**\*\*1AC**

**Adv One**

**Advantage One is Federalism**

**The status quo upholds “Parker immunity” – a doctrine that doesn’t account for interstate spillovers.**

**Rosch 12** [J. Thomas Rosch, Commissioner, Federal Trade Commission 10-3-2012 https://www.ftc.gov/sites/default/files/documents/public\_statements/returning-state-action-doctrine-its-moorings/121003stateaction.pdf]

**The FTC’s State Action Report**

Over a decade ago, the FTC became concerned that the lower courts had expanded the scope of **the state action doctrine** beyond what the Supreme Court had intended. In 2001, the FTC established a State Action Task Force, which issued a Report two years later that analyzed the current state of the law, identified areas of concern, and recommended clarifications to the law.28 The Report observed that the scope of the state action doctrine had **expanded dramatically** since first articulated by the Supreme Court in 1943. The doctrine had become **unmoored from its original objectives**, the report concluded, and was frequently invoked to protect **private commercial interests** with no relation to state policy.

The report identified a number of specific concerns with the way in which some lower courts had applied the state action doctrine. Chief among these was a persistent weakening of the clear articulation and active supervision requirements. In particular, some courts had found that a legislative grant of general corporate powers satisfied the clear articulation requirement. Although the exercise of these powers in the private sector had no particular antitrust significance, some courts had reached the opposite conclusion when the powers were granted through legislation.

The Report also found that there was a lack of clear standards to guide the application of the active supervision requirement. Without guidance on how to implement the various formulations of the requirement articulated by the lower courts, the active supervision requirement had had a minimal impact.

The Task Force raised several other concerns. Some courts, according to the Report, had interpreted the state action doctrine in a manner that **ignored interstate spillovers**, which forced the citizens of one state to absorb the costs imposed by another state’s regulations. In addition, some courts had interpreted the doctrine to shield virtually any municipal activity, despite the fact that municipalities were increasingly engaging in business on a for-profit basis, while simultaneously using their law-making power to block competitive challenges.

**Our arg is not “State’s Rights are categorically good”. Rather, failing to account for out-of-State externalities means State reforms seem better than they truly are. Limiting Parker is key.**

**Sack 21** [John Sack, J.D., Duke Law School, Class of 2022, B.S. University of Michigan, 2019, 2021 – modified for language that may offend - https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1196&context=djclpp\_sidebar]

III. DOCTRINAL CRITICISM

Although the Court has continued to re-affirm Parker v. Brown’s central holding, many have criticized the Parker doctrine. Both scholars and the Federal Trade Commission (FTC) have highlighted problems with the doctrine and offered a number of solutions for how to remedy its faults.63

The first common critique of the doctrine is that it does not account for **out-of-state economic effects**. Unless a regulation runs afoul of another constitutional barrier, no consideration of interstate spillovers applies.64 One need not look farther than Parker itself to see how the state action doctrine can **impose costs** on out-of-state residents, even though those residents have diminished political capital in the state. At the time Parker was decided, between 90 and 95 percent of raisins produced in California entered interstate commerce and California provided almost all of the nation’s raisins.65 Most American raisin consumers lived outside of California and had no political means to oppose the state’s legislative program, yet they bore the costs of California’s state-sanctioned monopoly.66

Second, similar concerns about **political representation** animate critiques of Parker immunity. The policy at issue in Parker restricted output and artificially raised prices, two results federal antitrust law generally seeks to prohibit.67 Although the benefits of such a program were borne almost exclusively by California, the costs of the program were incurred by raisin consumers across the nation.68 The political incentives to promote such a program follow closely with economic costs and benefits.69 California raisin producers have a strong incentive to lobby their own government to install such a program, but it would be nearly impossible for non-California residents to challenge such a policy through the normal political channels.70 The government of California is **not the appropriate body** to properly weigh the benefits to in-state raisin producers with the costs to out-of-state consumers, yet the Parker doctrine grants California per se immunity on federalism grounds.71 Although the California program was implicitly endorsed by Congress, one is just as likely to find similar programs with no similar implicit endorsement.72

The U.S. Constitution embodies a system of **federalism** where the federal government is sovereign in some respects, and the several states are sovereign in others.73 This system of federalism gives states the power to regulate local matters and the federal government the power to regulate issues that states are less suited to regulate.74 **When costs spill over** into other states, **the national government becomes the appropriate body** to regulate the costs and benefits of such a program.75 The Court has recognized such spillover effects, and how political actors, even government entities, can act solely in self-interest.76 Such **state self-interest** can directly harm consumers outside of its territorial jurisdiction.77

Parker immunity, as it ~~stands~~ (exists), **runs counter** to longstanding ideals of national unity that harken back to the Founding era. The law has long **prohibit**ed **states from imposing excessive costs** on the nation as a whole, solely for the purpose of furthering its own **intrastate policy interest**s. McCulloch v. Maryland illustrates the Court’s wariness of self-serving state action.78 In McCulloch, Chief Justice Marshall held that states may not tax the national bank, as they would be wielding power against the whole of the United States, even though the whole of the United States is not represented by each state.79 Similar to a state tax being problematic since it is the part acting on the whole, anticompetitive restraints by the states would unduly impose costs on the nation. The people of the United States, acting through Congress, christened competition and free markets through the Sherman Act.80 Just as one state could not tax the resources of the United States, one state should not be allowed to use state policy to **burden** the national economy. Because the potential costs to state-created monopolies are so high,81 federal policy should **prohibit states** from allocating those costs beyond their borders. Any state that wishes to impose monopoly costs outside of its borders to benefit itself and undermine competition should be **carefully scrutinized** when it does so. This scrutiny would not be fatal-in-fact for the legislation, but it should be enough for states to second-guess an attempt to enrich itself to the detriment of its sister states.

IV. PROPOSED SOLUTIONS

The Sherman Act, and specifically Parker immunity, should be interpreted in light of the above concerns. After all, the Sherman Act is the standard-bearer for the U.S. free market system, and so our interpretation of it should evolve with our understanding of constitutional principles and economic conditions.82 Justice Burger’s concurrence in City of Lafayette elaborates on this point:

Our conceptions of the limits imposed by federalism are bound to evolve, just as our understanding of Congress’ power under the Commerce Clause has evolved. Consequently, since we find it appropriate to allow the ambit of the Sherman Act to expand with evolving perceptions of congressional power under the Commerce Clause, a similar process should occur with respect to “state action” analysis under Parker. That is, we should not treat the result in the Parker case as cast in bronze; rather, the scope of the Sherman Act’s power should parallel the developing concepts of American federalism.83

As states impose costs on each other through state-sanctioned monopolies, the Court’s understanding of federalism and the Commerce Clause counsels scrutiny of the Parker doctrine. An entirely new doctrine is not necessary to curtail Parker immunity. Rather, the issue **can be resolved** by applying Parker immunity in light of the American dual system of federalism and the Commerce Clause. Modern scholarship critiques the lack of **concern for interstate spillovers**. By that token, the modern Parker doctrine fails to account for economic efficiency and undermines political representation values meant to be protected by **federalism**.84 So while scholars almost universally recognize that interstate economic spillovers are problematic, there is no consensus on what remedy is most appropriate.

**Well-crafted models are ideal – but the iterative learning process is only *accurate* if costs are internalized**

**Adler 12** [Jonathan, John Verheij Memorial Professor of Law and Director of the Center for Busi‐ ness Law & Regulation, Case Western Reserve University School of Law, “INTERSTATE COMPETITION AND THE RACE TO THE TOP,” March 2, www.harvard-jlpp.com/wp-content/uploads/2013/.../35\_1\_89\_Adler.pdf]

Not only does decentralization enable policymakers to take advantage of localized information about policy problems and their potential solutions, but decentralization and interjurisdictional competition also **foster policy discovery** and policy entrepreneurship. Decentralization allows for states to act, in Jus‐ tice Brandeis’s famous characterization, as “laboratories of democracy.”32 Different states may adopt different approaches to various public policy concerns, whether because of regional differences, variable preferences, or different expectations about the viability or practicality of competing policy approaches. State‐level policy initiatives often are experiments from which others may learn. States learn from each others’ successes and failures, fostering an **iterative process** through which state‐level policy can **improve** over time.

Allowing state‐level experimentation also reduces the risks of policy failures. When states try different things, all of the proverbial eggs are not in a single basket. If the policy succeeds, other states retain the ability to follow suit (as does the federal government, which has often modeled federal measures on successful state initiatives).33 If the policy fails, however, only one jurisdiction must undo it, and others can learn to avoid such mistakes. This discovery process can be slow and messy, but the federal alternative—as it exists in practice—is no better.

Even though there is a strong case for presuming that decentralization is favorable, it is rebuttable. Leaving policy questions in state hands might be desirable more often than not, **but in some instances** there are persuasive justifications for federal intervention. Appropriate federal intervention can even **reinforce the competitive dynamic** across jurisdictions.

Perhaps the **most compelling case** for federal intervention is the existence of **interstate spillovers,** such as pollution generated in one state that crosses into another.34 If, for example, pollution generated in one state causes problems in another state, there is a case for federal action. Allowing such spillovers to exist **undermines interjurisdictional competition** because spillovers enable states to **extraterritorialize the costs** of their own policy decisions onto other jurisdictions.35 In a truly competitive dynamic, on the other hand, each jurisdiction would bear the costs and reap the benefits of its own decisions.

**Pricing-in State spillovers improves the data set that informs well-crafted actions.**

**Adler 12** [Jonathan, John Verheij Memorial Professor of Law and Director of the Center for Busi‐ ness Law & Regulation, Case Western Reserve University School of Law, “INTERSTATE COMPETITION AND THE RACE TO THE TOP,” March 2, www.harvard-jlpp.com/wp-content/uploads/2013/.../35\_1\_89\_Adler.pdf]

Federalism is an essential part of the Constitution’s design. The division of sovereign power between the States and the federal government helps foster **interjurisdictional competition**, which, in turn, checks government power.1 Provided a right of exit is maintained, the excessive imposition of economic burdens in one jurisdiction will cause taxpayers and businesses to flee to other jurisdictions. For this reason, federalism often is seen as a friend of the free market.2 The existence of competing jurisdictions disciplines state intervention in the marketplace.3 But it would be a mistake to assume that interjurisdictional competition invariably favors market‐oriented policies, at least insofar as alternative policy measures would enhance the welfare of state residents. Federalism is not just for free marketeers.

**Provided states cannot externalize** the **costs** of their own policy choices, robust interjurisdictional competition facilitates the enactment of better public policy at the state level.4 Rather than inducing a “race to the bottom,” such competition can create a race **toward the top**.5 Although those of us who generally favor freer markets believe federalism will advance that cause, those who believe more stringent regulation is welfare‐enhancing should support interjurisdictional competition too. On both theoreticaland empirical grounds, competition among jurisdictions is a **powerful means** to discover and promote the policies that are **most effective** at providing people with what they desire.

**With or without government, biological and synthetic tech is inevitable. Accurate data from state regulatory experiments avoids downsides and maximize benefits.**

**McGinnis 11**

(John, George C. Dix Professor of Law, Northwestern Law School, “LAWS FOR LEARNING IN AN AGE OF ACCELERATION,” <http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=3404&context=wmlr>)

The twenty-first century’s information age has the potential to usher in a more harmonious and productive politics. People often disagree about what policies to adopt, but the cornucopia of data that modern technology generates can allow them to better update their beliefs about policy outcomes on the basis of shared facts. In the long run, convergence on the facts can lead incrementally to more consensus on better policies. More credible factual information should over time also help make for a less divisive society, because partisans cannot as easily stoke social tensions by relying on false facts or exaggerated claims to support conflicting positions. Thus, a central task of contemporary public law is to **accelerate a politics of learning** whereby democracy improves a public reason focused on evaluating policy consequences. Government should be shaped into an instrument that learns from the analysis of policy consequences made available from newly available technologies of information.1 Greater computer capacity is generating more empirical analysis.2 The Internet permits the rise of prediction markets that forecast policy results even before the policies are implemented.3 The Internet also creates a dispersed media that specializes in particular topics and methodologies, gathers diverse information, and funnels salient facts about policy to legislators and citizens.4 But a public reason focused on policy consequences will **improve only if our laws facilitate it**. For instance, constitutional federalism must be reinvigorated to permit greater experimentation across jurisdictions, because with the rise of empiricism, **decentralization** has more value for social learning today than ever before.5 Congress should include mandates for experiments within its own legislation making policy initiatives contain the platforms for their own selfimprovement.6 Creating a contemporary politics of democratic updating on the basis of facts is a matter both of great historical interest and of enormous importance to our future. In the historical sweep of ideas, a government more focused on learning from new information moves toward fulfilling the Enlightenment dream of a politics of reason—but a reason based not on the abstractions of the French Revolution, but instead on the hard facts of the more empirical tradition predominating in Britain. By displacing religion from the center of politics, the Enlightenment removed issues by their nature not susceptible to factual resolution, permitting a focus on policies that could be improved by information.7 The better democratic updating afforded by modern technology can similarly increase social harmony and prosperity by facilitating policies that actually deliver the goods. For the future, a more consequentially informed politics is an urgent necessity. The same technological acceleration that potentially creates a more information-rich politics also generates a wide range of technological innovation—from nanotechnology to **biotech**nology to [AI] artificial intelligence. Although these technologies offer unparalleled benefits to mankind, they **may** also **create** catastrophic **risks**, such as rapid environmental degradation and new weapons of mass destruction.8 Only a democracy able to rapidly assimilate the facts is likely to be able to **avoid disaster** and reap the benefits inherent in the technology that is transforming our world at a faster pace than ever before. Every industry that touches on information—book publishing, newspapers, and college education to name just a few—is undergoing a continuous series of revolutionary changes as new technology permits delivery of more information more quickly at lower cost. The same changes that are creating innovation in such private industries can also quickly create innovation in social governance. But the difference between information-intensive private industries and political institutions is that the latter lack the strong competitive framework for these revolutions to occur spontaneously. This Essay thus attempts to set out a blueprint for reform to make better use of some available information technologies. Part I describes the reality of technology acceleration as the acceleration both creates the tools for democratic updating and prompts its necessity. Technological acceleration is the most important development of our time—more important even than globalization. Although technologists have described and discussed its significance, its implications for law and political structure have been barely noticed. Part II briefly discusses how better social knowledge can change political results. A premise of the claim is that some political disagreements revolve about facts, not simply values. As a result, better social knowledge can help democracies design policies to achieve widely shared goals. Social knowledge energizes citizens to act on those encompassing interests, like improved public education, because they come to better recognize the policy instruments to advance those interests. Better social knowledge provides better incentives for citizens to vote on these interests. Part III considers the mechanisms for creating a contemporary politics of democratic updating that begins to meet the needs of the age of accelerating technology. It focuses on two of the new resources that can have substantial synergies in improving social common knowledge and shows how an increase in common knowledge can systematically improve political results by providing better incentives for citizens to work for encompassing social goods. First, Part III considers the improvement in empirical analysis of social policy that flows from increasing computational capacity. It then discusses how specialized and innovative media does much more than disseminate opinions: it widely distributes facts and factual analysis. The combination of these technologies can better discipline experts and representatives, providing stronger incentives for them to update on the basis of new facts. Part IV discusses the information-eliciting rules that will maximize the impact of new technologies of information. These steps include a program of restoring, where possible, governmental structures that permit appropriate **decentralization for experimentation**, empirical testing, and learning. Congress and regulatory agencies should structure legislation and regulations to include social experiments when such experiments would help resolve disputed matters of policy. The Supreme Court should generally refrain from imposing new substantive rights for the nation so that it is easier to evaluate the consequences of different bundles of rights chosen by the states. But it should also protect the dispersed media, like blogs, from discriminatory laws, because this dispersed media plays a crucial role in modern policy evaluation. In short, the Supreme Court needs to emphasize a jurisprudence fostering social discovery and the political branches need to create frameworks for better social learning. Constitutive structures encouraging and evaluating experimentation become more valuable in an age where better evaluation of social experiments is possible. I. TECHNOLOGICAL ACCELERATION It is the premise of this Essay that technological acceleration is occurring and that our political system must adapt to the world it is creating. The case for technological acceleration rests on three mutually supporting kinds of evidence. First, from the longest-term perspective, epochal change has sped up: the transitions from hunter-gatherer society to agricultural society to the industrial age each took progressively less time to occur, and our transition to an information society is taking less time still. Second, from a technological perspective, computational power is increasing exponentially, and increasing computational power facilitates the growth of other society-changing technologies like biotechnology and nanotechnology. Third, even from our contemporary perspective, technology now changes the world on a yearly basis both in terms of hard data, like the amount of information created, and in terms of more subjective measures, like the social changes wrought by social media. From the longest-term perspective, it seems clear that technological change is accelerating and, with it, the basic shape of human society and culture is changing.9 Anthropologists suggest that for 100,000 years, members of the human species were hunter-gather- ers.10 About 10,000 years ago humans made a transition to agricultural society.11 With the advent of the Industrial Revolution, the West transformed itself into a society that thrived on manufacturing.12 Since 1950, the world has been rapidly entering the information age.13 Each of the completed epochs has been marked by a transition to substantially higher growth rates.14 The period between each epoch has become very substantially shorter.15 Thus, there is reason to extrapolate to even more and faster transitions in the future. This evolution is consistent with a more fine-grained evaluation of human development. Recently, the historian Ian Morris has rated societies in the last 15,000 years on their level of development through objective benchmarks, such as energy capture.16 The graph shows relatively steady, if modest, growth when plotted on a log linear scale, but in the last 100 years development has jumped to become sharply exponential.17 Morris concludes that these patterns suggest that there may be four times as much social development in the world in the next 100 years than there has been in the last 14,000.18 The inventor and engineer Ray Kurzweil has dubbed this phenomenon of faster transitions “the law of accelerating returns.”19 Seeking to strengthen the case for exponential change, he has looked back to the dawn of life to show that even evolution seems to make transitions to higher organisms ever faster.20 In a more granulated way, he has considered important events of the last 1000 years to show that the periods between extraordinary advances, such as great scientific discoveries and technological inventions, have decreased.21 Thus, both outside and within the great epochs of recorded human history, the story of acceleration is similar. The technology of computation provides the second perspective on accelerating change. The easiest way to grasp this perspective is to consider Moore’s Law. Moore’s Law—named after Gordon Moore, one of the founders of Intel—is the observation that the number of transistors that can be fitted onto a computer chip doubles every eighteen months to two years.22 This prediction, which has been approximately accurate for the last forty years,23 means that almost every aspect of the digital world—from computational calculation power to computer memory—is growing in density at a similarly exponential rate.24 Moore’s Law reflects the rapid rise of computers to become the fundamental engine of mankind in the late twentieth and early twenty-first centuries.25 The power of exponential growth is hard to overstate. As the economist Robert Lucas has said, once you start thinking about exponential growth, it is hard to think about anything else.26 The computational power in a cell phone today is a thousand times greater and a million times less expensive than all the computing power housed at MIT in 1965.27 Projecting forward, the computing power of computers twenty-five years from now is likely to prove a million times more powerful than computing power today. To be sure, many people have been predicting the imminent death of Moore’s Law for a substantial period now,29 but it has nevertheless continued. Intel—a company that has a substantial interest in accurately telling software makers what to expect—projects that Moore’s Law will continue at least until 2029.30 Ray Kurzweil shows that Moore’s Law is actually part of a more general exponential computation growth that has been gaining force for over a 100 years.31 Integrated circuits replaced transistors that previously replaced vacuum tubes that in their time had replaced electromechanical methods of computation.32 Through all of these changes in the mechanisms of computation, its power increased at an exponential rate.33 This perspective suggests that other methods under research—from carbon nanotechnology to optical computing to quantum computing—are likely to continue growing exponentially even when silicon-based computing reaches its physical limits.34 Focusing on the exponential increase in hardware capability may actually understate the acceleration in computational capacity in two ways. First, a study considering developments in a computer task using a benchmark for measuring computer speed over a fifteen-year period suggests that the improvements in software algorithms improved performance even more than the increase in hardware capability.35 Second, computers are interconnected more than ever before through the Internet, and these connections increase collective capacity, not only because of the increasing density among computer connections, but because of the increasing density of connections among humans made possible by computers. The salient feature of computers’ exponential growth is their tremendous range of application compared to previous improvements. Almost everything in the modern world can be improved by adding an independent source of computational power. That is why computational improvement has a far greater social effect than improvements in technologies of old. Energy, medicine, and communication are now being continually transformed by the increase in computational power.36 As I will discuss in Part II, even the formulation of new hypotheses in natural and social science will likely be aided by computers in the near future. The final perspective on accelerating technology is the experience that the contemporary world provides. Technology changes the whole tenor of life more rapidly than ever before. At the most basic level, technological products change faster.37 Repeated visits to a modern electronics store—or even a grocery store—reveal a whole new line of products within very few years. In contrast, someone visiting a store in 1910 and then again in 1920—let alone in 1810 and 1820—would not have noticed much difference. Even cultural generations move faster. Facebook, for instance, has changed the way college students relate in only a few years,38 whereas the tenor of college life would not have seemed very different to students in 1920 and 1960. Our current subjective sense of accelerating technology is also backed by more objective evidence from the contemporary world. Accelerating amounts of information are being generated.39 Information, of course, is a proxy for knowledge. Consistent with this general observation, we experience exponential growth in practical technical knowledge, as evidenced by the rise in patent applications.40 Thus, the combination of data from our present life, together with the more sweeping historical and technological perspectives, makes a compelling case that technological acceleration is occurring. It is this technological acceleration that creates both the capacity and the need for improving collective decision making. As technology accelerates, it creates new phenomena, from climate change to biotechnology to artificial intelligence of a human-like capacity. **These technologies may themselves have very large positive or negative externalities and may require government decisions** about their prohibition, regulation, or subsidization to forestall harms and capture their full benefits. They may also cause social dislocations, from unemployment to terrorism, that also require certain collective decisions. Society can best handle these crises not only by making better social policy to address them directly but by improving social policy more generally to create both more resources and more social harmony to endure them. Thus, society must deploy information technology in the service of democratic updating if it is to manage technological acceleration

