# 1AC Quarterfinals

### 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 prohibited states from imposing excessive costs on the nation as a whole, solely for the purpose of furthering its own intrastate policy interests. 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 biotechnology 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

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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 synthetic biology. 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 biology, 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 regulations 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 Synthetic Biology? 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 wastes, 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 lacked 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 laboratory. “I am not nearly as worried about terrorists as I am about an 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."

#### 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 influenza 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)

### Plan

#### The United States Federal Government should pivot-away from the legal protection it affords to anti-competitive practices via the state action immunity doctrine.

**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 (SOP) 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.”

**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.

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

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

When I first arrived at the Grove, I was taken aback by the kind of intensive management that happened in its exam rooms. Very little of the activity in the clinic looked anything like what I expected to see within the medical encounter. But after months of observation, my initial surprise had settled into expectation. The case of Ms. Payne was not an outlier. Nor was Michelle an organizational aberration. The knitting together she performed for Ms. Payne was emblematic of the work of all the Grove’s NPs—not only for patients undergoing low-risk surgeries but also for those living with end stage renal disease, struggling through the uncertainties of multiple sclerosis, or dying from cancer. After months of watching these NPs at work, I confess that I had started to take this state of affairs for granted: this was the work these NPs did; this was the work the Grove needed them to do. Michelle, however, may not have seen things in quite the same way. As we ended our last conversation about Ms. Payne, Michelle flashed a smile that was not really a smile and asked, “Now what part of all that was medical care?” Her question shook me out of my analytical complacency and, to a large extent, animates the questions at the heart of this account. How should we understand the care that NPs provide? And whose problems are they intended to solve?

From the ten-thousand-foot view of policy, the answers to both questions seem fairly clear. The care NPs provide should, ideally, be the same as that of physicians. Physician indignation notwithstanding, the scholarly consensus is that this is the case. Fifty years of research has demonstrated that patients who see NPs largely have the same outcomes as those who see physicians; when there is a discrepancy, it is usually in the NPs’ favor (Buerhaus et al. 2018; DesRoches et al. 2017; Horrocks, Anderson, and Salisbury 2002; Landsperger et al. 2016; Laurant et al. 2004; Lenz et al. 2004; Martínez-González et al. 2014; Mundinger et al. 2000; Naylor and Kurtzman 2010; Newhouse et al. 2011; Ohman-Strickland et al. 2008; Ramsay, McKenzie, and Fish 1982; Stanik-Hutt et al. 2013). This robust evidence of equivalence grounds our collective assumptions about what NPs are for: to fill in for the missing physician.

Nurse practitioners were, in fact, intentionally created to deal with the growing scarcity of primary care physicians. In the 1960s, that scarcity was triggered by increased demand for services caused by the baby boom and the creation of public health insurance in the form of Medicare and Medicaid (Fairman 2008; Silver, Ford, and Steady 1967). Today, that scarcity is exacerbated by our aging population and the expansion of insurance through the Patient Protection and Affordable Care Act. Meeting this growing demand comes with a cost for insurers as well as health care organizations. That NPs are cheaper to train and less costly to employ than physicians has led to their being championed by policy makers and economists alike.

The NP as policy solution rests on a logic of substitution: when physicians cannot be found or afforded, the NP is a reasonable facsimile. The story of Ms. Payne suggests an alternate view of NP utility. Although paying for medical care remains an issue for many, it was not one for Ms. Payne. Like most Americans, she became eligible for Medicare when she reached the age of sixty-five. However, despite having a payer for medical services, she did not always have access to the full range of assistance she required. Ms. Payne needed help getting back and forth to medical interventions such as her cataract surgery. She needed help adhering to medical regimens such as her postoperative care instructions. Even before any of this practical work commenced, she needed someone to help her think through the help she needed and to coordinate with a range of people and organizations to make it happen. None of this assistance is paid for by Medicare because none of it qualifies as medical care. Even if she qualified for public or charitable programs to meet these needs, accessing and navigating those resources would require both knowledge and time. Although much has been made of the physician shortage, Ms. Payne’s hurdles equally arose from the **scarcity of supportive care**.

Ms. Payne’s story is also an illustration of the intertwined problems of economic and social precarity. Ms. Payne was not only a beneficiary of Medicare; she was also a recipient of Medicaid. Because poverty is the primary eligibility criterion for Medicaid, we often think of it as health care for the poor. However, it might be more accurate to call it long-term care for the ~~disabled~~. While long-term care sometimes includes skilled nursing, it is primarily designed to assist with the activities of daily living, such as bathing, dressing, eating, and toileting. Because these services are excluded from Medicare, individuals and families have to pay for them on their own.

