack de la Rocha of Rage Against the Machine said in a speech, ‘The racism and hatred we are ~~seeing~~ (witness) *here* inflicts in us a collective wound. The only way to heal from those wounds and address those assaults on our dignity is to resist.’ If injustice results in collective wounds, healing comes from collective struggle. At the core, and when at it’s best, the conversation of self-care is seeking an answer to the question, “What must be done so that each one of us can maximize our participation in efforts that move us toward a world where we are more free?” Too often it sounds different. Below I hope to identify some ways ‘self-care’ strays from its path in order to move us further down the road of healthier lives and more vibrant struggles. There’s No Time for Self-Care Self-care is often referred to as a task to add to a to-do list that is already overflowing. After several years running an immigrant worker organization together, my co-worker and I went on a yoga retreat to decompress and reflect (readers pause to clap.) The retreat granted us space to re-find ourselves in the grueling work and commit to continuing a practice that would keep us centered upon our return. When we returned, we’d ask each other, “So, you meditate today? You stretch?” I, with professional parents in a city far from mine and an apartment mainly to myself, usually would say yes (and the readers clap). But he returned to a bustling home with the noise of TV and the family responsibilities of caring for his brother and completing family chores. He’d usually say no (and the readers frown disapprovingly). As long as self-care is discussed as an individual responsibility and additional task, it will be something that middle-class people with leisure time will most easily relate to and will include barriers to the lives of people without time to spare. It becomes one more unchecked box on a to-do list to feel bad about, an unreal expectation, or a far-off dream. The movement is my self-care not my reason for needing it. Don Andres awoke every morning at 5:00am to arrive at a street corner to look for work by 6:00am. He’d work a full day of heavy construction and still arrive at the 7:00pm meeting. He’d routinely fall asleep but he was there. Why? Because organizing together to improve conditions, to create alternatives, to band together, was the only option for how care could be anything but alien in his life as a day laborer. Being at the meeting was self-care. Lack of care is systemic. Therefore resistance to those systems is the highest affirmation of care for oneself and one’s community. Movement work is healing work. What self-care often misses is the reality that for the majority of people engaged in social justice movements, participation is out of necessity. That a collective effort in the form of social movement is the highest articulation of caring for one’s own self in a world designed to deny your worthiness of care. Too many people discussing self-care overlook the structural barriers that make access to the care they are speaking of impossible without the struggle they often discuss as the cause of their need to ‘take care of themselves.’

## K

### 2ac – micro

#### better strat than the ballot.

Cross 14 (Katherine Cross is a PhD Candidate in the CUNY Graduate Centre’s Sociology programme. Among other things, she is a writer, an editor at The Border House – a blog for those who are feminist, queer, disabled, people of color, transgender, poor, gay, lesbian, and others who belong to marginalized groups, as well as allies.Her work has been published in Women’s Studies Quarterly, The Occupied Times of London, and Bitch Magazine. She wrote this piece under the name “Quinnae Moongazer” – Nuclear Unicorn –“Beyond Niceness: Further Thoughts on Rage” – Jan 7th – http://quinnae.com/2014/01/07/beyond-niceness-further-thoughts-on-rage/)

What I am calling for is a nuanced ethic of action that is responsive to individual circumstances. To treat things on a case-by-case basis, and to be forthright without being “nice.” Empowered and merciful. We need that nuance to judge the infinite variety of quotidian issues we are confronted with– from microaggressions to international law. Yet we too often have a hammer and nail problem; each case is treated with the same blanket ruleset and the same system of call-outs. The lack of a “middle gear” is a major problem here. There are some people whose records are such that they could indeed be justly called “an unrepentant racist” or “pathological transphobe,” but there are many more whose mistakes deserve far, far less fire in response. Some may not have made prejudicial mistakes at all. So what is going wrong here? Punishment and Justice As I wrote in my recent article criticising internet mob justice of a more general variety, the impulse to act as judge, jury, and executioner all at once is a dangerous one. In the hands of, say, 4chan or angry Redditors, that impulse is obviously dangerous, even frightening. But we must cease pretending that social justice activists are somehow above the temptations to misuse that power. We, too, yearn to punish. That is an impulse that must be resisted with every fibre of our beings. It is a dangerous, bloodied path to dehumanisation.

### 2ac – saviorism

#### better to require non-black debaters to engage with racial implications of their advocacy

Bhambra 10 – Dr. Gurminder K Bhambra, Professor of Sociology at the University of Warwick, and Victoria Margree, Principal Lecturer on the Humanities Programme at the University of Brighton, “Identity Politics and the Need for a ‘Tomorrow’”, http://eprints.brighton.ac.uk/12679/1/Identity\_politics.pdf

We suggest that alternative models of identity and community are required from those put forward by essentialist theories, and that these are offered by the work of two theorists, Satya Mohanty and Lynn Hankinson Nelson. Mohanty’s ([1993] 2000)post-positivist, realist theorisation of identity suggests a way through the impasses of essentialism, while avoiding the excesses of the postmodernism that Bramen, among others, derides as a proposed alternative to identity politics. For Mohanty ([1993]2000), identities must be understood as theoretical constructions that enable subjects to read the world in particular ways; as such, substantial claims about identity are, in fact, implicit explanations of the social world and its constitutive relations of power. Experience – that from which identity is usually thought to derive– is not something that simply occurs, or announces its meaning and signiﬁcance in a self-evident fashion: rather, experience is always a work of interpretation that is collectively produced (Scott 1991).