**Synthetic-Bio viruses already sit in labs. They cannot be wished away. Lab accidents will kill millions. Some positive regulatory scheme is needed.**

**Wilson ‘13**

(Grant Wilson has an extremely diverse academic and professional background is former Representative for several nations at the 2010 Climate Change Conference in Cancun. Mr. Wilson \*also\* holds a JD, as well as a Certificate in Environmental and Natural Resources Law, both from the Lewis & Clark Law School. He \*also\* has worked on issues related to the environment and human rights in Kenya, South Korea, Hungary, Mexico, Belgium, the United States. He \*also\* is currently the Deputy Director at the Global Catastrophic Risk Institute (GCRI), a nonprofit think tank that engages in research, education, and professional networking in areas related to global catastrophic risks. “MINIMIZING GLOBAL CATASTROPHIC AND EXISTENTIAL RISKS FROM EMERGING TECHNOLOGIES THROUGH INTERNATIONAL LAW” – Virginia Environmental Law Journal – 31 Va. Envtl. L.J. 307 – lexis; allrev)

States should consider creating an international treaty to regulate emerging technologies if they perceive these technologies to pose a GCR/ER. This section considers the current and future risks and benefits posed by three **emerging technologies**--bioengineering, [\*313] nanotechnology, and AI. This section concludes that bioengineering is the only emerging technology that poses an immediate GCR/ER, while nanotechnology and AI pose future GCR/ERs. 1. Bioengineering Simply defined, bioengineering is the "engineering of living organisms." n23 Bioengineering is commonly associated with genetically modified ("GM") foods made from crops that scientists develop to have qualities like pest resistance or increased nutrition. However, bioengineering is rapidly expanding beyond agriculture into fields like medicine, disease control, and life-extension. The technology behind bioengineering has also developed quickly, with scientists now able to understand and manipulate life at the molecular level such that biology is viewed as a "machine" that can be tweaked, like in genetic engineering, or even built from the ground up, like in **syn**thetic **bio**logy**.** n24 While breakthroughs in bioengineering research could significantly benefit mankind and the environment, bioengineering research can also be misused to the detriment of humans, animals, and environmental health. n25 Such "dual use" research currently poses significant risks to humankind and even greater risks in the future. Furthermore, both current and future bioengineering technologies pose the risk of an accident that has significant detrimental effects. In exploring these issues, this section demonstrates that bioengineering poses an immediate GCR/ER. a. Current technology Bioengineering is already widely used to modify existing organisms, and scientists are **on the cusp** of creating **entirely** synthetic organisms. For example, scientists controversially use bioengineering to "improve" natural biological products and activities, resulting in increased nutrient value, bigger yields, and insect and disease resistance n26 in various types of crops. n27 In 2011, ninety-four percent by acre of soybeans in the [\*314] United States were genetically engineered, while seventy-three percent of all U.S. corn was genetically engineered to be insect resistant and sixty-five percent to be herbicide tolerant. n28 Another controversial current bioengineering technology is genetically engineered viruses, highlighted by the 2011 genetic engineering of the H5N1 virus to become highly contagious amongst ferrets. Many scientists argue that creating this genetically engineered virus was necessary to develop a remedy in case the H5N1 virus mutates naturally, but skeptics argue that the modified H5N1 virus is dangerous because of risks that the virus will escape or that malicious actors will engineer a similar virus. n29 Another example of recent advancements in bioengineering is a project spearheaded by biologist Craig Venter that transplanted a completely synthetic DNA sequence, or "genome," into an E. coli bacteria. Scientists then also added DNA "watermarks" such as the names of researchers and famous quotes. Craig Venter termed this "the first self-replicating species we've had on the planet whose parent is a computer." n30 Bioengineering has also become vastly cheaper and more accessible to the general public. For example, massive databases of DNA sequences are available online from the Department of Energy Joint Genome Institute ("JGI") and the National Center for Biological Information's GenBank(R) database. n31 To materialize these DNA sequences, individuals can order custom genomes online for a few thousand dollars, which are "printed" from a DNA synthesis machine and shipped to them, opening the door for amateur biologists to engage in genetic engineering. n32 DNA synthesis machines can print DNA strands long enough for certain types of viruses, which untrained [\*315] individuals can obtain within six weeks of purchase. n33 Even the synthesizing machines themselves can be purchased on the Internet on sites like eBay. n34 Much like bioengineering costs, the necessary expertise to engage in bioengineering is also plummeting. For example, since 2003, teams of entrepreneurs, college students, and even high school students submitted synthetic biology creations to the International Genetically Engineered Machine ("IGEM") competition, such as UC Berkeley's "BactoBlood" creation--a "cost-effective red blood cell substitute" developed by genetically engineering E. coli bacteria. n35 b. Forthcoming technology Perhaps the greatest forthcoming development in bioengineering is **synthetic** **bio**logy, which includes techniques to "construct new biological components, design those components and redesign existing biological systems." n36 This is in contrast to the traditional form of bioengineering that utilizes "recombinant DNA" techniques in which the DNA from one organism is stitched together with DNA from other organisms or synthetic DNA. n37 One method of synthetic biology involves "cataloguing" DNA sequences like "Lego bricks" and assembling them in unique ways (assembling natural molecules into an unnatural system, like combining the molecules from several types of bacteria to create new bacteria with novel properties). Another method of synthetic biology involves using DNA synthesizers to create life "entirely from scratch" n38 in what has been called the "the biological equivalent of word processors" n39 (using unnatural molecules to emulate a natural system, like creating the synthetic equivalent of a natural strand of influenza). n40 One way to generate synthetic DNA is to insert [\*316] the DNA into a "biological shell"--an organism, often a bacteria, that had its own genes removed--that can run the synthetic DNA like a computer runs software. n41 And while the technology to create eukaryotic cells (i.e., "a cell with a nucleus, such as those found in animals, including human beings") is a long ways away, synthetic viruses and bacteria are just around the comer. n42 c. Benefits of bioengineering Bioengineering is already demonstrating its potential to remedy major human health and environmental problems. For example, bioengineering is responsible for some important pharmaceuticals and vaccines, such as modern insulin and a vaccine for Hepatitis B, while "gene therapy" employs genetically engineered viruses to help treat cancer. n43 Environmental benefits resulting from the 15.4 million farmers who grew genetically modified crops in 2010 include increased yield of six to thirty percent per acre of land, pest-resistant crops that require fewer pesticides (resulting in 17.1 percent less pesticide use globally in 2010), lower water use for drought-resistant crops, decreased CO[2] emissions, and crops that do not require harmful tilling practices. n44 Forthcoming benefits to human health could be a new wave of ultra-effective drugs (e.g. antimalarial and antibiotic drugs), bioengineered agents that kill cancer cells, and the ability to rapidly create vaccines in response to epidemics. n45 Bioengineering could also serve as a beacon of human diagnostics by analyzing "thousands of molecules simultaneously from a single sample." n46 Meanwhile, forthcoming benefits to the environment could be organisms that remedy harmful pollution and superior forms of biofuel, for example. n47 Bioengineering could also spur an environmental revolution in which industries reuse modified waste from biomass feedstock and farmers grow [\*317] bioengineered crops on "marginally productive lands" (e.g. switchgrass). n48 d. Risks from bioengineering While bioengineering offers current and future benefits to humans and the environment, there are also significant yet uncertain risks that could devastate human life, societal stability, and the environment. n49 This paper focuses on three predominant GCR/ER risks arising from bioengineering: (1) the accidental release of harmful organisms (a "biosafety" issue), (2) the malicious release of harmful organisms ("bioterrorism"), and (3) the bioengineering of humans. The first two are current GCRs/ERs, while the third is a future GCR/ER. i. Risk of an accident The accidental release of a bioengineered microorganism during legitimate research poses a GCR/ER when such a microorganism has the potential to be highly deadly and has never been tested in an uncontrolled environment. n50 The threat of an accidental release of a harmful organism recently sparked an unprecedented scientific debate amongst policymakers, scientists, and the general public in reaction to the creation of an airborne strain of H5N1. n51 In September 2011, **Ron Fouchier**, a scientist from the Netherlands, announced that he had genetically engineered the H5N1 virus--his lab "**mutated the hell out of H5N1,"** he professed--to become airborne, which was tested on ferrets; a laboratory at the University of Wisconsin-Madison similarly mutated the virus into a highly transmittable form. n52 The "natural" H5N1 killed approximately sixty percent of those with reported infections (although the large amount of unreported cases means that this is higher than the actual death rate), but the total number of fatalities--346 people--was relatively small because the virus is difficult to transmit from human to human. The larger risk comes from the possibility that a mutated virus would spread more easily amongst [\*318] humans, n53 which could result in a devastating flu pandemic amongst the worst in history, if not the very worst. n54 To put this in context, about one in every fifteen Americans--**twenty million people**--**would die every year** from a seasonal flu as virulent as a highly transmittable form of H5N1. n55 **Lax reg**ulation**s** and a rapidly growing number of laboratories exacerbate the dangers posed by bioengineered organisms. While lab biosafety n56 guidelines in the United States and Europe recommended that projects like reengineering the H5N1 virus be conducted in a BSL-4 facility (the highest security level), neither laboratory that reengineered the H5N1 virus met this non-binding standard. n57 Meanwhile, a 2007 Government Accountability Office ("GAO") report indicated that BSL-3 and BSL-4 labs are rapidly expanding in the United States. While there is significant public information about laboratories that receive federal funding or are registered with the Centers for Disease Control and Prevention ("CDC") and the U.S. Department of Agriculture's ("USD") Select Agent Program, much less is known about the "location, activities, and ownership" of labs that are not federally funded and not registered with the CDC or the USD Select Agent Program. n58 The same report also concluded that no single U.S. agency is responsible for tracking and assessing the risks of labs engaging in bioengineering. n59 While some claim that critics are **overreacting to the risk** from this genetically engineered H5N1 virus, **there have been a series of accidental releases** of microbes from laboratories that demonstrate the risks of largely unregulated laboratory safety. In 1978, an employee died from an accidental smallpox release from a laboratory on the floor below her. n60 Many scientists believe that the global H1N1 ("swine flu") [\*319] outbreak in the late 2000s originated from an accidental release from a Chinese laboratory. n61 Reports concluded that the accidental releases of Severe Acute Respiratory Syndrome ("SARS") in Singapore, Taiwan, and China from BSL-3 and BSL-4 laboratories all resulted from a low standard of laboratory safety. n62 In the United States, a review by the Associated Press of more than one hundred laboratory accidents and lost shipments between 2003 and 2007 shows a pattern of poor oversight, reporting failures, and faulty procedures, specifically describing incidents at "44 labs in 24 states," including at high-security labs. n63 In 2007, an outbreak of Foot and Mouth Disease likely came from a laboratory that was the "only known location where the strain [was] held in the country" n64 because of a leaky pipe that had known problems. n65 This long history of faulty laboratory safety is why some experts, such as Rutgers University chemistry professor and bioweapons expert Richard H. Ebright, believe that the H5N1 virus **will "inevitably escape, and within a decade**," citing the hundreds of germs with potential use in bioweapons that have accidentally escaped from laboratories in the United States. n66 While the effects of such lapses in laboratory safety have not yet been felt aside from relatively small events such as the swine flu outbreak mentioned above, the increasing ability of less-sophisticated scientists to engineer more deadly organisms vastly increase the possibility that a lapse in biosafety will have detrimental effects. An accidental or purposeful release of a bioengineered organism has potentially grave consequences. For example, researchers in Australia recently accidentally developed a mousepox virus with a 100 percent [\*320] fatality rate when they had merely intended to sterilize the mice. n67 Scientists in the United States also created a "superbug" version of mousepox created to "evade vaccines," which they argue is important research to thwart terrorists, sparking a debate amongst scientists and policymakers about whether the benefits of such research is worth the associated risks. n68 If such a bioengineered organism escaped from a laboratory, the results would be unpredictable but potentially extremely deadly to humans and/or animals.

**Our arg is the best middle ground – it’s not that SynBio is good or bad. It’s that regs needs to be well-crafted.**

**Miller ‘12**

et al; Henry I. Miller, a physician, is also the Robert Wesson Fellow in Scientific Philosophy and Public Policy at Stanford. He was also the founding director of the Office of Biotechnology at the FDA. This piece wasco-authored with Drew L. Kershen, who is the Earl Sneed Centennial Professor of Law (Emeritus), University of Oklahoma College of Law – Forbes – Aug 29th – modified for language that may offend - http://www.forbes.com/sites/henrymiller/2012/08/29/will-overregulation-in-europe-stymie-synthetic-biology/

Will Overregulation In Europe Stymie **Syn**thetic **Bio**logy? The promising new field of “synthetic biology” involves the design and construction of new biological components, devices and systems, as well as the re-design of existing, natural biological systems. It is intended to move microbiology and cell biology closer to the approach of engineering so that standardized biological parts can be mixed, matched and assembled similar to the way that off-the-shelf chassis, engines, transmissions and so on can be combined to build a hot-rod. Building on the foundations of molecular biology, biological chemistry, gene sequencing informatics, systems biology and systems engineering, synthetic biology is not fundamentally new but involves the synergistic combination of many areas of science and technology. It could offer scientists unprecedented opportunities for innovation and better enable them to craft made-to-order microorganisms and plants with improved abilities of many kinds — for example, to produce vaccines, **clean** up **toxic waste**s, and obtain (or “fix”) nitrogen from the air (obviating the need for chemical fertilizers). In any one of several fields of endeavor, synthetic biology could lead to technology’s Next Big Thing. Synthetic biology is only just emerging into public awareness. As it progresses, the field will present several dilemmas to both public opinion and existing legal and regulatory regimes. Two recent publications do much to introduce synthetic biology to the general public: “A synthetic biology roadmap for the UK,” from Research Councils UK; and “Planted Obsolescence: Synagriculture and the Law,” by Andrew Torrance, in the Idaho Law Review. In his article Torrance explains that several organizations – for example, BioBricks (www.biobricks.org) and the International Genetically Engineered Machine (http://igem.org/About) – actively promote biotechnology as an open source discipline, a sharing of genetic designs, systems and modular components with no or minimal protection of intellectual property. **The open source movement** in biology, as in software, **is antagonistic to corporate control and** attempts to democratize the inventive process in biology. Taking it a step further, Torrance describes organizations such as DIYBio.org and BioCurious.org that **promote “garage science”** – **amateurs tinkering at home** using basic biological tools and supplemented by modular genetic components ordered from the Internet. This harkens back to the small-scale inventiveness of the likes of Thomas Edison, Alexander Graham Bell and Thomas Fogarty (who invented a critical and widely used catheter as a medical student). (Some would say it’s redolent as well of the Unabomber, but that’s a subject for another day.) The future **success** of synthetic biology depends in large part on whether public policy toward its applications **is well-crafted.** Policymakers should learn from the regulatory ~~missteps~~ (errors) inflicted on genetic engineering that illustrate how choosing **how choosing a flawed paradigm** has critical implications for a technology.

**We’re NOT arguing malevolent release – instead, risks of accidents require well-crafted regs.**

**Specter ‘12**

Michael Specter may be the most prominent and credentialed health reporter alive. He has been a staff writer at The New Yorker since 1998, and has written frequently about AIDS, T.B., and malaria in the developing world, as well as about agricultural biotechnology, avian influenza, and synthetic biology. Before joining the Times, he served as the Washington Post’s national science reporter and, later, as its New York bureau chief. He has twice received the Global Health Council’s annual Excellence in Media Award: in 2002, for “India’s Plague,” and in 2005, for “The Devastation,” about the ethics of testing H.I.V. vaccines in Africa. The New Yorker: Annals of Medicine – March 12, 2012 Issue – “The Deadliest Virus” – Modified for potentially offensive language – http://www.newyorker.com/magazine/2012/03/12/the-deadliest-virus

To ignite a pandemic, even the most lethal virus would need to meet three conditions: it would have to be one that humans hadn’t confronted before, so that they **lack**ed **antibodies**; it would **have to kill** them; and it would have **to spread easily**—through a cough, for instance, or a handshake. Bird flu (H5N1) meets the first two criteria but not the third. Virologists regard cyclical pandemics as inevitable; as with earthquakes, though, it is impossible to predict when they will occur. Flu viruses mutate rapidly, but over time they tend to weaken, and researchers hoped that this would be the case with H5N1. Nonetheless, for the past decade the threat of an airborne bird flu lingered ominously in the dark imaginings of scientists around the world. Then, last September, the threat became real. At the annual meeting of the European Scientific Working Group on Influenza, in Malta, several hundred astonished scientists sat in silence as **Ron Fouchier**, a Dutch virologist at the Erasmus Medical Center, in Rotterdam, reported that simply transferring avian influenza from one ferret to another had made it highly contagious. Fouchier explained that he and his colleagues “**mutated the hell out of H5N1**”—meaning that they had **altered the genetic sequence** of the virus in a variety of ways. That had no effect. Then, as Fouchier later put it, “someone finally convinced me to do something really, really stupid.” He spread the virus the old-fashioned way, by squirting the mutated H5N1 into the nose of a ferret and then implanting nasal fluid from that ferret into the nose of another. After ten such manipulations, the virus began to spread around the ferret cages in his lab. Ferrets that received high doses of H5N1 died within days, but several survived exposure to lower doses. When Fouchier examined the flu cells closely, however, he became alarmed. There were only five genetic changes in two of the viruses’ eight genes. But each mutation had already been found circulating naturally in influenza viruses. Fouchier’s achievement was to place all five mutations together in one virus, which meant that nature could do precisely what he had done in the lab. Another team of researchers, led by Yoshihiro Kawaoka, at the University of Wisconsin, created a slightly different form of the virus, which, while not as virulent, was also highly contagious. One of the world’s most persistent horror fantasies, expressed everywhere from Mary Shelley’s “Frankenstein” to “Jurassic Park,” had suddenly come to pass: a dangerous form of life, manipulated and enhanced by man, had become lethal. Fouchier’s report caused a sensation. Scientists harbored new fears of a natural pandemic, and biological-weapons experts maintained that Fouchier’s bird flu posed a threat to hundreds of millions of people. The most important question about the continued use of the virus, and the hardest to answer, **is how likely it is to escape the lab**oratory. “**I am not** nearly **as worried about terrorists as I am about a**n incredibly **smart, smug kid at Harvard**, or a lone crazy employee **with access to these sequences**,” Michael T. Osterholm, the director of the Center for Infectious Disease Research and Policy at the University of Minnesota Health Center, told me. Osterholm is one of the nation’s leading experts on influenza and bioterrorism. “We have seen many times that accidental releases of dangerous microbes **are not rare**,” he said. Osterholm’s anxiety was based in recent history. The last person known to have died of smallpox, in 1978, was a medical photographer in England named Janet Parker, who worked in the anatomy department of the University of Birmingham Medical School. Parker became fatally ill after she was accidentally exposed to smallpox grown in a research lab on the floor below her office. In the late nineteen-seventies, a strain of H1N1—“swine flu”—was isolated in northern China, near the Russian border, and it later spread throughout the world. Most virologists familiar with the outbreak are convinced that it came from a sample that was frozen in a lab and then released accidentally. In 2003, several laboratory technicians in Hong Kong were infected with the SARS virus. The following year, a Russian scientist died after mistakenly infecting herself with the Ebola virus.