Few can shoulder these costs for years on end. In 2018, the yearly cost for forty hours a week of home care assistance was just under forty-six thousand dollars (Genworth 2018). These expenses are in addition to the mounting costs of medical care. Even the insured are expected to pay some portion of the costs of medications, hospitalizations, and provider visits. If nursing home placement becomes necessary, these costs can increase exponentially. In 2018, the annual cost of a semiprivate nursing home room was just over eighty-nine thousand dollars (Genworth 2018). While some may enter older adulthood in poverty, a great many others become poor as a consequence of failing health and mounting costs. For adults, it is often the combination of poverty and disability that results in eligibility for Medicaid. As a consequence, Medicaid 6 has become the single largest payer for long-term care in the US. In 2015, Medicaid paid for 36 percent of all home health care and 31.7 percent of all nursing home care (Burwell 2016).

Entering older adulthood intensifies not only economic needs but also social needs. In addition to paid care, most older adults rely on the unpaid assistance of family and friends (Freedman and Spillman 2014). Much of this assistance is material, such as help with transportation, grocery shopping, or household maintenance. Social support is also important. While aging itself does not increase social isolation, the illness and disability that often accompany it do (E. Y. Cornwell and Waite 2009a, 2009b; B. Cornwell, Laumann, and Schumm 2008). As one’s needs increase, the resources in one’s personal networks can become strained and sometimes exhausted. Medical vulnerability is often exacerbated by economic and social vulnerability, which in turn can negatively impact health and quality of life (Krause, Newsom, and Rook 2008; Newman 2003).

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

Clinic Work

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

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

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

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

Organizational Care Work

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

Nursing’s Utility under State Retrenchment

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

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

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

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

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

I suggest that, as providers with different professional experiences and held accountable to different expectations, NPs are opening the exam room to a different kind of clinical performance. Not only is this performance **reshaping** our ideas about **medical work**, but it is also a mirror that reflects how we choose to care for our most vulnerable citizens. In this account, I have avoided revisiting the question of what kind of work NPs should or should not do. Rather, I provide a closer look at the work they are actually doing, not just for their patients but for the health care organizations that employ them and for the state, which chooses to care in some ways but not others. In focusing on the work NPs do, I hope to both illuminate and trouble the relationship between who we think should solve our problems and what we understand those problems to be.

#### 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]

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.

**Nurse practitioner led communities of care are effective at managing chronic disease**

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Although evidence-based guidelines on the management of cardiovascular disease (CVD) and type 2 diabetes have been widely published, implementation of recommended therapies is suboptimal.1 The effectiveness of national guidelines for the management of blood pressure, cholesterol, and blood sugar, depends upon how well healthcare providers implement the recommended therapies and how well patients adhere to them. Optimizing adherence to healthy lifestyle behaviors and prescribed drugs to manage cardiovascular risk factors is associated with better outcomes and may reduce healthcare costs.2, 3, 4

Nurse-led, team-based case management including community health workers (CHW), has been shown to be an efficacious strategy to improve CVD risk factors in our own and other studies.5, 6, 7, 8, 9, 10, 11 Research also has demonstrated that nurse practitioners (NP) can provide primary care services of equivalent or better quality and at lower cost than similar services provided by other healthcare professionals.12, 13