Mohanty’s work resonates with that of Nelson (1993), who similarly insists upon the communal nature of meaning or knowledge-making. Rejecting both foundationalist views of knowledge and the postmodern alternative which announces the “death of the subject” and the impossibility of epistemology, Nelson argues instead that, it is not individuals who are the agents of epistemology, but communities. Since it is not possible for an individual to know something that another individual could not also (possibly) know, it must be that the ability to make sense of the world proceeds from shared conceptual frameworks and practices. Thus, it is the community that is the generator and repository of knowledge. Bringing Mohanty’s work on identity as theoretical construction together with Nelson’s work on epistemological communities therefore suggests that, “identity” is one of the knowledges that is produced and enabled for and by individuals in the context of the communities within which they exist.

The post-positivist reformulation of “experience” is necessary here as it privileges understandings that emerge through the processing of experience in the context of negotiated premises about the world, over experience itself producing self-evident knowledge (self-evident, however, only to the one who has “had” the experience). This distinction is crucial for, if it is not the experience of, for example, sexual discrimination that “makes” one a feminist, but rather, the paradigm through which one attempts to understand acts of sexual discrimination, then it is not necessary to have actually had the experience oneself in order to make the identiﬁcation “feminist”. If being a “feminist” is not a given fact of a particular social (and/or biological) location – that is, being designated “female” – but is, in Mohanty’s terms, an “achievement” – that is, something worked towards through a process of analysis and interpretation – then two implications follow. First, that not all women are feminists. Second, that feminism is some-thing that is “achievable” by men. 3

While it is accepted that experiences are not merely theoretical or conceptual constructs which can be transferred from one person to another with transparency, we think that there is something politically self-defeating about insisting that one can only understand an experience (or then comment upon it) if one has actually had the experience oneself. As Rege (1998) argues, to privilege knowledge claims on the basis of direct experience, orthen on claims of authenticity, can lead to a narrow identity politics that limits the emancipatory potential of the movements or organisations making such claims. Further, if it is not possible to understand an experience one has not had, then what point is there in ~~listening to (~~reflecting upon) each other? Following Said, such a ~~view~~ (perspective) seems to authorise privileged groups to ignore the discourses of disadvantaged ones, or, we would add, to place exclusive responsibility for addressing injustice with the oppressed themselves. Indeed, as Rege suggests, reluctance to speak about the experience of others has led to an assumption on the part of some white feminists that “confronting racism is the sole responsibility of black feminists”, just as today “issues of caste become the sole responsibility of the dalit women’s organisations” (Rege 1998).Her argument for a dalit feminist standpoint, then, is not made in terms solely of the experiences of dalit women, but rather a call for others to “educate themselves about the histories, the preferred social relations and utopias and the struggles of the marginalised” (Rege 1998). This, she argues, allows “their cause” to become “our cause”, not as a form of appropriation of “their” struggle, but through the transformation of subjectivities that enables a recognition that “their” struggle is also “our” struggle. Following Rege, we suggest that social processes can facilitate the understanding of experiences, thus making those experiences the possible object of analysis and action for all, while recognising that they are not equally available or powerful for all subjects. 4 Understandings of identity as given and essential, then, we suggest, need to give way to understandings which accept them as socially constructed and contingent on the work of particular, overlapping, epistemological communities that agree that this or that is a viable and recognised identity. Such an understanding avoids what Bramen identiﬁes as the postmodern excesses of “post-racial” theory, where in this “world without borders (“racism is real, but race is not”) one can be anything one wants to be: a black kid in Harlem can be Croatian-American, if that is what he chooses, and a white kid from Iowa can be Korean-American”(2002: 6). Unconstrained choice is not possible to the extent that, as Nelson (1993) argues, the concept of the epistemological community requires any individual knowledge claim to sustain itself in relation to standards of evaluation that already exist and that are social. Any claim to identity, then, would have to be recognised by particular communities as valid in order to be successful. This further shifts the discussion beyond the limitations of essentialist accounts of identity by recognising that the communities that confer identity are constituted through their shared epistemological frameworks and not necessarily by shared characteristics of their members conceived of as irreducible. 5 Hence, the epistemological community that enables us to identify our-selves as feminists is one that is built up out of a broadly agreed upon paradigm for interpreting the world and the relations between the sexes: it is not one that is premised upon possessing the physical attribute of being a woman or upon sharing the same experiences. Since at least the 1970s, a key aspect of black and/or postcolonial feminism has been to identify the problems associated with such assumptions (see, for discussion, Rege 1998, 2000).

We believe that it is the identiﬁcation of injustice which calls forth action and thus allows for the construction of healthy solidarities. 6 While it is accepted that there may be important differences between those who recognise the injustice of disadvantage while being, in some respects, its beneﬁciary (for example, men, white people, brahmins), and those who recognise the injustice from the position of being at its effect (women, ethnic minorities, dalits), we would privilege the importance of a shared political commitment to equality as the basis for negotiating such differences. Our argument here is that thinking through identity claims from the basis of understanding them as epistemological communities militates against exclusionary politics (and its associated problems) since the emphasis comes to be on participation in a shared epistemological and political project as opposed to notions of ﬁxed characteristics – the focus is on the activities individuals participate in rather than the characteristics they are deemed to possess. Identity is thus deﬁned further as a function of activity located in particular social locations (understood as the complex of objective forces that inﬂuence the conditions in which one lives) rather than of nature or origin (Mohanty 1995:109-10). As such, the communities that enable identity should not be conceived of as “imagined” since they are produced by very real actions, practices and projects.