**Some regs are needed to minimize lab risks. But, poorly-informed ones hamper SynBio’s upsides.**

**Philp ‘14**

et al; Jim C. Philp – formerly a Reader in Environmental and Industrial Biotechnology at Edinburgh Napier University. The report was drafted primarily by Jim Philp with significant contributions from Mineko Mohri. Mohri earned her law degree at Keio University in Tokyo. She has also served as a lecturer at Keio University. From: “Emerging Policy Issues in Synthetic Biology”, which was published June 4th, 2014. Available in full text via Google Books. p. 117-126 – THIS SPECIFIC PORTION IS FROM PAGE 118

The potential for improper or malicious use of synthetic biology challenges the need for regulation, at least at the level of DNA synthesis. Among the greatest challenges facing those who develop such regulations will be weighing the costs and benefits of rules and developing an effective enforcement system. The situation in the United States and the European Un-ion is described by Bar-Yarn et al (2012), bearing in mind that many other countries have their own procedures. Policies for regulating synthetic biology should aim to ensure the implementation of well-crafted regulations that do not hinder beneficial research. The most critical difference for regulation between synthetic biology and genetic modification (GM) lies in the ability to make tailored DNA sequences. GM technology is restricted to complex laboratory operations. In synthetic biology, the design of DNA can theoretically be done from a computer in any location, without organisational regulation Biigl (2007) argues that modern DNA synthesis challenges the existing recombinant DNA safety framework on two fronts: 1. DNA can be readily designed in one location, constructed in a second and delivered to a third. The resulting use of the material can therefore take place far from its originators. 2. Synthesis max provide an effective alternative route for those who seek to obtain specific pathogens in order to cause harm, thereby circumnavigating national or international approaches to ensuring biosecurity. Although much additional expertise would be needed to produce infectious agents from the resulting genetic material, such work may not be subject to review or oversight. The DNA synthesis industry requires **regulatory** protocols to ensure that it does not become a vehicle for biosafety biosecurity violations. The industry can only continue to advance and realise the potential of synthetic biology if it supports best practices in biological safety and security. Sec. for example. IASB on the effective deterrence and investigation of criminal uses of synthetic DNA."

**Ironically, SynBio’s upsides are important since the way to counter accidental releases is re-utilizing SynBio against itself.**

**Philp ‘14**

et al; Jim C. Philp – formerly a Reader in Environmental and Industrial Biotechnology at Edinburgh Napier University. The report was drafted primarily by Jim Philp with significant contributions from Mineko Mohri. Mohri earned her law degree at Keio University in Tokyo. She has also served as a lecturer at Keio University. From: “Emerging Policy Issues in Synthetic Biology”, which was published June 4th, 2014. Available in full text via Google Books. p. 40

Synthetic biology principles are providing new opportunities for the design of attenuated pathogens for use as vaccines. Wimmer and Paul (2011) described the first synthesis of a virus (poliovirus) in 2002 accomplished outside living cells. They commented on the reaction of lay people and scientists to the work, which shaped the response to de novo syntheses of other viruses. In pioneering a safe live vaccine Coleman et al (2008) synthesised de novo large DNA molecules for the rational design of live attenuated poliovirus vaccine candidates. They postulated that this strategy could be used to attenuate many kinds of viruses. Similarly, the synthetic attenuated virus engineering approach **was applied** to influenza virus strain A/PR/8/34 for the rational design of live attenuated influenza virus vaccine candidates. Mueller et al. (2010) state that the approach can be applied rapidly to **any emerging** in**flu**enza virus in its entirety, an advantage **that is especially relevant for** seasonal epidemics and pandemic threats, such as H5N1 or the 2009 H1N1 influenza. During the latter pandemic, vaccines for the virus became available in large quantities only after human infections peaked. To accelerate vaccine availability for future pandemics, a synthetic approach that rapidly generates vaccine viruses from sequence data has been developed (Dormitzer et al.. 2013).

(Note: A/PR/8/34 - internally referenced – is a strain of influenza)

#### \*\*Diverse “Receptions” holds for SynBio Reps.

Jefferson ‘14

(et al; Dr. Catherine Jefferson – Department of Social Science, Health & Medicine, King’s College, London. – Prior to this position, Catherine was a member of SSHM from January 2013-December 2014. Before joining the department, she worked as a senior policy advisor for international security at the Royal Society, where she led a project on Neuroscience, Conflict and Security. “Synthetic Biology and Biosecurity: How Scared Should We Be?” – May – http://www.kcl.ac.uk/sspp/departments/sshm/research/Research-Labs/CSynBI@KCL-PDFs/Jefferson-et-al-(2014)-Synthetic-Biology-and-Biosecurity.pdf)

Some synthetic biologists and some policy makers argued strongly that the way in which the media reported science was a major obstacle for rational debate. However, for good or ill, the primary role of the media is not to communicate science calmly and rationally. It is an industry that, just like any other, seeks to make money and in many cases this is best achieved by entertaining their audiences. In addition, it is entirely legitimate for debates among scientists about the purposes and findings of research to be represented, so that citizens are more able to understand and participate in such debates and to have their say about future directions. It is also interesting to note that scientists often perceive dramatic scare stories about science as damaging, but that dramatic – and often equally overstated - stories of scientific breakthroughs, which are the mirror image of such scares, are usually welcomed as generating support for science. Scientists also often assume that lay members of the public are easily swayed by negative accounts of science, and that the tenor of media reports will determine whether ‘the public’ will be ‘for’ or ‘against’ a particular technology. This set of beliefs about science and the media, and about public understanding of science is, however, challenged by social science research that demonstrates that members of the public are not passive recipients of media messages and that they can hold nuanced views on scientific and technological developments.

**Plan**

**Plan:**

**The United States Federal Government should limit the state action immunity exemption for anti-competitive business practices.**

**Adv Two**

**Adv Two is Practitioner Shortages:**

**Antitrust authority would check such shortages. The FTC does challenge State-Level “*Scope Of Practice*” restrictions on Nurse Practitioners. But they lose due to Parker immunity. An untouched market can’t solve - local elites use leverage to cement a physician-only squo.**

**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/54-2\_McMichael\_color.pdf

The United States’ affordable care crisis and chronic physician shortage have required nurse practitioners to assume increasingly important roles in the healthcare system. **N**urse **p**ractitioner**s** can address critical access-to-care problems, provide safe and effective care, and lower the cost of care. However, restrictive occupational licensing laws — specifically, **scope-of-practice laws** — have limited their ability to care for patients. Spurred by **interest groups** opposed to allowing **n**urse **p**ractitioner**s** to practice independently, states require physician supervision of nurse practitioners. Research has discredited many of the traditional reasons for these restrictive laws, but emerging arguments assert that independent practice will deepen the ongoing opioid crisis by allowing unsupervised nurse practitioners to overprescribe opioids. The opioid crisis has become one of the defining public health emergency of this generation, so these arguments warrant serious investigation. If granting nurse practitioners independence will exacerbate the opioid epidemic, restricting their practices may be justified despite the clear benefits that independence could create for patients and the healthcare system.

This Article provides **new empirical evidence** on the role of nurse practitioner independence in opioid prescriptions by analyzing a dataset of approximately 1.5 billion individual opioid prescriptions. Containing information on approximately 90% of all prescriptions filled at outpatient pharmacies between 2011 and 2018, this dataset provides unprecedented insight into the ongoing opioid epidemic. An analysis of these data reveals that allowing nurse practitioners to practice independently reduces the quantity of opioids prescribed across all physicians and nurse practitioners. Thus, this Article demonstrates that, contrary to exacerbating the opioid crisis, granting nurse practitioners independence is a valid policy option for addressing this crisis. These results can inform the ongoing state and national debates over nurse practitioner scope-of-practice laws and the opioid epidemic more generally. And based on these results, the Article proposes several policy options at the state and federal levels that could both address restrictive scope-of-practice laws and ameliorate the ongoing opioid crisis.

INTRODUCTION

For many people, access to healthcare means the difference between life and death, the difference between constant pain and the ability to get out of bed in the morning, or the difference between an all-consuming mental illness and the ability to remain an active member of society. Even nearly a decade after the passage of the **A**ffordable **C**are **A**ct (“ACA”), however, access to healthcare continues to dominate local and national health policy debates, and the issue remains unresolved. The ACA **certainly** reinvigorated the country’s interest in access to care in unprecedented ways, and it **drastically altered** healthcare and healthcare provision in the United States. Unfortunately, it effected both of these changes with a **near laser-like** focus on increasing access **to** health **insurance.**1 For all of its virtues, this treatment of access to healthcare as effectively coextensive with access to health insurance has obscured a **more fundamental** problem with access to care as the following example from the New York Times illustrates.

A lifelong resident of rural Nebraska and registered nurse, Murlene Osburn saw a desperate need for mental health care in her community.2 To meet this need in an area where psychiatrists refused to practice, Osburn completed a master’s degree and a national certification process to become a psychiatric nurse practitioner (“NP”).3 Unfortunately, when she was ready to begin caring for patients, Osburn found herself stymied by the problem that spurred her to action in the first place: the lack of psychiatrists. Nebraska law prohibited NPs from practicing without physician supervision, and the nearest physician who could supervise her “was seven hours away by car and wanted to charge her $500 a month” for that supervision.4

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

**Scope of Practice – or “S.O.P.” – restrictions *block access* and *hamper options for patient health*.**

**LDI ‘20**

Internally quoting Dr. Margo Brooks Carthon - LDI Senior Fellow, a Nurse Practitioner, PhD, RN, FAAN, and is also an Associate Professor at Penn’s School of Nursing. The LDI is the Leonard Davis Institute of Health Economics at the University of Pennsylvania (Penn). Six expert panelists are quoted and we are quoting the section from Margo Brooks Carthon – “Scope of Practice Restrictions and Vulnerable Populations: LDI Virtual Conference Explores The Issue's Changing Dynamics” - November 21, 2020 - #E&F - https://ldi.upenn.edu/our-work/research-updates/scope-of-practice-restrictions-and-vulnerable-populations/

The most heavily publicized debates around the SOP issue over the last 60 years have been about **n**urse **p**ractitioner**s** whose work is often focused on underserved communities that lack the most basic kinds of medical care. Panelist and LDI Senior Fellow Margo Brooks Carthon, PhD, RN, FAAN, is an NP and health services researcher in that field. She is also an Associate Professor at Penn’s School of Nursing, and a core faculty member at the Penn Center for Health Outcomes Policy Research.

“There are over two hundred thousand NPs in the United States working under varying degrees of **s**cope **o**f **p**ractice restrictions, depending on the states where they’re employed,” **Carthon said.** “These barriers have implications for population health as well as health equity.”

“Twenty-two states and the District of Columbia fully license NPs to practice independently. Others require career-long collaborative agreements with a supervising physician. Some require a physician to review a percentage of NP charts — ten percent every year in Alabama and Georgia; twenty percent every 30 days in Tennessee. NPs are often limited in the distance they can be from a physician and are required to jump through other hoops just to provide basic care.”

#### Physician shortages are increasing in underserved populations – state regulation blocks NP practice there

McMichael 20 [Benjamin J. McMichael, Assistant Professor of Law, University of Alabama School of Law, December, 2020, “Occupational Licensing and the Opioid Crisis” 54 U.C. Davis L. Rev. 887]

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

**Solvency is *empirical* and the *impact is significant*. Some States have relaxed SOP restrictions to differing degrees. Studies confirm this has saved many lives *per day* *per State*.**

**Chung ‘20**

Bobby W. Chung is a labor economist. He receives his Ph.D.in Economics at Clemson University. He is now a postdoctoral research associate at the School of Labor and Employment Relations in the University of Illinois (Urbana-Champaign). He is also a network member of the Human Capital and Economic Opportunity Global Working Group. His recent work includes social network, occupational licensing, and kidney-exchange network. “The Impact of Relaxing Nurse Practitioner Licensing to Reduce COVID Mortality: Evidence from the Midwest” - #E&F - http://publish.illinois.edu/projectformiddleclassrenewal/files/2020/06/The-Impact-of-Relaxing-Nurse-Practioner-Licensing8413.pdf

**N**urse **p**ractitioner**s** (NP) are well-trained health care personnel for primary, acute, and specialty care in the US. However, 32 states have restrictions on their **s**cope **o**f **p**ractice and Illinois is one of them.

In response to the shortage of health care workers during the coronavirus pandemic, twenty-one states granted NP full practice authority to cope with the increasing demand for health care services. In the Midwest, **Kansas**, **Indiana,** **Michigan**, **Missouri**, and **Wisconsin**, adopted a more expansive scope of service for NP.

This report evaluates the effect of this policy change on the rate of COVID-related deaths in the Midwest states, which expanded NP authority and sheds light on healthcare policy in Illinois.

**Findings:**

NP in Illinois have full practice authority only if they have had 4,000 hours of clinical experience and completed 250 training hours.

Illinois and Ohio are the only two Midwest states, which did not expand the scope of practice for NP during the pandemic.

In the states that **did expand** the **s**cope **o**f **p**ractice **for NP**, COVID related deaths were potentially reduced by **10** cases **per day**

**If Illinois had** expanded the scope of practice, **8% fewer** COVID-19 **deaths would have occurred** in Cook County, which is the most affected area in the state.

The findings reveal that granting NP full practice authority **is effective** in easing the shortage of health care workers and improves health care quality. Our result echoes the findings by other healthcare researchers that granting NP independent practice authority improves patient outcomes. This report recommends that health care regulators in Illinois grant all NP independent practice authority in order to meet the states’ growing health care demand.

Introduction

The shortage of healthcare professional in the US has been a notable concern among health policy makers. According to the Bureau of Health Workforce, in 2017 only 55 percent of the need for primary care professional was met.1 For Illinois, the Bureau estimated that 468 extra primary care health providers were needed to address the shortage problem, which is roughly 188% of the existing number of primary care providers in the state. The shortage problem is the biggest in the Midwest.

The nationwide healthcare labor force shortage manifests itself **even more during the** COVID-19 **pandemic.** To address the health workforce shortage, a number of states temporarily expanded the scope of practice for nurse practitioners (NP). NP are well-trained health care personnel, typically requiring post-graduate training. According to the American Association of Nurse Practitioners (AANP), NP with full autonomy are authorized to \evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments".2 Although they are well-prepared to provide primary, acute, and specialty care, their scope of practice varies by state. According to the classification by AANP, in a state with "restricted/reduced practice," NP need to have a collaborative agreement with, or work under direct supervision of a licensed health professional (e.g. physician, dentist). The limited authority of NP has not only reduced health access in rural areas, but also significantly increased the administrative burden of the supervising personnel. It has also reduced the amount of time dedicated for patient care (Traczynski and Udalova, 2018). Healthcare researchers have claimed that granting NP independent practice authority would have a positive impact on patient outcomes.

This report estimates the impact of expanding the scope of practice for NPs on COVID mortality in the Midwest. In the region, seven states were classified prior to the pandemic as "restricted/reduced NP practice" by the AANP. Among those, **Kansas,** together with **Indiana,** **Michigan**, **Missouri**, and **Wisconsin** granted NPs independence, whereas Illinois and Ohio did **not** implement changes.3 In the empirical exercise, we leverage on this quasi-experimental setting to compare daily COVID mortality in the treated states with that in **Illinois and Ohio** before and after the emergency response. Although the discussion evaluates the recent emergency response under the pandemic, the finding here contributes to the ongoing debate of whether NP should be granted independent authority.

According to our estimates, expanding the **s**cope **o**f **p**ractice for NPs potentially reduced COVID-related deaths by ten per day. To put this figure into context, the number amounts to a reduction of 8% of in those states that implemented the changes the average death toll in Cook County during the sample period. These results add support to granting NP full independent authority to ease the healthcare workforce shortage.

Restriction on NP and State Emergency Response

The scope of practice for nurse practitioners varies by state. According to the American Association of Nurse Practitioners (AANP), five of the Midwest states allow full practice (light blue in Figure 1a), meaning that NP can work independently and are authorized for patient diagnosis and prescription.

Illinois with four other Midwest states (Figure 1a) classify NP under "reduced practice" restrictions. Illinois regulations amended in 2017 do allow a subset of NP full practice authority, but the change only applies to NP who have had at least 4,000 hours of clinical experience and completed 250 training hours.4 In contrast, North Dakota, South Dakota, Nebraska, Minnesota and Iowa permit a full scope of practice for all NP without a minimum threshold of accrued work hours.

In Illinois, NP are required to have a collaborative agreement with a health professional (e.g. licensed physician), listing the types of care, treatment and procedures the NP is allowed to perform. NP in Illinois and five other Midwest states can work quasi-independently because physicians are not required to be physically present with the NP. Prior to the pandemic outbreak, Missouri and Michigan had the most restrictive rules, requiring that NP work under direct supervision of a physician (Figure 1a).

As the pandemic unfolded, states with reduced or restricted practice authority began to expand the scope of practice for NP. The aim of the change was to enlarge the healthcare workforce capable of providing COVID-19 care.

Among the Midwest states shown in Figure 1b, Missouri and Indiana were the first to waive part of the supervision requirements. At the date of this report, Illinois and Ohio were the only two states, which have not taken action to expand the scope of practice for NP.

Policy Effect on COVID-related Mortality

To evaluate the effectiveness of expanded scope of practice, this report looks into the impact on COVID-related mortality. Data on county level daily mortality are retrieved from the New York Times.5

To estimate a cause-and-effect relationship between expanded **s**cope **o**f **p**ractice and COVID-19 mortality, this report employs the **synthetic control method** (Abadie and Gardeazabal, 2003; Abadie, Diamond, and Hainmueller, 2010). The essence of this statistical technique is to construct **a counterfactual** which mirrors the post-policy mortality that would have been observed had the policy not happened. We then obtain the daily policy effect by directly comparing the counterfactual mortality with the observed mortality. To ensure the counter-factual offers a valid comparison, we make use of several important indicators that would predict COVID-related deaths. These include the pre-policy number of COVID death, pre-policy number of confirmed cases (also retrieved from the New York Times database), and county characteristics (number of NPs, population size, percent of 65+ population, percent of black, number of hospital, and number of beds) obtained from the Area Health Resource Files (AHRF, 2020).

An important property of the synthetic control technique is that the pre-policy number of COVID death has to be informative enough to produce reliable post-policy predictions. In other words, we rely on the pre-policy trend to predict the post-policy movement. This limits the start of the sample period to late March because many counties did not record any COVID deaths until then. For this reason, we are not able to produce a dependable counterfactual for the counties in Missouri and Indiana because they granted authority to NP prior to reporting any COVID-19 deaths.

Figure 2, shows the estimation result for Kansas, Wisconsin, and Michigan. The solid line of each graph represents the actual daily mortality of a state (average of all counties), whereas the dotted line shows the predicted counterfactual using the synthetic control technique. The red vertical line in the middle of each graph represents the day before the policy takes place. For example, in the top-left corner, the solid line shows that Kansas counties recorded an increasing number of COVID-related death with a modest decline in magnitude since April 22, which is the date Kansas started to authorize temporary independent practice for NPs. The trend afterward clearly diverges from the predicted no-policy counterfactual, which implies that the policy slowed down the death toll. Until the end of the sample period, the maximum impact by the policy reduces the daily death toll by 10 cases. We also observe a similar pattern in Wisconsin and Michigan, though the magnitude of death reduction in Michigan is smaller.