This paper summarizes the outcomes and reports on the cost-effectiveness analysis of a program of CVD risk reduction delivered by NP/CHW teams versus enhanced usual care to improve lipids, blood pressure, and HbA1c levels in patients in federally-qualified metropolitan community health centers. Trial Design Complete details of the design of the randomized trial, methods and main findings have been reported previously.8, 14 Briefly, the Community Outreach and Cardiovascular Health (COACH) study was a randomized controlled trial in which 525 patients were randomly assigned to one of two groups: management of CVD risk factors by a NP/CHW team or an enhanced usual care (EUC) group. Patients in the EUC group received care from their primary provider which was enhanced by providing feedback on CVD risk factors to both the patients and their providers. Management by the NP/CHW team included tailored educational and behavioral counseling for lifestyle modification, pharmacologic management, and telephone follow-ups between visits. Participants Patients were recruited between July 2006 and July 2009 from two community health centers which are part of Baltimore Medical Systems Incorporated (BMS), a corporation of federally - qualified community health centers. Patients were identified from medical records using ICD 9 codes and were eligible if they had diagnosed CVD, type 2 diabetes, hypercholesterolemia, or hypertension. They had to be African American or Caucasian, ≥ 21 years of age and able to speak and understand English. In addition, they had to have at least one of the following criteria at the time of the medical record reviews: (1) an LDL-C ≥100 mg/dl or LDL-C ≥ 130 mg/dl if no diagnosed CVD or diabetes, (2) a blood pressure > BP 140/90 mm Hg or > 130/80 mm Hg if diabetic or renal insufficiency, or (3) if diabetic, a HbA1c 7% or greater or glucose ≥ 125 mg. Patients were excluded if they had a non-cardiac co-morbidity with a life expectancy of less than 5 years or if they had a serious psychiatric or neurological impairment that would prevent them from participating in their own care. Of the 3899 screened for eligibility, 525 were enrolled in the trial (Figure 1). The participants were randomly assigned, stratified by ethnicity and sex, to receive the NP/CHW intervention or EUC. All participants provided written informed consent. The protocol was approved by the Johns Hopkins University Institutional Review Board. Intervention The NP/CHW intervention focused on evidence-based behavioral interventions to effect therapeutic lifestyle changes and adherence to drugs and appointments as well as the prescription and titration of drugs. The NP and CHW worked as a team and managed patients for one year. The NP functioned as the case coordinator for each patient. She managed the intervention plan, conducted the intervention including counseling for lifestyle modification, drug titration and prescription, supervised the CHW, and conferred with the physician. Patients also met with a CHW who reinforced instructions by the NP related to lifestyle modifications and drug therapies and assisted patients in designing strategies to improve adherence. The intensity of the NP/CHW intervention was based on the achievement of goals and was guided by study algorithms developed from national guidelines.8 (Algorithms available in Appendix for reference.) Patients in the EUC group and their BMS providers received reports of baseline lipids, BP, and HbA1c along with recommended goal levels. Patients also received an American Heart Association pamphlet on controlling CVD risk factors. Clinical Outcome Measures The primary outcomes were changes from baseline evaluation to one year follow-up evaluation in lipids, BP, and HbA1c. Total cholesterol, triglycerides, and high-density lipoprotein cholesterol (HDL-C) were measured directly after a 12 hour fast. Low-density lipoprotein cholesterol (LDL-C) was estimated using the Friedewald equation.15 If triglyceride levels were greater than 400 mg/dL, LDL-C was measured directly through ultracentrifugation methods. HbA1c was measured using high pressure liquid chromatography. Blood pressure was measured using the Omron Digital Blood Pressure Monitor HEM-907XL automatic blood pressure device according to JNC VII guidelines.16 The average of three blood pressures was noted. Resource Use Measurement and Cost Assignment The cost effectiveness evaluation was performed from a health services perspective. It was assumed that if a healthcare organization were to add these NP/CHW case management services, no additional office space and equipment would be necessary. Costs were not discounted since the time period of the intervention was one year. Costs that related to the process of the research rather than delivery of the intervention were not included. Provider Costs Nurse practitioner and CHW time spent delivering the intervention was collected for a sample of 30% of patients for one year. Patients in this sample were selected consecutively, beginning with a randomly selected patient. The NP and CHW recorded details of patient encounters, including the length of encounters to the closest minute and the types of activities carried out as part of the interventions such as medication counseling, lifestyle counseling, feedback on laboratory results, and physical examinations. They also captured time for preparation and followup activities related to the intervention but outside of the direct encounter with the patient. This non-encounter time included activities such as preparation for visits, documentation in the medical record, consultation with other health care providers, contacting the pharmacy or insurance agency. The number of visits during the year of intervention was also captured. The NP and CHW salaries were based upon the standard wage rates in the 2010 Occupational Employment and Wages from the Bureau of Labor Statistics national estimates for the respective occupations17. The median hourly wage for NP’s (health diagnosing and treating practitioners) was $33.32 and for CHW’s (community and social services specialists) $18.32. Adjustments of an additional 30% for benefits resulted in a final hourly rate of $51.14 for the NP and $25.78 for the CHW. To determine the costs of providing health care for the management of the same conditions in the usual care group, a chart review was completed on a random sample of 53 patients randomized to receive usual care. Data were collected on the number of visits to a Baltimore Medical System health care provider for the treatment of their cardiovascular disease, hypertension, hypercholesterolemia, or diabetes during the year of enrollment in the clinical trial. Expert opinion from the primary care practitioners estimated one hour to conduct the patient encounter and necessary follow-up documentation of these moderate to high intensity level visits. According to the national estimates, the mean hourly wage for family and general physicians was $83.59.17 Adding 30% for benefits the hourly wage for other healthcare provider visits was $108.67. Laboratory Test Costs The costs for laboratory tests used to monitor response and side effects of therapy over the year that patients were in the study were included in the calculations. A chart review of a random sample of 53 usual care patients and 53 intervention patients provided an average number of lipid panels, liver function tests, and hemoglobin A1C tests per patient. The laboratory costs for the tests used in the analyses were $36 for a lipid panel, $42 for liver function tests, and $35 for hemoglobin A1C. Drug Costs An annual per patient average estimate of drug costs was calculated for each group. Current cardiovascular, lipid-lowering, anti-hypertensive and diabetes drugs were identified by patient interview at 6 and 12 months. It was assumed that the patient was on the same drugs for the previous 6-month period. The categories included in these assessments were anti-hypertensive drugs, lipid lowering drugs, drugs to treat coronary artery disease, oral hypoglycemics and insulin. The cost of a 1-month supply of each drug was determined from the 2010 Drug Topics Red Book average wholesale price.18 This cost was multiplied by six (six months of drug) and added to the other six month cost to determine the annual cost for each drug. A total annual cost of all cardiac, hypertensive, lipid-lowering and diabetes drugs was calculated for each patient. Statistical Methods Primary outcome measures were analyzed with an intention-to-treat analysis. General linear mixed models were used to model each outcome variable as a function of time and intervention group controlling for age, sex, race, education, body mass index, insurance and an indicator of in-control for clinical outcome at baseline. A clinician time cost for each patient was calculated by multiplying the average cost per hour of the practitioners’ time (NP and CHW for intervention group and other BMS primary care provider in usual care group) by the average time per visit by the average number of visits. This provider cost was added to the average total cost of drugs and laboratory testing to determine the average total costs per patient. Cost-effectiveness was calculated using four cost effectiveness ratios with the cost associated with the usual care group subtracted from the cost associated with the intervention group as the numerator and the clinical benefit (percent reduction in LDL-C; systolic and diastolic blood pressure; and HbA1c) in the usual care group subtracted from the clinical benefit in the intervention group as the denominator. Sample Characteristics

The sample was predominantly Black (79%) and female (71%). A majority of patients had annual incomes less than $20,000 in spite of having at least a high school education. Less than half had private health insurance. The groups were similar in sociodemographic and baseline measures except for higher HbA1c levels in the NP/CHW intervention group compared to the EUC group (Table 1). There was no statistically significant differential attrition between the two groups. Ninety four percent (n=467) completed the 1-year assessment with no differences between completers and non-completers in baseline lipids, HbA1c, BP, age, education, race, or sex.

Over the course of the one year of intervention, patients had an average of 7.6 (6.9, 8.2) encounters with the NP and 5.3 (4.8, 5.9) encounters with the CHW. (Table 3) This is relative to the average of 2.8 (2.2, 3.5) of visits to other health care providers for cardiac or diabetes management in the usual care group. A total of 84 percent of patients randomized to the intervention group completed an initial visit, and 70 percent had at least four in-person visits with the nurse. Figure 2 details the percentage of time the NP and the CHW spent in the various activities that comprised the intervention. The NP averaged 17 (CI 16, 19) minutes per direct encounter time with the patient and another 16 (CI 14, 17) minutes for non-encounter activities. The highest percentage of time with the patient was spent in counseling regarding medications (43%), followed by lifestyle counseling (22%), physical examination (22%), and providing feedback about laboratory results (13%). A large majority (76%) of non-encounter time was spent in documentation, followed by preparation activities (17%) and coordination of care (7%). The CHW spent an average of 11 minutes per encounter which included in person and telephone follow-ups with a majority of her time focusing on lifestyle counseling (66%), followed by reinforcement of medication counseling (28%), and evaluation of barriers to control (6%). Documentation was the major focus of the CHW’s time outside of direct patient contact (70%).