There is however the possibility that the reduction in deaths was caused by some other concurrent policies and any reduction in fatalities would then be falsely attributed to the expanded scope of practice. This concern is particularly valid because there were many policies adopted in response to the nationwide health risk.

Therefore, to check the robustness of our prediction of reduced deaths associated with NP scope of authority, we tested to see if the social distancing policy, a major attempt by states in response to the pandemic, had the same associated improvement on the cases of COVID-19 deaths.

For Kansas, Wisconsin, and Michigan, social distancing measures were implemented in late March. We therefore implemented the same estimation procedures using the synthetic control method but moving the treatment date in each state to correspond to the start of the state's shelter-in-place order. As shown in Figure 3, in each of the three states, the actual cases of death continues to grow at a higher rate than the predicted counterfactual. This finding suggests that the **lock down policies** did not produce the same reduction in the number of COVID-related fatalities as the expanded **s**cope **o**f **p**ractice

**Conclusion and Policy Implication**

Amid the unprecedented health crisis, it is important that state regulators consider the cost of occupational regulations.

The argument for occupational licensing is that it protects the consumer. In the case of NPs scope of practice, regulators often worry about the quality of service if the scope is widened. This report however suggests there is **empirical ev**idence that granting NPs independent authority has contributed to a reduction in COVID-19 deaths.

#### Nurse practitioners provide much better care---Best studies are aff

McMichael 20 [Benjamin J. McMichael, Assistant Professor of Law, University of Alabama School of Law, December, 2020, “Occupational Licensing and the Opioid Crisis” 54 U.C. Davis L. Rev. 887]

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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.

**The Aff is not centrally about the ACA – but we have a perfect take on it:**

* **It’s good – in that it raised the floor of coverage.**
* **It’s bad – in that it falsely assumes coverage is enough. Providers are needed.**

**The way out of the dilemma isn’t the squo or scrapping government. That would default to an untouched market.**

**Instead – we should pair the ACA with nurse practitioners. That tempers ongoing provider crunches.**

**Auerbach ‘13**

et al., David Auerbach is on the faculty of the Pardee RAND Graduate School.He is a former RAND policy researcher specializing in the health care workforce and on the Affordable Care Act. He is a leading national expert on the nursing and advanced-practice nursing workforce in particular, as well as primary care providers and new models of care delivery. “New Approaches for Delivering F Could Reduce Predicted Physician Shortages, Research Highlight”- Rand Corporation, Research Briefs RB9752, 2013, http://www.rand.org/pubs/research\_briefs/RB9752.html.

Numerous forecasts have predicted **shortages of physicians** **in the United States**, particularly in light of the expected increase in demand from the **A**ffordable **C**are **A**ct (ACA). Such predictions, however, might be far from the mark. Several recent innovations are attempting **to change the way primary care is delivered** — by expanding who provides care (e.g., physicians, **n**urse **p**ractitioner**s**, physician assistants) and how care is coordinated (e.g., through teams).

RAND researchers analyzed the potential impact of two emerging models of care — the patient-centered medical home (PCMH) and the nurse-managed health center (NMHC) — on future shortages of primary care physicians. The PCMH delivers primary care using a team of providers, including physicians, advanced practice and other nurses, physician assistants, pharmacists, nutritionists, social workers, educators, and care coordinators. NMHCs, also known as nursing centers or nurse-led clinics, are managed and operated by nurses, with nurse practitioners functioning as the primary providers.

The study found that projected shortages of primary care physicians could be **substantially reduced** by increasing the prevalence of these new models of care — **without increasing the number of physicians**. Researchers also developed an interactive online tool that allows users to change the assumptions used in this research and see the effect on future shortages or surpluses of physicians, nurse practitioners, and physician assistants.

Estimating the Supply and Demand for Primary Care Providers

Researchers used published estimates of supply and demand for primary care providers, accounting for expected increases in demand resulting from the ACA. To estimate supply and demand for providers under the alternative models of care, researchers combined published estimates with data from observing actual staffing at a number of practices.

The figure shows the projected supply of providers in each category in 2025. The share of primary care providers who are physicians is expected to shrink from 71 percent to 60 percent in 2025. In 2010, there were nearly four primary care physicians for every nurse practitioner in primary care, but the RAND team estimated that in 2025 there would be just over two physicians per nurse practitioner.

The Effect of New Care Models on Provider Shortages

RAND researchers combined these supply estimates with published forecasts of demand for primary care providers to derive shortage estimates for the year 2025 under several alternative scenarios, as described below. As is standard practice, researchers assumed that supply and demand for providers were balanced in 2010. Results are shown in the table.

**Status Quo.** If primary care practices use the same mix and combinations of providers in 2025 as they did in 2010, these assumptions would lead to a forecast shortage of 45,000 primary care physicians in 2025 (i.e., **20 percent below demand**), together with **a surplus of 34,000** **n**urse **p**ractitioner**s** (**48 percent above demand**) and of 4,000 physician assistants (10 percent above demand).

Increasing the Prevalence of Alternative Models of Primary Care. Increasing the prevalence of alternative models of primary care **reduced the projected shortage** of **primary care** providers, especially when the prevalence of both alternatives increased.

**The Aff can solve.**

**Malleability holds in contingent instances - Health access is distinct from other modes of violent power. Claiming it as “liberalism” creates false equivalencies. Such State-Alarmism is wrong and generates support for ACA rollback.**

**Schotten ’15**

Dr. C. Heike Schotten is an Associate Professor of Political Science and an affiliated faculty in Women’s and Gender Studies at The University of Massachusetts-Boston. What following is from Schotten’s own faculty bio: Her research lies at the unlikely intersection of Nietzsche studies, queer theory, and revolution. “Against Totalitarianism: Agamben, Foucault, and the Politics of Critique,” Foucault Studies, No. 20, pp. 155-179, December 2015, Modified for language that may be objectionable - #E&F – the letter “u” is moved from Capitalized to a lower-case in one instance – this is for readability. <http://rauli.cbs.dk/index.php/foucault-studies/article/view/4935/5361>

**III. Moralism and Totalitarianism**

Foucault’s methodological and political commitments are all the more significant in light of Agamben’s demanded corrective of Foucaultian biopolitics and understanding of sovereignty. For even as Foucault expands his methodological rejection of the state as ahistorical political principle or sociological object, Agamben effects not simply a return to sovereignty, as already argued, but a return to sovereignty in what, following Foucault, **we must recognize** as totalitarian forms. This is the case not only methodologically, as will become clear, but also morally, an aspect of political critique that does not even enter into the Foucaultian schema. Methodologically, Agamben’s persistent focus on Auschwitz as the West’s political paradigm and Nazism as the teleological culmination of sovereignty’s political trajectory results in his offering an “anti-totalitarian” theory of sovereignty that renders any other historical or political outcome besides totalitarianism impossible. Hence Agamben’s dispute with Foucault is actually a “corrective” of Foucault, a disappointingly moralizing rebuke rather than a constructive scholarly engagement.

In BB, Foucault says his choice to talk about governmentality rather than **the** state is purposeful, a **methodological choice** that is “obviously and explicitly a way of not taking as a primary, original, and **already given** object, notions such as the sovereign, sovereignty, the people, subjects, the *state, and* ***civil society***, that is to say, all those **universals** employed by sociological analysis, historical analysis, and political philosophy.”92 **Rather,** Foucault says, he would like to do “exactly the opposite” and, instead of using “state and society, sovereign and subjects, etcetera” as points of departure, he wants to show how they “were actually able to be formed” so that their status can be called into question.93 At one level, this is simply Foucault’s methodological preference. At another level, as we have seen, it is a political commitment, insofar as refusing to begin with these sociological givens facilitates resistance to the power-effects of what he calls “totalitarian theories.” While, in “SMBD,” these totalitarian theories were Marxism and psychoanalysis, in BB the target is now what Foucault calls “historicism,” which he describes as a practice of taking universals and running them through the mill of history in order to deduce their “meaning.” Significantly, historicism, like Marxism and psychoanalysis, unfolds a similarly reductive and deductive logic that “starts from the universal and, as it were, puts it through the grinder of history.”94 Instead, Foucault suggests the supposition “that **universals do not exist**. And then I put the question to history and historians: How can you write a history if you do not accept a priori the existence of things like the state, society, the sovereign, and subjects?”95 Insofar as historicism in BB functions the way Marxism and psychoanalysis do in “SMBD,” then historicism can also be considered a totalitarian theory that Foucault seeks to critique. In seeking to undertake an analysis that is “exactly the opposite of historicism,”96 Foucault is in some sense continuing his practice of thwarting or undermining totalitarian theories, a methodology that is animated by a specifically political commitment to insurrection.97

Foucault is also cautious about indulging the fearful discourse of the all-powerful state. He names this anxiety “state ~~phobia~~” 98 (“**state alarmism”**) and says it has two related versions: first,

the idea that the state possesses in itself and through its own dynamism a sort of power of expansion, an **endogenous imperialism** constantly pushing it to spread its surface and increase in extent, depth, and subtlety to the point that it will come to take over entirely that which is at the same time its other, its outside, **its target**, and its object, namely: civil society.99

If this leaves the impression of a kind of suffocating beast whose tentacled grasp is ever extending over and sliding in between any cracks of resistance to its domination, this is no accident: Foucault refers to this as the “cold monster” version of the state, the “threatening organism above civil society.”100 Foucault does not spend much time unpacking the problems with this theory, presumably because they **are self-evident** on the basis of his earlier work: not only is the state here presupposed as a causal entity that exists “above” its subjects, but it is also possessed of a kind of vitalism or life principle that Foucault dismisses out of hand as **an inadequate** or **irresponsible account of power**. The state as “cold monster” is, quite literally, yet another version of the Leviathan, the great sea monster from the book of Job, for whose beheading Foucault has already vigorously advocated.

The second bit of “critical commonplace”101 regarding the state that Foucault seeks to avoid is the notion that there are no significant differences between or among different forms of it. This is the notion that, as Foucault puts it,

there is a kinship, a sort of genetic continuity or evolutionary implication **between different forms of the state,** with the administrative state, the welfare state, the bureaucratic state, the fascist state, and the totalitarian state all being, in **no matter which** of the various analyses, the successive branches of one and the same great tree of **state control** in it**s** continuous and unified expansion.102

Here Foucault explicitly puts totalitarianism and the state together in order to distinguish **“the totalitarian state” as a *distinct***ive state **form**, rather than the paradigm case of the state itself.

Indeed, here we might understand Foucault as attempting to disentangle a kind of doubling of totalitarianism in state phobia, wherein the cold monster view anoints the state with the kind of omniscience and omnipotence often ascribed to totalitarian versions of it. This specifically totalitarian version ultimately **becomes synonymous with the state itself.**

What links the “cold monster” view and the “genetic continuity” view is their consideration of the state as a malevolent principle in itself, such that distinctions among types become **irrelevant** and ***any state action*** can be interpreted as a sign of its increasing repressiveness and violence. Foucault uses the example of an unduly harsh criminal sentence, which he says can be interpreted as evidence of the increasing fascism of the state, regardless of whatever may actually be true—this is once again a correct answer produced by the particular truth mill that is “state phobia.” Foucault warns that this kind of thinking can verge on ~~paranoid~~ (alarmist) **fantasy**, which ~~sees~~ (perceives) evidence of the ever-growing, increasingly-fascistic state everywhere it looks. In this case, one’s “grasp of reality”103 is not what matters, but rather the endless confirmation and reproduction of the theory itself. **It can** also **issue in** absurd (**illogical**) **conclusions**, such as the following:

**As soon as we accept** the existence of **this continuity** or genetic kinship **between different forms of the state,** and as soon as we attribute a constant evolutionary dynamism to the state, it then becomes possible not only to use different analyses to support each other, but also to refer them back to each other and so **deprive them of their specificity.** For example, an analysis of social security and the administrative apparatus on which it rests ends up, via some slippages and thanks to some plays on words, referring us to the analysis of concentration camps. And, in the move from social security to concentration camps the***requisite* specificity** of analysis is **diluted**.104

While Foucault is referencing right-wing fantasies about governmental power (one is reminded of **Sarah Palin’s warnings about “death panels”** should Obama’s **A**ffordable Health **C**are **A**ct pass the U.S. Congress), his caution is **also** apposite to left anarchist discourses that similarly ~~see~~ (perceive) the state as a malevolent principle in itself. In suggesting that the state has no essence or is “nothing else but the mobile effect of a regime of multiple governmentalities,”105 Foucault is not claiming that we should be uncritical of the state or exercises of state power. Quite the opposite. In destabilizing the operative presumptions about the state in history, sociology, philosophy, and politics, Foucault is instead working to make the state something that is possible to critique and resist. We lose sight of this possibility when the state is presumed to be a prime mover of history or politics, an omnipotent principle or an essentially annihilatory institution that culminates, inevitably, in the genocidal logic of concentration camps. Part of the task of proceeding in the exact opposite manner as that of historicism is admitting that mechanisms of power ***are*** transferable and that they do not exhaustively characterize **any** particular society.106 Foucault’s resistance to historicism and state phobia, then, are yet further resistances to totalitarianism—of theory (or science) but also of specific state forms and beliefs about the state and its forms that function in totalitarian ways.

As is perhaps already evident, Agamben’s approach to the state in Homo Sacer epitomizes both the historicism and state ~~phobia~~ (“state alarmism”) that Foucault explicitly rejects. Rather than seeking, from below, to untangle and document the subjugated knowledges that have produced existing dominations, Agamben instead seeks to read these latter for what they reveal about the essential workings of Western politics. Indeed, Agamben presumes that power inheres in the sovereign demarcation of the zoē/bios divide, the status of which exhaustively defines life and politics in “the West” (itself an underspecified geographical and historical entity). The method of Homo Sacer is thus clearly expressed in Foucault’s description of “historicism”: Agamben starts from a universalist claim regarding the sovereign exception and then proceeds to examine how history has inflected it in the West. This is what allows him to conflate all versions of the state with the totalitarian one and also to suggest that all versions of sovereignty culminate inevitably in the Nazis’ creation of concentration camps. As he says, the camp is “the hidden paradigm of the political space of modernity, whose metamorphoses and disguises we will have to learn to recognize.”107

Like all declension narratives, this one too echoes the chronology of the fall from grace, except that, in Agamben’s version, the pre-lapsarian moment dates from Aristotle rather than the Creation. The result, however, is a valorized hypostatization of an at-best questionable moment of origin, from which the logic of the events of Western history can be understood to have unfolded and to be still in the process of unfolding to this day.108 At one end, then (at “the beginning,” or archē), stands the Aristotelian distinction between zoē and bios; at the other end (“now,” or in modernity), lie the Nazi death camps. These two moments are tied inevitably, irretrievably together by the exceptional logic of sovereignty:

The totalitarianism of our century has its ground in this dynamic identity of life and politics, without which it remains incomprehensible. If Nazism still appears to us as an enigma, and if its affinity with Stalinism (on which Hannah Arendt so much insisted) is still unexplained, this is because we have failed to situate the totalitarian phenomenon in its entirety in the horizon of biopolitics. When life and politics—originally divided, and linked together by means of the no-man’s-land of the state of exception that is inhabited by bare life—begin to become one, all life becomes sacred and all politics becomes the exception (148, original emphasis).

Nazism will remain “an enigma,” on this telling, insofar as we fail to “situate” it within the essential principle of Western biopolitics—the sovereign exception, the zoē/bios divide. Once we do that, however, the meaning of Nazism becomes clear and we understand how there could ever have been death camps, perhaps the real question Agamben is trying to answer in this text. Already latent in the zoē/bios divide, then, is the concentration camp, which is why its historical development inevitably culminates there.

Agamben’s political theory thus not only re-iterates the assumptions of the sovereign model as Foucault explains it, but itself becomes a kind of totalitarian theory of sovereignty in the West that can only ever issue in the same answer **over and over again**: the camp. Agamben’s methodological historicism is what allows him to come to the political conclusions Foucault explicitly repudiates above; namely, that there is no meaningful difference between democratic states and totalitarian ones, and this because the sovereign exception is a formation of power that fundamentally defines the entity “Western politics” from its earliest days through to its catastrophic contemporaneity. Thus it is perhaps also unsurprising that Agamben concludes there is no difference between democratic and totalitarian regimes insofar as their “fundamental referent” is bare life; the “only real question to be decided,” he says, is “which form of organization would be best suited to the task of assuring the care, control, and use of bare life.”109 As well, Agamben’s state ~~phobia~~ (“**state alarmism**”) , in which we can recognize both the “cold monster” and “genetic” versions, predictably culminates, as do the absurdist theories Foucault documents, with nothing other than concentration camps. U(u)nless the enigma of the sovereign exception is solved, Agamben insists, we **will** remain mired in totalitarianism and death camps: “Today politics knows no value (and, consequently, no nonvalue) other than life, and until the contradictions that this fact implies are dissolved, Nazism and fascism—which transformed the decision on bare life into the supreme political principle— will remain stubbornly with us.”110 The consequence of Agamben’s methodology here is not simply a return to sovereignty, then, but **in fact** a **resurrection of the sovereign** and the restoration of his omnipotence in what, following Foucault, can be called totalitarian forms. Agamben’s reading of the text of Western politics from the guiding principle of the sovereign exception leaves us no other option, no other conclusion, than that with which Foucault claims his work is constantly being misinterpreted as saying: “This is the way things are; you are trapped.”111 This outcome is all the more ironic, of course, given that the entire exercise of Homo Sacer was ostensibly spurred by Agamben’s desire to “correct” Foucault’s oversight regarding 20th century totalitarian regimes and, presumably, overcome the disastrous legacy of Nazism and totalitarianism.

\*Note to students: the word “endogenous” means having an internal cause or origin)

#### *For health*, pessimism, root cause, and ontology claims are wrong. This frames a *racial materiality disad* to the Neg’s Alt and framework.

Gaffney ‘16

Adam Gaffney, Instructor in Medicine at Harvard Medical School and a Pulmonary/critical care doctor. The author holds an MD from New York University and expressly identifies as an “advocate for Single-Payer” as the lead on the author’s Twitter handle. Internally quoting Damon Tweedy – the author of the book Black Man in a White Coat. Tweedy identifies as black and is a graduate of Duke University School of Medicine. He is an associate professor of psychiatry at Duke University School of Medicine and staff physician at the Durham Veteran Affairs Health System. Also internally quoting Dayna Bowen Matthew, a leader in public health who focuses on racial disparities in health care. Matthew identifies as a black female. 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. “Is the Path to Racial Health Equity Paved with “Reparations”? The Politics of Health, Part II” – LA Review of Books - 3-7-2016 – #CutWithRJ - [https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/#](https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/)!

Only through the combined force of the civil rights movement, the Civil Rights Act of 1964, a number of key legal challenges, and the passage of Medicare in 1965 could the rollback of American apartheid medicine begin, as will be discussed in more detail below. For now, it’s worth noting that the impact of the civil rights movement on black health was not insignificant, as demonstrated in a revealing 2013 study by epidemiologist Nancy Krieger and colleagues. In the early 1960s, these investigators found that black infant death rates were significantly higher in “Jim Crow” states (the 21 states, plus the District of Columbia, with racial discrimination on the law books) than in non-Jim Crow states. This is hardly surprising. Yet, during the late 1960s, the death rate of the former group did improve, and by the 1970s the difference had evaporated. This can be touted as evidence that political change can yield real improvements *in health* over time. But two additional facts complicate this interpretation. First, after 2000, the gap again opened up, albeit to a lesser extent. And, second, regardless of the impact of the Civil Rights movement on disparities among blacks, throughout this period black infant death rates were still twice that of whites.[10]

Meanwhile, in terms of life expectancy, recent years have seen the reduction — but not the elimination — of black-white inequalities. As the Centers for Disease Control reported last November, the difference in life expectancy between the two groups fell from 5.9 years (in 1999) to 3.6 years (in 2013). However, even this may not be entirely goods news. A widely covered study published last fall found a unique and disturbing rise in mortality among middle-aged whites (of lower socioeconomic status) between 1999 and 2013, leading the investigators to conclude that falling white-black mortality disparities in this age group “was largely driven by increased white mortality.”[11]

Moreover, during this same period and on into the present, a series of events have functioned as starkly visible and undeniable examples of ongoing structural health racism. Following the death last year of Freddie Gray while in polic[e] custody, many made note of the enormous chasm in health and mortality between black neighborhoods like his and adjacent wealthier and whiter ones. Other commentators have highlighted “environmental racism,” or inequities in exposure to environmental hazards by race, emblematic of embedded structural inequality. Revealing reporting by the Washington Post, for instance, described Gray’s history of childhood lead poisoning, an exposure that is in part racially patterned. More recently, mass poisoning by lead in Flint, Michigan — the disastrous consequence of dimwitted austerity and structural marginalization — has provided yet more evidence of the downstream health consequences of political exclusion.