At 12 months, patients in the intervention group had significantly greater overall improvement in LDL cholesterol, systolic and diastolic BP, and HbA1c compared to patients receiving EUC (Table 2). The estimated between group differences were statistically and clinically significant. At the 12 month follow-up, a significantly higher percentage of patients in the intervention group compared to the EUC group had values that reached guideline goals or showed clinically significant improvements in LDL cholesterol (EUC=58%; I=75%, p<0.001), systolic BP (EUC=74%; I=82%, p=0.018), and HbA1c (EUC=47%; I=60%, p=0.016).

Resources used per patient by arm are presented in Table 3. The increase in laboratory testing and medications in the more intensive intervention arm are apparent, contributing to the increased overall cost of the intervention compared to the cost for usual care. Although patients in the intervention arm were on average taking less than one additional medication compared to those in the usual care arm, the drugs of patients in the intervention arm were more likely to be titrated to a higher dosage which likely contributed to better efficacy but also significantly more expense. In addition, closer monitoring according to guideline recommendations, lead to an increased number of laboratory tests in the intervention group. The total cost for one year of intervention from the NP/CHW team exceeded the cost for MD care; however, the average per patient incremental total cost (NP/CHW - MD) was only $627 (248, 1015).

The cost-effectiveness ratios are presented in Table 4. The cost-effectiveness of the one year intervention was $157 for every one percent drop in systolic blood pressure and $190 for every one percent drop in diastolic blood pressure; $149 per one percent drop in HbA1c; and $40 per one percent drop in LDL-C. The costs for every unit drop in outcome were similar except for HbA1c, with a cost of $1255 for a drop of one unit (i.e. from 8% to 7%).

Comprehensive management of cardiovascular risk factors by NP/CHW teams that includes lifestyle counseling, drug prescription and titration and promotion of compliance is a cost-effective strategy to reduce cardiovascular risk and thereby address health disparities in underserved, minority populations. Chronic illness care in medically underserved patients with CVD or at high risk for CVD is complex. These data add to the body of evidence that specially trained nurse-led teams are efficacious strategies to improve management. A sizeable body of research reinforces that patient care outcomes are similar and sometimes better when patients are managed by NP’s as primary care providers as compared to physicians.19 As the costs of health care for chronic diseases continues to increase, NPs are in pivotal positions to address the need for safe, effective, patient-centered, efficient, and equitable health care.20

This study also provides evidence that a nurse-led team which includes CHWs is an effective model of care. Community health workers are critical members of these teams. They share perspectives and experiences that enhance trust enabling them to effectively bridge communication gaps between patients and healthcare providers and intervene to decrease barriers to adherence. However, adoption and sustainability of this model of care will require financing mechanisms for CHWs. Funding, reimbursement and payment policies for CHWs must be established to ensure that CHW models are adopted in mainstream health care.21, 22

While it is atypical to have four separate cost-effectiveness ratios in a single study, the relatively low incremental cost-effectiveness ratios for each outcome suggests that the effect of any one of the clinical changes may be sufficient to offset the costs. With all four changes simultaneously this would only amplify the individual economic outcomes. The relatively small incremental cost for the additional benefit of LDL-C, blood pressure and HbA1C lowering seen in the NP/CHW group could yield meaningful downstream differences in morbidity and mortality from CHD. Clinical trials with statin lipid-lowering drugs in patients indicate that a 1% decrease in LDL-C reduces risk for CHD by about 1%.23 The **benefit is even greater in those with existing CHD or diabetes**, a CHD equivalent, decreasing stroke rates, improving angina and myocardial perfusion, and decreasing the need for subsequent revascularization.23 Stamler and colleagues estimated that a five mmHg reduction of systolic blood pressure in the adult population would result in a 14 percent overall reduction in mortality due to stroke.24

In conclusion, this study supports NP/CHW teams using evidence-based treatment algorithms as a cost-effective, successful strategy to implement national guidelines for the management of hyperlipidemia, hypertension, and diabetes in high risk vulnerable populations. This is particularly relevant as we plan for the release of new national guidelines in 2013.

Over the next five years, the Affordable Care Act legislation will be infusing 11 billion dollars into community health centers such as the Baltimore Medical Systems.25 Nurse practitioner and community health workers are underutilized resources who should be incorporated into this healthcare reform to increase the quality of care and improve patient outcomes for patients with chronic conditions. The results of this trial also support the potential for nurse-led patient-centered medical homes to improve the quality of care in high risk underserved populations.

**Plan’s a vital structural enabler of increased access and collaboration between communities and health care systems – key to mitigate the distrust that magnifies the impact of structural racism on maternal health outcomes**

**Cortés et al 21** (Yamnia I. Cortés, PhD, MPH, FNP-BC, University of North Carolina—Chapel Hill School of Nursing; and Khadijah Breathett, Division of Cardiovascular Medicine, Sarver Heart Center, University of Arizona; “Addressing Inequities in Cardiovascular Disease and Maternal Health in Black Women,” Circulation: Cardiovascular Quality and Outcomes, 14(2), February 2021, DOI: 10.1161/CIRCOUTCOMES.121.007742)

Recommendations and A Call to ACTION

Bond et al7 present the **Association of Black Cardiologists’** (ABC) working agenda to address the Black maternal health crisis. The ABC was founded over 40 years ago to **address inequities** in CVD burden and **access to cardiovascular care** in populations of color. On June 13, 2020, ABC convened the Black Maternal Heart Health Roundtable, a collaborative task force of stakeholders (eg, community partners, state agencies, researchers, clinicians), to identify strategies to improve Black women’s maternal health. ABC is a stakeholder organization in the Black Maternal Health Caucus and has endorsed the Black Maternal Health Momnibus,11 which calls for investment in: (1) social determinants of health; (2) community-based organizations; (3) women veterans; (4) diversifying the perinatal workforce; (5) data collection and quality measures; (6) maternal mental health care; (7) digital tools to improve maternal health; (8) maternal health of incarcerated women; and (9) innovative payment models supporting quality care and health insurance coverage from pregnancy to one year postpartum. With **Black women** being **disproportionately affected by CVD** and the maternal health crisis, “ABC is proud to be the cardiovascular society at the forefront in addressing the disparate maternal morbidity and mortality.”

The ABC has developed several **recommendations to improve Black maternal heart health**, many of which **address the downstream impact of structural racism**. ABC calls for **collaborative efforts** between community partners, the media, health care workers, educators, researchers, government agencies, and the private sector. An overview of some of these recommendations follows:

Developing community partnerships: **Health care systems** and organizations can work with **community members** to understand and address issues most pertinent to the cardiovascular health of the community. Cardiovascular health has been successfully promoted through outreach programs partnered with churches, faith-based organizations, and local businesses. Dissemination of similar programs can encourage conversations, offer health care services, engage community members to share their experiences, and establish trustworthy relationships.

Using media to enhance public education: Bond et al7 point to the use of media outlets to raise awareness and highlight the stories of influential Black women who can share their experiences. In addition to diversifying the stories that are published, there is a call to include more women of color in the media workforce.

Using multidisciplinary care teams: Access to multidisciplinary care teams is needed across the care continuum from preconception to postpartum care with inclusion of obstetricians, perinatologists, cardiologists, primary care clinicians, emergency medicine professionals, **nurses**, **midwives**, and **doulas**. Moreover, Bond et al7 underscores the **need to diversify the maternal health care team** and incorporate education on racism and bias during their training.

Increasing access to maternal health care: Insurance coverage is needed beyond the immediate postpartum period. Postpartum care is important for monitoring the health of women and preventing complications, particularly among women with chronic conditions. Expanding access to doulas and coverage for doula services is also highlighted. Bond et al7 stress investment in maternal health care for veterans, rural communities, low-income communities, and incarcerated women.

Innovative technologies and telehealth: The use of innovative technologies, particularly during the COVID-19 pandemic, is one strategy to improve access to maternal health care that allows women to interact with specialists’ who are not local. Tools that support telecommunication and remote diagnosis can provide patients more immediate access to care and enhance efficiency of care. However, Bond et al7 caution that the **lack of in-person interactions** may contribute to **patient-provider distrust**.

Research: There is a need to address critical gaps in knowledge in the identification and care of Black women at elevated risk for CVD during the care continuum. Recommendations from ABC include standardizing the management of patients with heart disease in pregnancy and the development and use of interdisciplinary care registries such as the Heart Outcomes in Pregnancy: Expectations Registry. Availability of evidence-based information and data sets, including the Office of Research on Women’s Health Maternal Morbidity and Mortality web portal and Centers for Disease Control and Prevention Pregnancy Mortality Surveillance System, is necessary to adequately track and measure inequities in maternal morbidity and mortality.