Inequalities in criminal justice itself — specifically mass incarceration and police violence — are now being explicitly contextualized within a framework of health.[12] In protest of such inequalities (made starkly visible by the killings of men like Eric Garner and the ensuing “Black Lives Matter” protests), medical students throughout the country have begun to advocate for change — for instance, with a solidarity “die-in” action on December 10, 2014, which in turn led to the formation of a new racial health justice organization (“White Coats for Black Lives”) on Martin Luther King Day in 2015.[13]

Finally, two new books are tackling head-on the problem of racial health inequality, albeit from very different “expert” perspectives — one from within medicine and the other from a legal perspective. Damon Tweedy’s Black Man in a White Coat, released last year, is a thoughtful memoir that explores the nexus of race and medicine through the eyes of a black physician. Law professor Dayna Bowen Matthew’s Just Medicine: A Cure for Racial Inequality in American Health Care, on the other hand, is an integration of legal analysis and social science that culminates in an overarching policy recommendation.

In what follows, I’ll first examine the issue of racism within the medical profession, turning to Tweedy’s experiences and reflections as described in his book. Next, I’ll focus on Matthew’s book, and examine the problem of explicit and implicit medical discrimination historically and in the present — and how civil rights law might be used to combat it. From there, I’ll discuss the place of the health system in the perpetuation of inequalities, and the largely neglected role that health care universalism plays in “health equality.”

Lastly — but most importantly — I’ll explore how health inequities by race and by class intersect. To phrase the question plainly: Does confronting the problem of racial health inequality mean that we must embrace the cause of economic redistribution, as discussed in the first part of this essay? If so, should this economic redistribution proceed within the context of social democracy (or democratic socialism?), or should it — must it — proceed along explicitly racial lines? Is the path to racial health equity paved with “reparations”?

2. Black doctors: Discrimination within the profession

The plotline of Steven Soderbergh’s unnerving and beautifully shot series The Knick tackles racism within the medical profession by making it viscerally visible in another era. Set in a downtown Manhattan hospital at the turn of the 19th century, the black, eminently qualified physician, Algernon Edwards (Andrew Holland), is treated with derision and disdain by many of the hospital’s white staff and administrators. At the same time, the hospital turns away black patients from its outpatient clinic; Edwards surreptitiously begins treating them — under rather suboptimal operative conditions — in the hospital’s basement.[14]

But what about after the time period depicted in this series? Into the mid-20th century, blacks were excluded from many medical schools, and those who graduated faced intense discrimination in the course of practice. For instance, even decades after the events depicted in the Knick, black physicians were unable to provide care for their hospitalized patients in the South. This was because physicians needed to gain entry into county medical societies as a prerequisite to hospital-admitting privileges; and, in the South, these societies entirely or almost entirely denied blacks membership. The AMA virtuously professed that it opposed discrimination, and yet excused itself from doing anything, claiming it was impotent to compel integration. It took decades of political pressure to force change. In 1968, the Medical Committee for Human Rights, a health-oriented civil rights group, took matters into its own hands, invading the AMA’s convention at the extravagant Fairmont Hotel in San Francisco. Such actions — in conjunction with the Civil Rights Act and the passage of Medicare — ultimately contributed to the AMA’s vote later that year to expel county societies that excluded black members, at long last forcing their disgracefully delayed integration.[15]

This is, of course, not to say that blacks subsequently gained equal footing within the medical profession. Black representation in US medical schools has remained proportionally low over the decades, especially for men. Indeed, a report from the Association of American Medical Colleges last year showed that the number of black male matriculants in medical school is lower now — in absolute terms — than it was in the late 1970s. Tweedy, now an assistant professor of psychiatry at Duke University Medical Center, was one of these matriculants. In his book, he describes some of the challenges he faced.

In addition to being one of only “a handful of black students” in his class at Duke Medical School, Tweedy came from a working class family, in stark contrast to the majority of his classmates. On the one hand, Tweedy highlights the importance of affirmative action: “So there it was: Not only was I admitted to Duke, when in a color-blind world I might not have been, but I had arrived with a full-tuition scholarship in hand.” On the other hand, his first exchange as a first year student with a medical school professor was markedly inauspicious: the professor approached him to ask if he was there to fix the lights. While he was a medical student, patients routinely queried him about his presumed basketball skills. Far worse was his interaction as a resident with a racist patient and his confederate-flag adorned family (“I don’t want no nigger doctor,” the patient told a nurse). Tweedy’s diligence and persistence ultimately, however, won them over. On another occasion, a black patient rejected him, presuming his medical skills to be inferior and seeing the assignment as evidence of racist mistreatment of him as a patient. Given the insecurities that afflict medical students and trainees in general, we can only imagine the additional strain created by such presumptions and prejudices.

Tweedy’s book is also very much about the experience of black patients. He bears witness to the second-class care they too frequently experience when, for instance, as a medical student he spends time in a makeshift rural clinic, “nestled within a group of dingy trailers and makeshift houses.” The clinic serves poor black patients who cannot afford prescribed treatments. They are likely to see a different doctor at every visit and receive grossly insufficient preventive care. In another chapter, he describes how one black patient, who quite reasonably declines one of his team’s medical recommendations, is dispatched with a punitive psychiatric diagnosis.

Toward the conclusion of his book, Tweedy briefly explores the larger and looming question: what is the cause of racial health inequalities? Early in his medical career, he had assumed — like many others — that genetic differences were the primary factor. And indeed, for years, a huge amount of resources have gone into uncovering the genetic sources of health disparities. However, as Jason Silverstein explains in a revealing article in The Atlantic (“Genes Don’t Cause Racial-Health Disparities, Society Does”), this money may have been better spent elsewhere. He describes a 2015 paper that systematically reviewed the collective evidence thus far for the proposition that genetic factors explain racial cardiovascular disparities. It’s worth quoting from the study’s conclusion:

The results reveal a striking absence of evidence to support the assertion that any important component of observed disparities in these diseases arises from main-effect genetic mechanisms as we currently understand them … Despite the enormous social investment in genomic studies, this research program has not yet provided valuable population-relevant insights into disparities in the most common cause of morbidity and mortality.[16]

Why then, Silverstein asks the study’s lead author, do genomics still get so much attention? The author responds with a sentiment I’ve long suspected: if inequalities are built into the very base pairs of our genetic code, what can we really do to alleviate them? More research? In effect, as the investigator tells Silverstein, the fact is that racism and inequities are let off the hook if our genes are the culprits. Tweedy notes that he came to reject this genetic explanation: even if genetic factors play some role with respect to specific diseases, they explain little of the overall differences in health between races.

In contrast, there are reams of evidence that point to social and economic inequalities as drivers of racial inequalities. In the first part of this essay, I focused on the impact of economic injustices on health: a large body of literature has demonstrated that poverty, for instance, is associated with a panoply of poor health outcomes, and some researchers argue that inequality itself causes worse health for everyone in society (perhaps via increased psychosocial strain as well as other factors).[17] No doubt such socioeconomic factors are a major factor in racial health inequalities, given the tight association between economic status and race.[18] Similarly, differences in health care access associated with race (like being uninsured) are no doubt factors as well.

But what might be said about the role of racially discriminatory treatment itself? This issue has received increased attention since the 2002 publication of an Institute of Medicine evidence report, Unequal Treatment: Confronting Racial Disparities in Health Care. Tweedy quotes from the report’s conclusion: “Although myriad sources contribute to [health] disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of the healthcare providers may contribute to differences in care.” Or, as he puts it, the “doctor-patient relationship itself serves as a catalyst for differing outcomes,” which is in part the result of the fact that “some doctors are prone to hold negative views about the ability of black patients to manage their health and therefore might recommend different, and possibly substandard, treatments to them.”

This issue — namely, the problem of racially disparate treatment — is the central focus of Dayna Bowen Matthew’s book. She explores how “implicit bias,” as she terms it, deforms physician behavior; in her view, it constitutes the most neglected determinant of inferior health among blacks.

3. Jim Crow medicine: Past and present

Matthew is a law professor with appointments at both the University of Colorado Law School and the Colorado School of Public Health. Matthew is also one of the founders of the Colorado Health Equity Project, a multidisciplinary organization that works to “remove legal barriers to equal health access and health outcomes for Colorado’s vulnerable populations,” as its website puts it. Her ambitious book lays out a case for a legal remedy for racial health inequality.

Key to her argument is the historical context of civil rights law, which she sees as a swinging pendulum. Hill-Burton, as we’ve seen, legally enshrined the “separate-but-equal” standard — established in the Supreme Court case Plessy v. Ferguson — within the health care system. Legal challenges to this standard were unsuccessful, until Simkins v. Moses H. Cone Memorial Hospital, the “watershed case,” as Matthew puts it, initiated its unraveling. As she recounts it, the case was brought by black practitioners and patients against a discriminatory hospital in North Carolina that received Hill-Burton funds. The Fourth Circuit Court of Appeals decided in favor of the plaintiffs, declaring, as quoted by Matthew, that “Racial discrimination by hospitals visits severe consequences upon Negro physicians and their patients.”

She describes two consequences that flowed from this decision. First, the case helped catalyze subsequent *successful* health-care related civil rights litigation throughout the country. Second, the decision — which the Supreme Court importantly declined to reconsider — helped lead the way to Title VI of the Civil Rights Act of 1964. According to Matthew, Congress took the Supreme Court’s decision not to accept the case as a signal that it saw hospital segregation as unconstitutional (and, indeed, several legislators explicitly cited the Simkins decision during debate over the bill). Much good came from this: “From 1963 through the early 1990s,” Matthew writes, “Title VI proved an effective weapon against the segregation and discrimination that minority patients and physicians had experienced in American health care since the colonial era.” For instance, the Johnson administration required hospitals to comply with Title VI in order to be eligible for Medicare payment. Few could afford not to, and so the age of explicit hospital segregation finally came to a close.

Yet Matthew asserts that, to an extent, this more auspicious era ended abruptly in 2001, when a more conservative Supreme Court ruled in Alexander v. Sandoval, in a decision written by Justice Antonin Scalia, that Title VI was applicable only in cases of deliberate discrimination; disparate impact was not enough.[19] This new standard precluded a great deal of civil rights litigation because it required that plaintiffs produce tangible evidence that racist health care was intentional, which is made difficult when, as she notes, “few Americans are careless enough to create an evidentiary record of outright bigotry.” Thus, according to Matthew, with respect to health care discrimination, this decision effectively rendered Title VI “a dead letter.” This decision, she argues, must be undone if progress against racial health inequalities is to proceed. In short, unconscious racism in health care must, according to her, be made illegal through an act of Congress and an expansion of Title VI.

This may sound Orwellian to some. Is it meaningful, after all, to talk about outlawing sentiments or attitudes that lie deep within the dark depths of our unconscious? Can we root out biases if we are, by definition, unaware of their very existence? Matthew marshals a body of literature from various disciplines to answer *in the affirmative*. Conscious racism, she argues, is slowly being replaced by the unconscious variety: “But while overt racism is subject to nearly universal derision, unconscious racism due to implicit bias is hidden, is tolerated, and even excused despite its destructiveness.” She persuasively explores various literatures demonstrating that physicians harbor unconscious negative perceptions of blacks. She cites studies that show that patient race affects which treatments doctors recommend, how much time they spend with patients, “the level of verbal exchange and shared decision-making in which they engage” with patients, and even the manner of their nonverbal engagement. She concludes that there is a sufficient base of evidence to conclude that these implicit biases contribute to disparities, that there is reason to believe that such biases, even though they are implicit, are remediable, and that health care providers — both on the individual and institutional level — can therefore be held legally responsible for the results of their implicit biases.

The “evidence of malleability” is strong, according to Matthew. In other words, she thinks specific interventions can mitigate implicit biases and, as a result, disparate outcomes. The sorts of interventions she envisions, however, seem of mixed applicability and utility. Nonetheless, overall, she makes a strong case that clinicians make racially biased decisions, whether or not they intend to, and that this issue must be directly addressed. People like me — that is to say, white physicians who believe they are immune from racially biased thought and action — have a great deal to gain from reading this book.

That said, it is also important to examine the larger picture. There is no question that more needs to be done to address physician bias. Yet we also have to keep in mind that, in the pre-Alexander v. Sandoval era (when Title VI was, according to Matthew, more robust), there were still large racial inequalities. Litigation may be a useful tool, but it’s a limited, post-facto modality.

More broadly, the recommendations of both Tweedy and Matthew ultimately seem inadequate. Neither gives much credence to the notion that further increasing the universalism of the health system might play an important role in reducing inequalities. Moreover, Tweedy says nothing, and Matthew only a little,[20] about the notion of economic redistribution as a tool against racial health inequalities. In fairness, these concerns are not the focus of their books. However, to my mind, they are crucial considerations in the larger discussion of racial health care justice.

4. Health equity and health system universalism

Martin Luther Kings Jr.’s statement on the evils of health inequality is frequently quoted, but not usually in its full form. In his 1966 speech at the annual meeting of the aforementioned Medical Committee for Human Rights, he said, “Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.”[21] Indeed, studies have shown a statistical association between lack of insurance and mortality. Removing the boundaries between individuals and the health care system is a critical step in the movement toward health care equality.

Tweedy, for instance, sees firsthand the harm inflicted on the uninsured when he works at the rural health clinic described earlier. But, even so, like Matthew, he gives insufficient attention in his book to the fact that, even with the reforms of the Affordable Care Act, we will continue to lack universal health care.[22] For instance, under current reforms, 27 million are expected to remain uninsured 10 years from now, according to an approximation of the Congressional Budget Office. We know that ~~Hispanics~~ (LatinX) and blacks are disproportionately represented among the uninsured.[23] Covering these excluded millions seems critical. Moreover, neither author discusses the fact that the US health care system imposes substantial financial burdens at the “point of use,” in the form of copayments, deductibles, and co-insurance for medical care, which may deter care for those who need it. Some have legitimately suggested that these forms of cost-sharing disproportionately harm minorities, who have lower median income and net wealth.[24] In other words, the potential harm of, say, a $2,000 medical deductible is dependent on your income and assets: those with fewer resources may lose out on important health care. And finally, though Tweedy refers to the shortcomings of Medicaid, neither he nor Matthew emphasizes that a health care system with a separate tier of access for the poor may be inherently unequal.

But would “true” universal health care do much to combat racial health inequalities, if it were, say, a single-payer system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] Or would it replicate current biases and inequalities? To some extent, the answer is yes to both questions. But even so, a body of research has suggested that, even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities. That evidence comes from what is arguably a quasi-single-payer system located in the US: the Veterans’ Administration (VA). Notwithstanding recent scandals that are indeed of great concern, the modern-era VA has justifiably earned praise for delivering a high — indeed, comparatively superior — quality of health care.[26] There is also evidence that it may indeed effectively reduce, even potentially eliminate, some racial health inequalities.

Last fall, a study published in Circulation, the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. “The US Veterans Health Administration (VHA),” as the study notes in its introductory section, “is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks.” The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a “healthcare system that allows enrollment independent of race or socioeconomic status.”[27] Consistent with previous studies, in their analysis of data from the general (non-VA) population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality (after adjusting for various other factors) as compared to whites (indeed, approximately 40 percent to 50 percent higher).[28]

In striking contrast, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually lower among blacks. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless, the fact is that, as described by the investigators, these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality.[29]

No doubt, there are still discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] If we moved to a single-payer system on a national level, such biases would still need to be addressed along the lines Matthew argues. But the point is that a more egalitarian structure of the health care system itself might go even further in reducing them. Indeed, in light of this research, it seems fair to say that health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities. Attaining health care equality, in other words, *requires* true *equality of access*. And *yet this* simple notion *is* all too *often ignored* entirely *in* any *discussion* of health “disparities.”

**Elements of the squo echo this call for an untouched market. That pro-rollback perspective would place *millions of lives at risk*.**

**Gee ‘20**

et al; Emily R. Gee is a senior fellow and the senior economist for Health Policy at American Progress. In her role, she guides policy development and advocates for reforms to expand coverage and improve care. Her areas of expertise include health coverage and affordability, health care financing, and the Affordable Care Act. She has been quoted and her work has been cited in The New York Times, The Washington Post, Politico, Forbes, Vox, and other publications. Prior to joining American Progress, she was an economist in the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services and worked on implementation of the Affordable Care Act. Gee also served as an economist on the staff of the Council of Economic Advisers in the Obama White House, tracking health care coverage and reviewing regulation related to provider payments, prescription drugs, and insurance. Gee earned her doctorate in economics from Boston University, where she researched health insurance markets and taught health economics. She holds a bachelor’s degree in government from Harvard College. “10 Ways the ACA Has Improved Health Care in the Past Decade” - March 23, 2020 - #E&F – modified for language that may offend - https://www.americanprogress.org/issues/healthcare/news/2020/03/23/482012/10-ways-aca-improved-health-care-past-decade/

Ten years ago this month, the Affordable Care Act (ACA) was signed into law. Since then, the law has transformed the American health care system by expanding health coverage to 20 million Americans and saving thousands of lives. The ACA codified protections for people with preexisting conditions and eliminated patient cost sharing for high-value preventive services. And the law goes beyond coverage, requiring employers to provide breastfeeding mothers with breaks at work, making calorie counts more widely available in restaurants, and creating the Prevention and Public Health Fund, which helps the Centers for Disease Control and Prevention (CDC) and state agencies detect and respond to health threats such as COVID-19.

Despite the undeniably positive impact that the ACA has had on the American people and health system, President Donald Trump and his allies have (~~been on a mission~~ (strived) to dismantle **the law** and reverse the gains made over the past decade—first through Congress and now through a lawsuit criticized by legal experts across the political spectrum. Even if the U.S. Supreme Court rules the ACA constitutional after it hears the California v. Texas health care repeal lawsuit this fall, President Trump’s administration cannot be trusted to put the health of the American people ahead of its political agenda. Trump’s administration hasn’t delivered on Trump’s commitment to “always protect patients with pre-existing conditions.”

The consequences of ACA repeal **would be dire**:

Nearly 20 million people in the United States would lose coverage, raising the nonelderly uninsured rate by more than 7 percent.

135 million Americans with preexisting conditions could face discrimination if they ever needed to **turn to the** individual **market** for health coverage.

States would lose $135 billion in federal funding for the marketplaces, Medicaid, and the Children’s Health Insurance Program (CHIP).

Insurance companies **would no longer be required to issue rebates** when they overcharge Americans. In 2019, insurance companies returned $1.37 billion in medical loss ratio rebates to policyholders.

The tax revenue that funds the expanded health coverage under the ACA would become tax cuts for millionaires, who would receive an average of $46,000 each.

As the nation awaits a final ruling on the lawsuit, the Center for American Progress is celebrating how the ACA has helped the American people access affordable health care in the past decade. In honor of the law’s 10th anniversary, here are 10 ways in which it has changed Americans’ lives for the better. Each of these gains remains at risk as long as the Trump administration-backed lawsuit remains unresolved.

1. 20 million fewer Americans are uninsured

The ACA generated one of the largest expansions of health coverage in U.S. history. In 2010, 16 percent of all Americans were uninsured; by 2016, the uninsured rate hit an all-time low of 9 percent. About 20 million Americans have gained health insurance coverage since the ACA was enacted. The ACA’s coverage gains occurred across all income levels and among both children and adults, and disparities in coverage between races and ethnicities have narrowed.

Two of the biggest coverage expansion provisions of the ACA went into full effect in 2014: the expansion of Medicaid and the launch of the health insurance marketplaces for private coverage. Together, these programs now cover tens of millions of Americans. Nationwide, 11.4 million people enrolled in plans for 2019 coverage through the ACA health insurance marketplaces. Medicaid expansion currently covers 12.7 million people made newly eligible by the ACA, and the ACA’s enrollment outreach initiatives generated a “welcome-mat” effect that spurred enrollment among people who were previously eligible for Medicaid and CHIP.

2. The ACA protects people with preexisting conditions from discrimination

Prior to the ACA, insurers in the individual market routinely set pricing and benefit exclusions and denied coverage to people based on their health status, a practice known as medical underwriting. Nearly 1 in 2 nonelderly adults have a preexisting condition, and prior to the ACA, they could have faced discrimination based on their medical history if they sought to buy insurance on their own.

The ACA added a number of significant new protections for people with preexisting conditions. One group of reforms involved changes to the rating rules, prohibiting insurers from making premiums dependent on gender or health status and limiting their ability to vary premiums by age. The ACA also established guaranteed issue, meaning that insurers must issue policies to anyone and can no longer turn away people based on health status.

Another crucial protection for people with preexisting conditions is the ACA’s requirement that plans include categories of essential health benefits, including prescription drugs, maternity care, and behavioral health. This prevents insurance companies from effectively screening out higher-cost patients by excluding basic benefits from coverage. The law also banned insurers from setting annual and lifetime limits on benefits, which had previously prevented some of the sickest people from accessing necessary care and left Americans without adequate financial protection from catastrophic medical episodes.

3. Medicaid expansion helped millions of lower-income individuals access health care and more

To date, 36 states and Washington, D.C., have expanded Medicaid under the ACA, with 12.7 million people covered through the expansion. While the Medicaid program has historically covered low-income parents, children, elderly people, and disabled people, the ACA called for states to expand Medicaid to adults up to 138 percent of the federal poverty level and provided federal funding for at least 90 percent of the cost.

Medicaid expansion has led to better **access** to care and **health outcomes** for low-income individuals and their families across the country. A **large body of ev**idence shows that Medicaid expansion increases utilization of health services and diagnosis and treatment of health ailments, including cancer, mental illness, and substance use disorder. Medicaid expansion is associated with improvements in health outcomes such as cardiac surgery outcomes, hospital admission rates for patients with acute appendicitis, and improved mortality rates for cardiovascular and end-stage renal disease. Beyond health outcomes, evidence points to improved financial well-being in Medicaid expansion states, including reductions in medical debt and improved satisfaction with one’s current financial situation. A study that assessed eviction rates in California found that Medicaid expansion is “associated with improved housing stability.”

Evidence shows that Medicaid **expansion saves lives**. According to a 2019 study, Medicaid expansion was associated with **19,200 fewer deaths** among older low-income adults from 2013 to 2017; **15,600 preventable deaths occurred in states that did not expand** Medicaid. As the Center on Budget and Policy Priorities points out, the number of adults ages 55 to 64 whose lives would have been saved in 2017 had all states expanded Medicaid equals about the number of lives of all ages that seatbelts saved in the same year.

**Access and a broader set of health options are good:**

**Medicine once exerted power over patients. Such concerns are increasingly dated – health is *now* a site to invert dyads of power.**

**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).

# 2ac – round 6

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### 2AC – A2: Epistemology/Framework

#### It’s a cookie-cutter over simplification to say that all scholarship or all subjectivity is neoliberal – it elides the nuance necessary to win the alt

Watts 21 [Galen Watts is Guest Professor with Special Appointment and Banting Postdoctoral Fellow, based at KU Leuven, “Are you a neoliberal subject? On the uses and abuses of a concept” 8-6-2021 Sage Journals]

On neoliberalism (4): What is a ‘neoliberal subject’?

Admittedly, scholarship on ‘neoliberal subjects’ varies in its theoretical sophistication and empirical support. Moreover, as social scientists have become increasingly familiar with the theoretical frameworks informing neoliberalisms (2) and (3), the number of empirical studies making use of one or both of these conceptions has grown exponentially. So, let me be clear: in what follows, my concern is with a particular type of social scientific scholarship on neoliberalism (4) and the distinct errors and oversimplifications it perpetrates. What distinguishes this type of scholarship is that it seeks not merely to critique the ideal typical notion of a ‘neoliberal subject’ (as defined by neo-Marxists and/ or Foucaultians), but also to demonstrate empirically the extent to which either/both neoliberalisms (2) and (3) have successfully penetrated into the psychic and embodied lives of actual individuals, by means of three discursive criteria: within this scholarship, neoliberal subjects are (a) those who invoke the language of personal responsibility or have been ‘responsibilized’; (b) those who value autonomy and speak in the language of individualism; and (c) those who employ the rhetorics of authenticity and selfrealization, and who conceive of their self as a thing to be worked on and improved. The problem with these criteria, we shall see, is that they are excessively broad, multivalent and insufficient to prove what they purport to.

Personal responsibility and responsibilization. Sociologists seem to agree on the ‘centrality of the discourse of personal responsibility in the neoliberal era’ (Foster, 2016, p. 94). As Luxton (2010, p. 180) illustratively remarks in Neoliberalism in Everyday Life, ‘The extent to which people accept personal responsibility both reveals the depth to which neoliberal ideologies have penetrated personal life and shows the centrality of such ideologies for the success of neoliberalism’. Indeed, if one had to boil what it means to be a ‘neoliberal subject’ down to a single concept, ‘responsibilization’ – the process whereby individuals are ‘made responsible’ for their choices and actions, while the state increasingly surrenders responsibility for their health, economic security and well-being – would be a legitimate candidate. Across a range of studies, scholars claiming allegiance to either/both neo-Marxist and Foucaultian theoretical traditions more and more interpret invocations of ‘personal responsibility’ as evidence of ‘neoliberalism’. For instance, in her analysis of the popular memoir Eat, Pray, Love, authored by Elizabeth Gilbert, Williams (2014, p. 620) finds in the book’s pages what she refers to as a ‘neoliberal spiritual subject’ on the grounds that this subject ‘is held responsible for putting in the “work” necessary to be happy and healthy’. And paying homage to Foucault, Williams writes that reading Gilbert’s popular memoir calls to mind ‘the neoliberal vision of the individual as entrepreneur of the self’ (2014, p. 625). Similarly, in his study of mindfulness programs in UK schools, Reveley (2016, p. 498, p. 499) draws on a synthesis of neo-Marxist and Foucaultian approaches, which he argues hold that ‘neoliberalism’s ideological correlates are personal autonomy, self-reliance, and responsibility’ in order to make the case that these programs responsibilize individual subjects because they make them ‘responsible for their own emotional well-being’. Reveley (2016, p. 498) further contends that mindfulness ‘is a practical technique that transmits the neoliberal self-responsibilizing impulse down to young people’. And in her study of Mexican migrants participating in an English language program, Ullman (2012, p. 463), drawing explicitly on the work of Harvey and Rose, argues that because her study participants view learning English as their own personal responsibility, they are repeating a ‘neoliberal mantra’. While I do not doubt the affinities between neoliberalisms (1), (2) and (3) and the rhetoric of personal responsibility, there are real problems with using the existence of the latter as evidence of the former. For one, there is nothing inherently ‘neoliberal’ about the discourse of personal responsibility, given its semantic approval by a whole gamut of other ideologies and political rationalities – be they, conservative, communitarian, civic republican and social democratic. Indeed, personal responsibility is a deeply entrenched value in democratic societies, widely considered integral to being a moral agent (Mounk, 2017, p. 160). For another, scholars have shown that in many texts alleged to disseminate ‘neoliberal discourse’, there often exist alternative conceptions of responsibility at play (e.g. Trunka & Trundle, 2014; Sletto & Nygren, 2016). Of course, an objection might be that whether or not individuals subscribe to alternative conceptions of responsibility, the fact of neoliberalism (1) cannot be dismissed. In other words, processes of responsibilization are taking place and these conditions force individuals to ‘become responsible’, regardless of their convictions. There is undoubtedly truth in this. As the Welfare State has been dismantled, leaving populaces increasingly unprotected and insecure, individuals have done what any and all humans do in the face of change: adapt. Thus, it is reasonable to conjecture that in order to ‘get by’ in these precarious times, we must become, to some extent, self-responsible subjects and furthermore, that reading Eat, Pray, Love, learning to practice mindfulness and accepting responsibility for learning English in some sense encourages and bolsters this process. Yet, even if the above story is correct, it is still not the case that what we end up with are going to be ‘neoliberal subjects’ if by this we mean something that bears some clear relation to neoliberalism (2), or even neoliberalism (3). Recall that neoliberalism (2) presumes a degree of popular, if alienated, consent; neoMarxist scholars presume that neoliberal ideology exists as doxa, in Bourdieu’s sense, informing common-sense understandings. But as Davies (2014, p. 316) remarks, there is a heated debate ‘as to whether neoliberalism is “alive,” “dead” or in some paradoxical “zombie” state’. While Don Kalb (2012, p. 319) contends that ‘neoliberalism, in whatever hybrid or even “parasitic” ... form, appears as less intellectually convincing, popularly legitimate, and more openly and radically confronted than ever in the last three decades’. In agreement, I would argue that neoliberal ideology is, in fact, extremely contested and actually not widely adhered to by ordinary citizens (even in the most ‘neoliberal’ country – America (see Saad, 2019)), so it seems unwarranted to treat the mere fact of adaptation as evidence of a wholesale embrace of neoliberal ideology. Indeed, we need to make space for the distinction proposed by Hilgers between ‘neoliberal dispositions’ and ‘dispositions produced by neoliberalism’ (2013, p. 85). But what of neoliberalism (3)? Arguably these case studies offer clear instances of neoliberal discourses and governmental technologies, which encourage individuals to become ‘entrepreneurs of the self’. But can we even say this much? Recall that, for Foucault, the new homo oeconomicus is the ultimate market actor, one who seeks opportunities for self-investment at every turn. It seems to me that this is patently not what we find in these case studies – or, more charitably, the evidence for this claim is rather weak. For why should we assume with Williams and Reveley that thinking one should bear some responsibility for one’s health and happiness is necessarily evidence of neoliberal reason? This stretches the notion of homo oeconomicus beyond anything resembling what one finds in Foucault’s writings. Or, consider how Ullman goes about identifying the ‘neoliberal mantra’ of the Mexican migrants she studied. One of her interviewees, Raul, informed her that he had a ‘failure of the will/una falta de voluntad’ because he only watched an hour of the English language program he had purchased. When asked why he did this, Raul responded that ‘it was boring’ (Ullman, 2012, p. 463) Ullman interprets this as follows: ‘This interpretation takes the program itself, its quality and the effectiveness of its pedagogical approach, out of the conversation, and makes learning English solely an individual responsibility’ – which, in Ullman’s view, is clearly ‘neoliberal’ (2012, p. 463). But is this conclusion justified? Is it really ‘neoliberal’ to feel one has failed personally because one got bored and failed to do one’s homework? Again, this is a long way from the figure of homo oeconomicus identified by Foucault. Still, there is another claim, implicit in Ullman’s analysis, which is worthy of consideration, as it has become increasingly common: discourses are allegedly ‘neoliberal’ to the extent that they obscure the structural dimensions of social life – that is, to the extent that they are methodologically individualistic.

Autonomy and individualism. Next to the discourse of personal responsibility, scholars tend to zero in on the language of autonomy and individualism as proof of ‘neoliberal subjectivity’. In fact, processes of responsibilization and ‘autonomization’ are generally considered discursively tethered, if not complementary. For instance, in their analysis of Norwegian and Turkish media discourse, Tu¨rken et al. (2016, p. 37), drawing on the work of Foucault and Rose, identify the normalization of ‘a responsible subject who needs “self-control” in order to “take charge of” and “to be able to live life”’ They write, ‘Different voices in our data discursively construct the individual as an autonomous subject who is encouraged to “take action”, “take personal responsibility”, and “work hard” to achieve a “happy life” (2016, pp. 37–38), thereby concluding that mainstream media discourse in these countries serves to disseminate ‘neoliberal thinking’ (2016, p. 35). In their study of psychotherapeutic discourse Lamarre et al. (2019, p. 239) write, ‘Neoliberal governmentality can be seen as a “conduct of conduct” (Foucault, 2008) or a strategic creation of a specific form of subjectivity’ (p. 239). They argue that psychotherapeutic discourse normalizes and produces this ‘normative neoliberal subjectivity’ which they characterize as ‘autonomous, freely choosing subjects continuously involved in self-improvement’ (2019, p. 244). They conclude, ‘Psychotherapy is inevitably informed by and potentially further perpetuates neoliberal ideology’ (Lamarre et al., 2019, p. 242). And in his study of ‘workplace spirituality’, invoking a synthesis of neoMarxist and governmentality approaches, LoRusso (2020, p. 6) contends that workplace spirituality is a ‘technology of the self’ which ‘produces the quintessential capitalist subject, a radically individualist subject for whom reality is itself merely the results of individual choices about how it is to be experienced’. Thus, for LoRusso, what makes ‘spirituality’ neoliberal is the fact that it promotes a ‘program of individual rather than social change’ (LoRusso, 2017, p. 68). Now, just as with the blanket condemnation of ‘personal responsibility’, the problem with automatically subsuming the language of autonomy and individualism under the conceptual umbrella of ‘neoliberalism’ is that it ignores Durkheim’s (1969) key insight that individualism is both a collective and polyvalent discourse, holding widely divergent consequences depending on how it is interpreted. Indeed, it is well established within sociology that there exist multiple individualisms, rooted in distinct cultural traditions (Bellah et al., 1985). Thus, as Barnett (2005, p. 11) fittingly cautions, by subsuming all individualistic rhetoric under the category ‘neoliberalism’ scholars theorize out of sight alternative political rationalities that, while wedded to the value of individual autonomy, may conceptualize this ideal in quite different ways. Moreover, as cultural sociologists have shown, individuals adopt different technologies, devices and discourses in different contexts, adapting them to their particular aims and present circumstances (Swidler, 1986). So, while it might be true that, in some instances, individuals invoke a methodologically individualistic discourse which exalts the individual over the social, it is theoretically naı¨ve to suppose that, by necessity, this discourse is always and everywhere invoked by said individual. As Scharff (2016, p. 115) remarks, ‘entrepreneurial discourses are negotiated in contexts that provide a range of discourses’. Accordingly, it seems reasonable to question any necessary connection between individualistic talk and endorsement of neoliberalism (2). Still, could we not plausibly interpret these case studies as instances of neoliberalism (3)? That is, as genealogical attempts to trace the forms of neoliberal reason underlying the governmental technologies and discourses of media, psychotherapy and workplace spirituality? Much as before, it is not clear that what we find in these case studies is in fact the kind of neoliberal reason of which Foucault has written, since mere talk of individual autonomy and free choice is insufficient evidence of homo oeconomicus. But even were we to accept this claim, it seems to me that these case studies do not actually limit themselves to neoliberalism (3), but rather make the leap to neoliberalism (4). The shift from neoliberalism (3) to neoliberalism (4) is subtle, but significant. It is characterized by a shift from the genealogical and textual analyses of Foucault and early governmentality scholars like Rose – which sought merely to chart the emergence of new discourses and associated technologies – to empirical analyses of how these discourses and technologies are allegedly internalized by actual subjects. Again, Foucault did not conceive of homo oeconomicus as a real empirical subject. Moreover, early governmentality scholars did ‘not suppose that governmental rationalities automatically determine subjectivities’ (Barnett et al., 2008, p. 629), nor did they concern themselves with the way specific discourses or technologies are implemented, adopted or refused by actual persons (Rose et al., 2006, p. 100). However, this epistemic humility has become increasingly rare in recent years – as these case studies aptly illustrate. For instance, Lamarre et al. write, ‘Following poststructuralist lines of thought, we might understand the power of the neoliberal capitalist state as both restrictive and Watts 11 productive, but always shaping what we know and how we know ourselves to be’ (2019, p. 239, emphasis added). While LoRusso maintains that, ‘At the individual level, these discourses penetrate, possess, and produce the expectations and dispositions of persons’ such that workplace spirituality ‘reshapes employees into willing participants in a neoliberal social order’ (LoRusso, 2020, p. 23, 13, emphasis added). Interestingly, Tu¨rken et al. (2016, p. 43) are more cautious. They conclude their study: ‘Although media is a powerful tool to disseminate meaning and thereby influence subjectivity in society, people do negotiate their own understandings and may even oppose media’s positioning of subjecthood’, adding, ‘The present study does not investigate how media discourse on self-development is negotiated by the readers’. And yet, after noting this critical and consequential limitation of their research, only a few lines below they boldly assert a claim for which they have provided little actual evidence: ‘the dominant individualistic subject of contemporary society is reproduced and refashioned as an entrepreneur of herself’ (Tu¨rken et al., 2016, p. 44). Accordingly, for these scholars, the homo oeconomicus identified by Foucault is no longer a mere speculative fiction of the human capital theorist’s making, but allegedly captures the psychic and embodied life of the majority of people in the twenty-first century.

The problem is that this methodological leap – from neoliberalism (3) to neoliberalism (4) – is frequently not warranted. As Tu¨rken et al. would admit, discourse analysis of media articles, psychotherapeutic manuals and workplace spirituality texts does not provide us with a transparent window into the psychic lives of individuals – what many accounts of ‘neoliberal subjectivity’ claim to have accessed. Indeed, the presumption that ‘publicly observable rationalities, procedures and techniques of state and non-state actors can be read as proxies for processes of subject-formation’ is simply untenable (Barnett et al., 2008, p. 626). And as Scharff (2016, p. 108) usefully reminds us, ‘there has been little empirical research that explores the contours of entrepreneurial subjectivity and, even more specifically, its psychic life’.

Here, then, we confront the gap between neoliberalism (3) and neoliberalism (4): It is one thing to identify discourses, technologies and apparatuses – it is something else entirely to contend that they actually induce subject-formation (Barnett, 2005, p. 10). Now, this is not to say that neoliberalism (3) cannot lead to neoliberalism (4). On the contrary, I do not doubt that neoliberal discourses have been internalized by some, shaping their behaviour and self-understanding. But the fact of the matter is these representative studies provide little evidence to show this. Furthermore, other empirical studies make clear that the story is far more complicated, involving processes of discursive contestation and refusal which are too often ignored. For instance, upon conducting interviews with freelance journalists about how they respond to popular ‘personal branding’ discourses within their industry, Vallas and Christin (2018, p. 24) found that ‘interviewees respond to entrepreneurial discourse in a multiplicity of ways, defying characterization in simple or uniform terms’. They also found that national cultural repertoires, occupational norms and the degree of material precarity experienced by these journalists considerably shapes the extent to which they become the ‘enterprising self’ naturalized in neoliberal reason (Vallas & Christin, 2018, p. 28). And in his qualitative study of how middle-class individuals read self-help books, Lichterman (1992, p. 422) writes, ‘They read books ambivalently, and in ongoing relation to other frameworks for situating personal selfhood in a social context’, thereby concluding, ‘We can not assume in advance that we know how strong or how unified an ideological message it is that self-help book readers read out of their self-help books’ (1992, p. 423). Houghton usefully explicates the implications that follow from these insights:

This difference between the actual and the ideal is a point that is at times forgotten in Foucauldian accounts of subjectivity: the extent to which individuals become a certain type of subject is always an empirical question, hence the need for empirical research. So, while we can talk of neoliberal subjects, this is not to say agents will operate exclusively through that frame. (Houghton, 2019, p. 622)

Ironically, while this might be typical of contemporary ‘Foucaultian accounts of subjectivity’, they actually conflict with the work of Foucault himself. As Green (2010, p. 318) notes, in his mature work Foucault endorsed the view that ‘disciplinary power is both more complex in its effect and perhaps less effective in subjectification than proposed by popular post-structural approaches’. It would seem, then, that even Foucault would have had trouble accepting much scholarship that claims to have identified neoliberalism (4).

Authenticity and self-realization. According to many sociologists, the ‘entrepreneurialization of subjectivity’ (Christiaens, 2019, p. 95) veils itself most conspicuously behind the language of authenticity and self-realization. The idea is that to speak, as so many today do, of the importance of ‘realizing one’s potential’, ‘improving oneself’ and ‘seeking personal growth’, is to have subjected oneself to neoliberal governmentality. To give some examples: in his analysis of the emerging discipline of Happiness Studies Binkley (2011, p. 383), an avowed disciple of Foucault, contends that ‘the current discourse on happiness’ serves as a technology of ‘neoliberal subjectification’. He writes, ‘To govern oneself through the maximization of one’s potential for happiness is to govern oneself as a subject of neoliberal enterprise’ (2011, p. 340). In their analysis of self-help discourse, Erjavec and Volcic (2009, p. 139), citing Wacquant and other neo-Marxists, critique ‘the (neo)liberal imperative of constant retraining, a “just-keep-on-learning” mentality, selfdevelopment and individual responsibility’. And in her study of contemporary spirituality, Altglas (2018, p. 87), drawing on Foucault and Rose, writes that ‘Spirituality’ entails ‘accepting the necessity for the individual to commit to a process of change, learning, and progress – what “spiritual seekers” and their teachers call “working on oneself”‘. She concludes, ‘Spirituality as self-discipline and the kind of self it celebrates... constitutes a particular way to exert power in affinity with neoliberalism’s political and economic mechanisms of privatisation’ (2018, p. 95). The notion that the rhetorics of authenticity and self-realization signal a ‘neoliberal subject’, while theoretically provocative, is problematic. For one, as Laidlaw (2015, p. 913) reminds us, ‘The idea of taking the self as a project of self-discovery in the West goes back at least to Stoicism and has been there in Asia in Buddhism and Confucianism for centuries’. In fact, the conviction that each individual has a potential that is unique to them, and that it is their life’s vocation to realize this is arguably constitutive of the modern identity (Taylor, 1989). So, why should we assume that maximizing one’s Watts 13 potential for happiness, a ‘keep-on-learning’ mentality, or continually seeking to develop one’s self are distinctly ‘neoliberal’? There seems to me no necessary connection between these qualities and endorsement of neoliberalism (2). Nor do I see a necessary connection between these features and the ‘entrepreneur of the self’ naturalized in human capital theory. Again, one potential response is that I have made an error in presuming that these scholars do, in fact, assume the success of these technologies and discourses in constituting or subjectifying actual individuals. Perhaps their only concern is with the governmental technologies and discourses themselves. That is, perhaps they are not endorsing neoliberalism (4), but rather limiting their analyses to neoliberalism (3). On this modified account, the claim would be that positive psychology, self-help and spiritual books function as technologies and devices of neoliberal governmentality, which naturalize ‘neoliberal discourse’, given their naturalization of the ideal of a self-responsible, autonomous and self-realizing subject. While this claim may be more modest, it is still not without issues. And the reason for this is that it is not merely neoliberalism which presupposes and prescribes the ideal of a self-responsible, autonomous and self-realizing subject, but that this has also been a staple of liberalism since its inception, given its critique of excessive government (Burchell, 1993). Indeed, it is for precisely this reason that Rose made sure to distinguish between ‘neoliberalism’ – which he views as a ‘highly specific rationality’ (Rose et al., 2006, p. 97) – and ‘advanced liberalism’ – which he views as ‘something with a more general salience, which underpins mentalities of government from all parts of the political spectrum’ (Rose, 1996, p. 60). In other words, according to Rose, while a neoliberal programme may well find alignment with advanced liberal forms of rule, it would be wrong to reduce the latter to the former. It should not surprise us, then, that Rose has offered strong words against what he refers to as

a kind of cookie-cutter typification or explanation, a tendency to identify any programme with neo-liberal elements as essentially neo-liberal, and to proceed as if this subsumption of the particular under a more general category provides a sufficient account of its nature or explanation of its existence. (Rose et al., 2006, p. 98).1

Furthermore, it is critical to note that Rose, like Foucault, has long distanced himself from the kind of socio-critique implicit in neoliberalism (2). And the reason for this is that he seems to think, given that advanced liberalism is the regnant form of political rule, we are all subject to it in one way or another (Barry et al., 1996).

Where does this leave us? I would put it this way: If we accept that neoliberalism (1) has created socio-economic conditions that have forced individuals to adapt and thereby become, to some extent, self-responsible subjects, then it might well be that all of us, simply by virtue of inhabiting these social conditions, have become ‘neoliberal subjects’. Indeed, if we accept Rose’s claim that we are all subject to advanced liberal forms of rule, then this would seem a natural corollary. However, the difficulty with this conception of ‘neoliberal subject’ is that it is not clear what ‘neoliberal’ in this instance actually means. It is clearly not neoliberalism (2), since this would entail not just adaptation, but acquiescence such that we, as individuals, had accepted the basic tenets of neoliberal 14 European Journal of Social Theory XX(X) ideology. Nor is it clear that it entails neoliberalism (3), which entails having one’s subjectivity constituted by neoliberal reason. Thus, it seems to me far more accurate to say that we are all (or most us, anyway) liberal subjects – those who, in one way or another, conceive of ourselves as self-responsible, autonomous and self-realizing subjects. Though it goes without saying that such a claim is not all that illuminating.

Conclusion

Let me be clear: I do not doubt that, in some cases, neoliberalisms (1), (2) and (3) have led to the production of actual ‘neoliberal subjects’ – that is, living breathing homo oeconomicus. For instance, I would conjecture that the world of corporate finance is probably densely populated with such subjects (e.g. Neely, 2020). And indeed, in my own research, I have found that Charismatic Christians who subscribe to ‘prosperity gospel’ approximate the ‘enterprising self’ normalized in human capital theory (Watts, forthcoming). However, I am quite sceptical of the claim that neoliberal subjects populate each and every social sphere, as if we are all in the thralls of neoliberal ideology, or govern ourselves exclusively according to the dictates of neoliberal reason. That said, this obviously remains an urgent research question. But if we are to pursue it, we require a methodological approach that is sensitive to institutional specificities, the extent to which discourses are polyvalent, and the complexities involved in the production of psychic and embodied subjectivities, not just a loose discourse analysis of governmental texts.

Why? For both academic and political reasons. First, the academic: to the extent that neoliberalisms (1), (2) and (3) exist, it only muddies the water to overinterpret them. Indeed, we would do better to practice analytic precision when labelling something (or someone) ‘neoliberal’. This is especially the case when researching across national contexts: it is simply not accurate that every citizen of Western liberal democracies is equally ‘neoliberal’, either in the sense that they adhere to neoliberal ideology or that they live according to neoliberal reason. And as a growing number of scholars have maintained, it is misleading to interpret the subjective lives of citizens of East Asia and the Global South as wholly colonized by either neoliberalisms (2) or (3) (Ferguson, 2009; Parnell & Robinson, 2012). However, even within specific national contexts, we must make sure to recognize that identities and discourses are multiple, such that mere invocations of aspects of ‘neoliberal discourse’ should not be taken as evidence of a comprehensive ‘neoliberal subjectivity’. In short, if our aim as social scientists is to capture the complexity, richness and diversity of subjective life in the twenty-first century, then we ought to broaden the ‘repertoire of subjectivity’ (Green, 2010, p. 331) carried in our analytic toolboxes.

Second, the political: for those of us who find something abhorrent about neoliberalisms (1), (2) and (3), it may actually undermine our cause to repeatedly give the impression that one or either of these have seeped into the subjectivities of everyone presently living. One reason for this is that to the extent that we overlook, or dismiss, extant alternative social and moral forms, we may unwittingly serve to bolster neoliberal ideology and reason, aiding and abetting their spokespeople in their goal of global domination. Indeed, John Welsh (2020, p. 68) suggests that if we are to oppose neoliberalism in all of its forms, academics must begin to ‘introduce contingency back into the interstices of this seemingly impenetrable edifice’. Interestingly, this strategy actually aligns with the mature work of Foucault, for whom scholarship should seek to disrupt that which is taken for granted. Drawing on this Foucaultian legacy, Cornelissen (2018, p. 144) convincingly argues that ‘resistance should be given a more prominent analytical role in the critique of neoliberalism’, adding, ‘resistance is not secondary to the elaboration of alternatives; rather, moments of refusal must guide the formulation of alternative analyses’. Cornelissen concludes, ‘what is at stake politically is our capacity to imagine practices or resistance to neoliberalism and to take seriously those modalities of resistance that already exist’. I could not agree more. And for this reason, I think we should be far more careful when invoking the monolithic notion of a ‘neoliberal subject’.

#### the AFF’s method of redeploying political institutions against resiliency solves

Juntunena 14 (Tapio Juntunen, School of Management, University of Tampere, and Ari-Elmeri Hyvönen, Department of Social Sciences and Philosophy, University of Jyväskylä, 2014, “Resilience, security and the politics of processes,” Resilience: International Policies, Practices and Discourses, 2(3), 2014, p.195-209)

Arendt’s emphasis on the public and collective nature of political action also sets our approach somewhat apart from the tentative suggestions made by Evans and Reid on the topic of going beyond the resilient subject. Their approach builds on the idea of the ‘poetic subject’, capable of ‘thinking the atmospheric-aesthetic-affective register differently’.68 As with Chandler above, we tend to agree with the general lines of their argument, such as the call for ‘reintroducing political meaning back into the world’.69 However, when it comes to Evans and Reid’s notion of the poetic subject, the above reservations apply here as well. Furthermore, our worry is that the Nietzschean–Foucauldian ‘art of the self’ promoted by them is not adequate to the task of rescuing politics proper from the perils of resilience.70 We fail to see how the politics of the ‘art of the self’ manages to overcome an individualistic bias in order to take the necessary step towards changing the structures and political institutions of the world. While it is important to resist resilience on the same ground where it makes its principal interventions – on the construction of the individual subject – it is even more crucial to act against the undoing of political structures and institutions – the processualisation of everything – by resilience policies. It is in the safeguarding of these shared structures of meaning that the Arendtian approach can make its foremost contribution. This brings us to the assessment made by Evans and Reid according to which resilience can be seen as an anti-politics of nihilism, a political will to nothingness. To us, this seems to hit the mark. From an Arendtian perspective, this is because practices of resilience intensify the process whereby public spaces and the shared world of meaningful structures disappear. Arendt argued that ours is the ‘objective situation of nihilism where nothingness and nobodyness threaten to destroy the world’.71 However, the problem of resilience is thus not so much that it ‘cheats us of the notion of learning to die’,72 as it is that resilience is the latest phase in the long process steadily depriving us of the possibility of a second birth, the birth of the public self. This loss is not unrelated to our conceptions of life, death and immortality, however. Resilience-centred liberalism is able to go on ‘living without death’ because the societal life process has taken the part of the individual, whose lifespan is limited. In our society, the only thing that can be ‘potentially immortal, as immortal as the body politic in antiquity and as individual life during the Middle Ages, [is] life itself, that is, the possibly everlasting life process of the species mankind’.73 However, for Arendt, ‘learning how to die’ is not the solution. Neither care for life (or ‘making life live’74) nor coming to terms with death is in itself political. What matters is the establishment of a public space where neither of these concerns constitutes the focal point of attention. In Heidegger’s and Arendt’s footsteps, we argue that death is always mine individually. In other words, there is no political potential in coming to terms with death. While fostering the life process surrenders politics to necessitarian-processual attitudes, the care for death is a question of the existential (Arendt says metaphysical), rather than the political, since it is essentially a question of the self and not of the world.75 Nihilism, then, derives from a deterioration of a meaningful common world and politics. As Arendt put it in a powerful passage: The answer to the question of the meaning of politics is so simple and so conclusive that one might think all other answers are utterly beside the point. The answer is: The meaning of politics is freedom [ . . . ] Today this answer is in fact neither self-evident nor immediately plausible [ . . . ] Our question is thus far more radical, more aggressive, and more desperate: Does politics still have any meaning at all?76 While such questions as free will and choice are no doubt important for human liberty, Arendt is steadfast in holding that the experience of freedom proper is only possible among equals in a public space. As she puts it in another succinct statement about the theme: ‘the raison d’eˆtre of politics is freedom, and its field of experience is action’.77 Without the human artifice and human institutions – public space in particular – any meaningful action is not possible. As Chandler has also pointed out, the exercise of freedom is only possible if we can ‘conceive of ourselves as acting meaningfully in the world – i.e. in relation to temporal and spatial structures’.78 As we already pointed out above, the public world, like every relationally constituted in-between, has the double function of bringing people together and separating them simultaneously; it gathers us together, and ‘prevents our falling over each other’.79 Consequently, as Margaret Canovan explains, without the world human beings cannot be plural individuals but merely interchangeable members of a species.80 Since the world is seen as a product of meaningful human interaction, it is also possible to change it. By acting together as a collective, human beings can change the structures of this world and start new endeavours within it.81 This Arendt-inspired conceptualisation is in stark contradiction to the image of human capabilities painted by the resilience-based security discourses, one of the key tenets of which is the belief that, amidst the demand to cultivate individual adaptive capacities and social cohesion, we cannot change the world in any meaningful sense. No radical departures from the societal life process are possible. Yet, if we consider humans as acting, instead of behaving beings, it is exactly the disruptions of processes that matter. Each political act, as Arendt explains, . . . bursts into the context of predictable processes as something unexpected, unpredictable, and ultimately causally inexplicable – just like a miracle. In other words every new beginning is by nature a miracle when seen and experienced from the standpoint of the processes it necessarily interrupts.82 Conclusion In this article, we have traced the emergence of the resilience discourse from ecology and complexity thinking to politics, and the area of security policy and governance in particular. We have noted that the modes of thinking derived from these sciences, when brought to the realm of politics, have detrimental consequences for the basic activities of politics as acting and for the exercise of public freedom. In ecology, resilience is understood as a capacity of a system to absorb disruptions, and it not only maintains its functions but also renews and reorganises as a result. In this kind of thinking, the processual nature of living systems becomes an all-embracing fact of life. We then moved to the analysis of the consequences of this kind of thinking for the concepts of security, public freedom and political action itself, emphasising the problematic nature of reactivity and vulnerability implied in resilience thinking. Towards the end of the article, we provided preliminary thoughts on the possibility of surpassing this predicament. We argued that what is needed is not another philosophical idea, or even a return to a previously articulated idea. As Chandler notes, we need to develop a ‘practical political approach’.83 Resilience invites us to accept that we are fundamentally vulnerable and that the world is a complex bundle of emergent and overlapping socio-ecological processes to which we can only respond by societal adaptation and assimilation, not through political structures in a traditional manner. We see this as an indication of actively promoted, self-imposed powerlessness. This is detrimental for a plurality of reasons, beginning with the fact that it prevents us from effectively tackling the political issues behind the insecurities we face. Our wager is that what is needed in today’s global and seemingly complex world is keeping open the agonistic spaces of political contestation, of public spaces where problems, challenges and threats to the common world can be addressed.

#### ( ) Perm – do the Alt. Doesn’t sever – that’s our Negative State Action thread.

#### ( ) Neg conditionality uniquely bad – they can’t “judge kick” and default to an ethics disad. Not reciprocal – plan can’t be kicked. Hurts depth of education by making Alt “no cost”. Voter.

### 2ac – neolib

#### Link is reductionist and can’t explain US-EU divergences

Foster 19 [Chase Michael Foster was a Doctoral Candidate at Harvard University at the time of this dissertation. The author has served as a Election Observer (OSCE, ODIHR) in Moldova, Belarus, Russia, Georgia and as a Teaching Assistant at the Harvard Kennedy School of Government. At the time of this writing, the author held a MPP (Democracy, Politics, and Institutions) from the Harvard Kennedy School of Government. “The Politics of Delegation: Constitutional Structure, Bureaucratic Discretion, and the Development of Competition Policy in the United States and the European Union, 1890-2017” – Doctoral dissertation to The Department of Government, Harvard University, Graduate School of Arts & Sciences. In partial fulfillment of the requirements for the degree of Doctor of Philosophy in the subject of Government - January 2019 - #E&F –https://dash.harvard.edu/bitstream/handle/1/41121359/FOSTER-DISSERTATION-2019.pdf?sequence=1]

Ideational Theories

Any analysis of the change in antitrust enforcement over time must begin with a consideration of ideas. Most of the existing social scientific scholarship on competition policy emphasizes the role of changing economic paradigms in spurring the transformation of European and American competition policy. A number of scholars of American antitrust have explained the dramatic decrease in antitrust enforcement as stemming from the shift in authority from lawyers to economists at the antitrust agencies (Eisner 1991). Others have emphasized the institutionalization of Chicago School-inspired economic ideas within antitrust jurisprudence (Ergen and Kohl 2017; Davies 2010; Pitofsky 2008). Both of these sets of accounts capture an important component of the shift. As theories of economic efficiency changed in the US academy during the 1960's and 1970's, much of the postwar enforcement program was delegitimized. Beginning in the early 1970's, both the prevailing judicial opinion on antitrust and the enforcement program of the antitrust agencies dramatically shift, leading to a precipitous drop in enforcement output, especially in areas such as vertical restraints, monopolies, and exclusionary practices.

The increase in the intensity of European enforcement has also been explained as the result of ideational change. Some EU scholars have argued that the institutionalization of neoliberal economic ideas in European regulatory law has led to the intensification of regulatory enforcement (Thatcher 2013; Buch-Hansen and Wigger 2010; Wigger 2008). Concomitant to the Single European Act, the European competition directorate began to more intensely apply competition rules, and to shift its enforcement focus to state aid, publicly-owned companies, and the promotion of competition in previously protected network industries (Quack and Djelic 2005). During the late 1990's, competition law modernization led to a more neoliberal approach to the evaluation of market competition, while also expanding the breadth and intensity of enforcement (Wigger and Nolke 2007).

While each of these accounts points to some of the real ways that ideational change affected competition policy in each system, there are problems with explaining opposite trends as the result of the same paradigm shift. An ideas-only approach leaves us in the awkward position of explaining both the increase in the intensity of competition enforcement in the EU and the decrease in antitrust enforcement in the US as resulting from the same (or similar) neoliberal policy paradigm. While any analysis of competition policy developments must account for ideational change, we need to understand why the same set of ideas has produced different patterns of enforcement in Europe and the United States.

Additionally, there are empirical gaps in the ideational explanation. Certainly, the influence of the Chicago School cannot account for why US regulators have failed to follow much of the neoliberal prescription for liberalization and industrial policy. Chicago School economists, after all, have long supported the application of antitrust in these areas (Van I lorn 2015; McChesney 1986; Bork 1978). Moreover, there is no shortage of classically-trained economists in the European competition system.

#### There’s no residual link – the antimonopoly tradition mobilizes reform coalitions, and it’s compatible with the goals of redistribution

Berk 19 [Gerald Berk, Professor of Political Science at the University of Oregon, 11-25-2019, "Antimonopoly and the Democrats," Dissent Magazine, <https://www.dissentmagazine.org/online_articles/antimonopoly-and-the-democrats>]

Democrats are waking up to the realities of economic power. Less than a decade ago, the subject was taboo. Even with the economy in ruins, Democratic leadership saw no option beyond neoliberalism. But since the 2016 primaries, a split has opened up in the party. With it has come a resurgence of antimonopoly politics that neoliberal leaders can no longer ignore.

At first blush, it looks like antimonopoly heightens the conflict between socialists committed to overcoming capitalism and establishment centrists seeking to save it from populist attacks on the left and right. But antimonopoly once contributed to mobilization, coalition building, and sustained reform across the liberal-left spectrum, and it might do so again today.

The Antimonopoly Tradition

Democracy and markets are fragile and demanding systems, easily corrupted by formidable concentrations of power. The antimonopoly tradition recognizes this fragility, and it makes no sharp distinction between economic and political power. Excessive concentrations of political power undermine economic prosperity no less than excessive concentrations of economic power corrupt democracy. The problem for law and public policy in a democracy with markets seems simple: how to check the constant tendency to concentrated power. There’s no clear-cut way to do that, because those who seek to attain power and lock in privilege are endlessly inventive. Under the right conditions, institutions designed to check power can be used to opposite ends. As a result, antimonopoly is far more than an ideology. It is a political project that requires vigilance, action, and constant adaptation.

Reformers have drawn on the antimonopoly tradition—which is far more wide-ranging than just antitrust, a set of policies designed to prevent predatory competition and break up concentrations of economic power—throughout U.S. history. In the 1830s, Jacksonians used it to authorize privatization, dismantling the Second Bank of the United States because it locked in the privilege of an overweening aristocracy. Abolitionists in the 1840s and 1850s drew on the antimonopoly tradition to dismantle the slave power. In the 1880s, populists enacted state antitrust laws to check the growth of corporate power. In the first decades of the twentieth century, Progressives went further, breaking up corporate power and boosting countervailing forces in government, unions, and proprietary enterprise. In the New Deal, the antimonopoly tradition broke the power of banks and industrial corporations and paved the way for regulation, collective bargaining, and welfare provision. In the 1940s, liberals drew on it to outlaw discriminatory pricing and check the predatory power of chain stores. In the 1950s and 1960s, antitrust administrators broke up patent monopolies, opening the way to high technology.

The antimonopoly tradition, as this sketch demonstrates, has enabled diverse political projects. In the first Gilded Age, it provided a challenge to laissez-faire constitutionalism—the legal doctrine that markets were autonomous from politics, and that property and contracts always protected individual liberty. In today’s Gilded Age, the antimonopoly tradition confronts market fundamentalism: the belief that liberty is best realized in market transactions insulated from democratic interference; that it is possible to organize markets effectively without government supervision; and that we ought not worry about concentrations of economic power, either because they are efficient or temporary.

The turn to market fundamentalism had a major impact on the practice of antitrust, severing it from its roots in the antimonopoly tradition. The University of Chicago–trained lawyer Robert Bork, who published The Antitrust Paradox in 1978, convinced Reagan’s Justice Department that antitrust blocked efficient forms of business organization. Left alone, corporations and capital markets could decide better than government regulators whether mergers, hostile takeovers, outsourcing, or breaking up and selling off corporate assets would serve consumers. If the result was concentrated power, so be it. In time, the Democrats agreed that the only goal of antitrust was to protect consumers. By 1992, antitrust had disappeared from their platform for the first time in a century.

The resurgence of the antimonopoly tradition among Democrats indicates a sea change in how they approach economic governance. Rather than limiting debate to after-the-fact redistribution, they have begun to ask how markets and business organizations can be structured to check concentrations of power. Many Democrats are converging on a platform to rebuild a more democratic economy, even as they disagree in fundamental ways over what that means, who should benefit, and how to achieve it. Still, the antimonopoly tradition’s shared appeal could open new possibilities for party politics and reform. This might seem overly optimistic, but a closer look at how the antimonopoly tradition has informed three ideological factions within the Democratic Party—democratic socialists, (neo)liberals, and antimonopolists proper—illustrates the potential for a broader politics focused on challenging concentrated power and building a more democratic economy.

#### Alt fails---transition is impossible and causes conflict. Even if transition occurs, it doesn’t solve

Smith 19 [Noah; 4/5/19; Bloomberg Opinion columnist, former assistant professor of finance at Stony Brook University; "Dumping Capitalism Won’t Save the Planet," https://www.bloomberg.com/opinion/articles/2019-04-05/capitalism-is-more-likely-to-limit-climate-change-than-socialism]

It has become fashionable on social media and in certain publications to argue that capitalism is killing the planet. Even renowned investor Jeremy Grantham, hardly a radical, made that assertion last year. The basic idea is that the profit motive drives the private sector to spew carbon into the air with reckless abandon. Though many economists and some climate activists believe that the problem is best addressed by modifying market incentives with a carbon tax, many activists believe that the problem can’t be addressed without rebuilding the economy along centrally planned lines.

The climate threat is certainly dire, and carbon taxes are unlikely to be enough to solve the problem. But eco-socialism is probably not going to be an effective method of addressing that threat. Dismantling an entire economic system is never easy, and probably would touch off armed conflict and major asdasd upheaval. In the scramble to win those battles, even the socialists would almost certainly abandon their limitation on fossil-fuel use — either to support military efforts, or to keep the population from turning against them. The precedent here is the Soviet Union, whose multidecade effort to reshape its economy by force amid confrontation with the West led to profound environmental degradation. The world's climate does not have several decades to spare.

Even without international conflict, there’s little guarantee that moving away from capitalism would mitigate our impact on the environment. Since socialist leader Evo Morales took power in Bolivia, living standards have improved substantially for the average Bolivian, which is great. But this has come at the cost of higher emissions. Meanwhile, the capitalist U.S managed to decrease its per capita emissions a bit during this same period (though since the U.S. is a rich country, its absolute level of emissions is much higher).

In other words, in terms of economic growth and carbon emissions, Bolivia looks similar to more capitalist developing countries. That suggests that faced with a choice of enriching their people or helping to save the climate, even socialist leaders will often choose the former. And that same political calculus will probably hold in China and the U.S., the world’s top carbon emitters — leaders who demand draconian cuts in living standards in pursuit of environmental goals will have trouble staying in power.

The best hope for the climate therefore lies in reducing the tradeoff between material prosperity and carbon emissions. That requires technology — solar, wind and nuclear power, energy storage, electric cars and other vehicles, carbon-free cement production and so on. The best climate policy plans all involve technological improvement as a key feature.

### 2ac – reps t/l

#### Our reps aren’t mobilized to drive violent responses. That “link” is wildly undertheorized. Prefer our epistemology because this card rules.

Van Rythoven ‘15

Eric Van Rythoven holds a Masters, Political Science and International Relations from Carleton University. The author is a PhD candidate at Carleton University studying emotion, securitization, and world politics. The author also serves as a Corporate Social Responsibility Analyst – From the Article: “Learning to feel, learning to fear? Emotions, imaginaries, and limits in the politics of securitization” - From the Journal: Security Dialogue - Vol. 46(5) 458-475 - October - obtained via Sage Journal Database

Despite a growing interest in the role of emotions in world politics, the relationship between emotion and securitization remains unclear. This article shows that persistent, if sporadic, references to fear and emotion in securitization studies remain largely untheorized and fall outside conventional linguistic and sociological ontologies. The tendency to discuss emotion but deny it ontological status has left securitization theory incoherent. This article offers a theoretical reconstruction of securitization where emotion, specifically collective fears, serve as the locus of an audience's judgment for the practice of securitization. Yet rather than simply accepting that fear facilitates securitizing moves, the article draws on appraisal theory from psychology to argue that collective fear appraisals are often fragile cultural constructs. The generation of these emotional appraisals is often constrained by the limited symbolic resources of the local security imaginary and how agents contest and employ these resources. When the capacity to generate collective fears is constrained, so too is the practice of securitization. An empirical discussion of threat images in US foreign policy is used to explore these constraints. The tendency for securitizing moves to be interpreted as comic underscores the precariousness of social practices seeking to elicit particular collective emotions.

### 2ac – health access reps

#### *If* disease reps cause reality, they CAUSE GOOD PREPARATION, *NOT* SECURITIZED RESPONSES.

Saksena ‘11

Mita – Former Lecturer, Jai Hind College, Bombay University. Also former Research Assistant University of Madras, Project on Implementation of Regulatory and Distributive Policies in Tamil Nadu Joint Project between University of Oslo and University of Madras. Dissertation was overseen and approved by Professor Paul A. Kowert, Associate Professor, Department of Politics and International Relations Florida International University. This Thesis is written by Mita Saksena – the author now holds a Ph.D. in International Health & Human Rights from FLORIDA INTERNATIONAL UNIVERSITY “FRAMING INFECTIOUS DISEASES AND U.S. PUBLIC OPINION” A dissertation submitted in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY in INTERNATIONAL RELATIONS – http://search.proquest.com/docview/952533573

Two hypotheses were tested in this chapter. First, frames represented prominently in the media will tend to mobilize public support for policies associated with those frames. This study indicates that the biomedical frame was the predominant frame in media reports in the sampled period 2004–2007 (Tables 5.4–5.9 and Figure 5.1-5.3). The study also highlights a strong correlation between the biomedical frame and the American public’s worry about the disease and their concern about the likelihood that the disease would strike the United States. The surveys were conducted mainly between December 2005 and in 2006 and the beginning of 2007. Figure 5.1 clearly indicates that between 2005 and the second quarter of 2007, the volume of stories that discussed the impact of avian flu on the United States and the globe as a whole increased. In the second quarter of 2007 all articles dealt with the impact of the disease on the United States. In February 2005, a news story reported that at the national meeting of the American Association for the Advancement of Science, scientists stated that they believed it highly likely that a virus that has swept through chickens and other poultry in Asia would genetically change into a flu that can be transmitted among people.38 At the same time, Cambodia and Indonesia reported their first human cases of avian flu, which turned out to be fatal.39 By November 2005, the WHO's official count of human cases of H5N1 reached 122, with 62 deaths in Vietnam, Thailand, Indonesia, and Cambodia.40 This was followed by news reports of the spread of avian flu to countries such as China, the Russian Federation, Turkey, Italy, and many other countries around the globe. This was also a time when the United States President and Congress launched several initiatives. The Pandemic and All Hazards Preparedness Act was adopted by Congress in December 2006. With this law, Congress mandated for the first time in United States history that the federal government prepare a National Health Security Strategy to guide improvement of the country’s public health emergency preparedness and response capabilities. The second hypothesis tested was that when the biomedical and economic frames dominate media coverage, which is the most common scenario, people will be more worried about the disease. They will be likely to support potentially inconvenient policies intended to address the dangers of the disease. The survey reports show high support for vaccine production and research and willingness on the part of the American public to undertake precautionary measures to deal with the disease. The public did not see the human rights and security frames as relevant. The security frame was more prominent in media stories about bird flu than it was for SARS. It did not, however, show any significant correlation with worries about bird flu. The human rights frame was not very prominent in news stories about bird flu. Part of the reason for this is that the bird flu did not infect humans in the United States, and there were no major issues arising over access to antiviral drugs and vaccines or about quarantine and isolation.

### 2ac – cybernet

#### The alt fails, the plan is good, and there’s no massive violence impact

Ferguson 11 – James Ferguson, Professor of Anthropology at Stanford University, “Toward a Left Art of Government: From ‘Foucauldian Critique’ to Foucauldian Politics”, History of the Human Sciences, 24(4), p. 61-63

One of the founding premises of this special issue and the conference with which it began is that Foucault has been read, and used, in different ways in different academic disciplines. In this article I will discuss one common way of using Foucault’s thought in my own discipline of anthropology. I will suggest that the strategy of using Foucauldian modes of analysis to ‘critique power’ (as it is often put) has frequently led to a rather sterile form of political engagement. Attention to some of Foucault’s own remarks about politics hints at a different political sensibility, in which empirical experimentation rather than moralistic denunciation takes center place. I will reference some examples of such experimentation that come out of my current research on the politics of social assistance in southern Africa (though I do not have space here to give a full exposition of these). The sort of use of Foucault that I have in mind is well represented in the anthropology of development (and the related field of what is sometimes called critical development studies). Here, the characteristic strategy is to use Foucauldian analysis to reveal the way that interventions, projects, etc., which claim to be merely technical or benevolent, really involve relations of power. This is a perfectly reasonable thing to do, but too often, in this field, such a simple demonstration is apparently seen as the end of the exercise. Power has been ‘critiqued’, an oppressive system has been exposed as such, and that seems to be taken as a satisfactory end to the matter.

This impasse in development studies and anthropology is related, I think, to a wider predicament that progressive or left politics seems to find itself in today. The predicament is that the left seems increasingly to be defined by a series of gestures of refusal – what I call ‘the antis’ (anti-globalization, anti-neo-liberalism, anti-privatization, anti-Bush, sometimes even anti-capitalism – but always ‘anti’, never ‘pro’). The current world system, the politics of the ‘anti-’ points out, rests on inequality and exploitation. The global poor are being screwed, while the rich are benefiting. The powerless are getting the short end of the stick. This is all perfectly true, of course, if not terribly illuminating. But such lines of argument typically have very little to propose by way of an alternative ‘art of government’. Governing is exercising power over others, which is what the powerful do to the downtrodden. It appears as something to be resisted or denounced, not improved or experimented with.

My first observation about this sort of analysis is that it rests on what seems tome a very un-Foucauldian idea of the political. Foucault did, certainly, valorize certain forms of resistance, and worked tirelessly to undermine and denaturalize taken-for-granted arrangements of power. But he never suggested that power ought not be exercised, or that it was illegitimate for someto seek to govern the conduct of others. On the contrary, he repeatedly insisted that it made no sense (in his scheme of things) to wish for a world without power.1 Naive readings of Foucault turned his skeptical analytics of power into a simple denunciation. Thus the question (once posed to him by an interviewer) of whether it would be an intolerable use of power for a parent to prevent a child from scribbling on the walls of a house. Foucault’s instructive answer was:

If I accepted the picture of power that is frequently adopted – namely, that it’s something horrible and repressive for the individual – it’s clear that preventing a child from scribbling would be an unbearable tyranny. But that’s not it. I say that power is a relation. A relation in which one guides the behavior of others. And there’s no reason why this manner of guiding the behavior of others should not ultimately have results which are positive, valuable, interesting, and so on. If I had a kid, I assure you he would not write on the walls – or if he did, it would be against my will. The very idea! (Foucault, 1988a: 11–13)

In the same interview, he complained of those who . . . think I’m a sort of radical anarchist who has an absolute hatred of power. No! What I’m trying to do is to approach this extremely important and tangled phenomenon in our society, the exercise of power, with the most reflective, and I would say prudent, attitude. . . . To question the relations of power in the most scrupulous and attentive manner possible, looking into all the domains of its exercise, that’s not the same thing as constructing a mythology of power as the beast of the apocalypse. (ibid.: 11–13)

### 2ac – governmentality

#### Violent governmentality is the squo for Parker immunity – aff solves

Shapiro 14 [Ilya Shapiro, Senior fellow in constitutional studies at the Cato Institute and director of the Robert A. Levy Center for Constitutional Studies, 10-20-2014 https://www.cato.org/commentary/will-real-government-crony-please-stand]

Whatever one’s opinion of antitrust law—mine isn’t too favorable because the law is typically too slow‐​acting to befit a dynamic marketplace—existing immunity doctrines are dangerous because they allow private entities cloaked in government authority to raise prices and restrict choice. Worse, state‐​established cartels frequently harm constitutional rights, such as the right to earn a living, by barring new businesses from opening. The North Carolina case is a prime example of private actors arbitrarily abusing government power to block entrepreneurs from entering an industry and providing for themselves and their families.

Occupational Licensing Laws Are a Government Racket

As George Will put it in his recent column on the case, occupational licensing laws and the monopoly power they grant “are growth‐​inhibiting and job‐​limiting, injuring the economy while corrupting politics. They are residues of the mercantilist mentality, which was a residue of the feudal guild system, which was crony capitalism before there was capitalism. Then as now, commercial interests collaborated with governments that protected them against competition.”

Cato and PLF filed a Supreme Court brief supporting the FTC—you know it’s a bad case when we’re on the federal government’s side!—arguing that courts should only rarely immunize private parties who act on government’s behalf. The Fourth Circuit was not only correct in applying the “active supervision” requirement, but existing immunity doctrines are too lax.

Instead, courts should grant antitrust immunity to private entities acting under state law only where state law commands their restraint on competition, and where that restraint substantially advances an important state interest. This test would help protect the constitutional right to economic liberty against the only entity that can normally create monopolies and yet which today enjoys immunity from antimonopoly laws: the government.

### Agency disad – 2AC

#### Their K’s denies *the option* of health access. That hurts agency and advances the violently essentialized trope of the passive black patient.

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.

RQ 3a: What are the resistance strategies used among marginalized patients with a history of previous discrimination?

Resistance strategies consisted of participants' efforts to challenge and reject the physician's recommended diagnosis or the recommended treatment plan. We reviewed previously identified instances of patient agency in order to identify the instances in which patients' enactments of agency simultaneously functioned as resistance. As Koenig (2011) discusses, resistance is a manifestation of patient agency. Building upon this conceptual understanding, we identified the instances of agency in which patients used both active and passive tactics for enacting resistance to the physician's treatment and/or diagnosis. Using context and Stivers' (2005) definition as a guide, we identified instances of passive resistance (behavior that didn't align with the physician's treatment plan), and several instances of active resistance (behavior that challenged or queried the diagnosis as well as the effectiveness of medication of alternate treatments, p.950).

#### \*Access\* differs from \*care\* - we’re the former – we don’t force patients to go to the doctor.

#### The K’s left paternalism – says black patients don’t deserve THE OPTION of coverage because they’ll underestimate how violent care can be.

#### That’s violent– and built on the trope of passive black patients. Reject that:

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>

Conclusion

In this project, I sought to understand the nature of agency and resistance among black primary care patients. This investigation interrogated several of the assumptions that guide current contemporary health interventions. Health scholars and their subsequent health interventions have asserted that marginalized patients are generally less active and may require "activation" in order to demonstrate the ideal participatory behaviors during the clinical interaction. This approach fails to consider the complexity of factors that influence the health behaviors and beliefs of marginalized and minority patients. It is therefore crucial for health scholars to understand the interdependent relationship between culture, structure and agency. This approach seeks to establish a starting point of inquiry for this research imperative by exploring the ways in which black primary care patients do enact their agency, and in some cases, resistance, during the clinical encounter. This line of research potentially offers an important contribution to behavioral research as it offers a new perspective for *understanding* how marginalized patients are already active, and strategic in their enactment of agency. Such an *understanding* can ultimately provide a cornerstone for accurately identifying and targeting the factors that contribute to health disparities.

### 2ac – Preciado

#### You should be skeptical of everything Preciado writes – They are WRONG about the pharmacy industry

Timothy Smith, PhD Cellular and Molecular Toxicology, “Pharmacopornography: An Interview with Beatriz Preciado”, Comments Section, December 2013, <http://www.theparisreview.org/blog/2013/12/04/pharmacopornography-an-interview-with-beatriz-preciado/> [brackets added to correct pronoun identification]

After reading the interview with Beatriz Preciado, as a scientist, I am compelled to caution others to deeply question anything BP has to say. Her [His] many completely erroneous facts and disturbing misunderstanding of science call into question any of her [his] assertions and even her reasoning. Let’s take just a few from the interview. “…goes back to the invention of agriculture like eighty thousand years ago.” Agriculture is generally thought to have begun about 10,000 years ago in just a few parts of the world. Agriculture arrived much later to many parts of the world. “when I say any technologies it includes writing, which is the oldest technology of all.” Writing emerged only about 3,200 BCE. Sharpened sticks and selectively chosen rocks are the earliest technological innovations. Early humanoids began to use those tools around 2.5 million years ago. Controlled use of fire came into play roughly around 700,000-400,000 BCE. There is also the wheel which first emerged somewhere around 6,000 BCE for pottery (some say as early as 8,000). At around 3,500 BCE the wheel was used for transportation. “That’s how I see the body, as a living political archive. You already have this archive. It’s not like you choose things that are more or less outside of yourself to add onto it. You realize that your body is really dense, stratified, and huge. There are connections and relationships that are already there. If you carefully look at it, you realize that your body archive is connected to the history of the city, the history of design, technologies, and goes back to the invention of agriculture like eighty thousand years ago.” Clearly, if Ms. Preciado’s body is an archive then it is clear that this bodily archive phenomenon is prone to grave inaccuracies and one should still refer to the (notably less whimsical) archives found at museums and respected learning institutions. “the pill, which is one of the most used substances in the history of humanity. Everybody is taking it and we don’t know much about it.” A simple search of PubMed, the US National Library of Medicine, reveals 46,600 scientific publications mentioning the pill. I believe we know something about it. You cannot become a “rat in your own laboratory.” The scientific method requires controls to compare to the test subjects. You cannot be a control for yourself. Stop referring to your testosterone usage as an experiment. Freud was addicted to cocaine; he was not contributing in any way to the scientific pharmacologic understanding of cocaine. Testosterone in 1990 was declared a controlled substance under the Anabolic Steroid Act. Countless athletes and body builders have abused testosterone for years (of both genders). It can be extremely dangerous to abuse and carries significant complications during withdrawal. I note this as Ms. Preciado’s treatment of the drug is so cavalier. “What is happening with AIDS research is that they are also thinking of consumers who can become lifetime consumers. This is how the pharmacopornographic regime works. The disciplinary regime would basically tell you not to have sex outside of reproduction. They would say, Do not go out and have sex in that back room. The pharmacopornographic regime says, No, no, you can fuck as much as you want, but be sure you take your pill.” The developments of AIDS treatments and maybe even a vaccine stems from the desire to ease suffering and disease. If millions of people were not suffering the ravages of AIDS pharmaceutical companies would use their resources to treat other diseases. It may sound exciting and conspiratorial to mischaracterize the pharmaceutical industry’s motives, but it is also misleading regarding the scientific process (which is not a regime rather an organic collaboration between academic researchers and industry scientists) regarding disease research and drug therapies. I hope that those reading the interview will treat what has been said in the interview with a very skeptical mind.