The current position article from the ABC is the first comprehensive statement from a cardiovascular society addressing the Black maternal health crisis. While we present a summary of key recommendations from the Black Maternal Heart Health Roundtable, Bond et al7 provide a working agenda and detailed strategies to reduce Black women’s maternal morbidity and mortality through education, research, advocacy, and collaborative efforts.

Current work by Boakye et al6 and Bond et al7 provide an important opportunity for a paradigm shift from models of maternal health that focus on individual behaviors and socioeconomic status, to a **more comprehensive approach** that **addresses the social and structural factors underlying maternal health inequities**. As the **impact of structural racism** on **Black maternal health** is increasingly documented, the time has come to **focus on upstream structural solutions**. **Only** then **can** we **improve existing policies and health care practices** to **tackle the Black maternal health crisis** in the United States.

**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).

**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)

## Additions b/c extra time

#### the aff is antiracist antitrust – the squo and overregulation are the equivalent of voter id laws - Parker immunity blocks enforcement of anticompetitive practices sanctioned by state licensing boards. These boards entrench incumbent interests and exclude communities that lack socio-economic privilege

Weissmann ‘21

Shoshana Weissmann, Senior Manager, Digital Media, Communications; Fellow, 3-11-2021 – modified for language that may offend - https://www.rstreet.org/2021/03/11/we-need-antitrust-reform-for-the-little-guy/

Overhauling antitrust is in vogue. Just last month the House Judiciary Committee launched a new series of hearings to flesh out potential changes to America’s current approach to antitrust enforcement. On Thursday, the Senate Judiciary Committee’s Subcommittee on Competition Policy, Antitrust, and Consumer Rights is having a hearing on antitrust reform. And, in a sign of the times, left-of-center advocates want to ensure antitrust enforcers adopt an “anti-racist” agenda that places marginalized communities at the front of the discussion.

So often when we ~~hear~~ (consider) about antitrust, we think about the government seeking to break up large corporate monopolies. Before Google and Facebook, it was Microsoft. Before that, Ma Bell. But there is plenty of anti-competitive behavior that takes place outside of the realm of big business, and there is a way to reform such behavior that also places an emphasis on protecting disadvantaged communities: Congress can overturn the “state action doctrine” as applied to occupational licensing boards. This doctrine has long allowed semi-governmental occupational licensing boards to act in a blatantly anti-competitive manner—one that has a stark and disproportionate impact on ~~minorities~~ (those lacking socio-economic and-or racial privilege), the poor, and small-business entrepreneurs.

The overwhelming burden these occupational licensing requirements place on these groups is staggering, keeping people from earning an honest living, providing for their families, and contributing to society in the profession of their choice. These requirements include expensive schooling to certify practical skills that can be learned in other ways, or policies that limit participation in fields in the name of “safety,” when those safety issues are overblown.

In the 1950s, 1 out of every 20 people in the United States needed a license to do his or her job. Today, it’s 1 out of every 4. From the Obama administration to President Donald Trump to President Joe Biden, virtually everyone recognizes that something is horribly amiss. Even the Federal Trade Commission (FTC) released a detailed report in 2018 highlighting the dangers of overly burdensome occupational licensing and its disproportionate negative effects.

Bad board behavior is rampant. In recent years, Arizona’s cosmetology board cracked down on a student helping his community by cutting hair for people experiencing homelessness. Had Republican Gov. Doug Ducey not stepped in to help, the student’s career could have been ruined. African hair braider Isis Brantley was once arrested for braiding hair without a cosmetology license—a license that wouldn’t have even taught her to braid hair. In Louisiana, elderly widow Sandy Meadows was prevented by the board from earning a living arranging flowers because Louisiana requires a license to do so and she couldn’t pass an exam with a lower pass rate than the state’s bar exam. When she died, she was living in poverty.

The dirty open secret of occupational licensing boards is that they are often composed almost exclusively of people in the industry who have a direct stake in keeping others out. Cosmetology boards are often stocked with salon owners, for example. This kind of collusive, anticompetitive behavior aimed at entrenching incumbents to the detriment of workers, consumers, and society more broadly is exactly why we have antitrust laws in the first place.

The problem isn’t that enforcers don’t want to act—it’s that they can’t because of the “Parker” or “state immunity” doctrine. For nearly 80 years, there have been severe limits on how federal agencies and private plaintiffs could enforce America’s antitrust laws against a state-sanctioned entity, like an occupational licensing board. Under this doctrine, states are overwhelmingly protected from any kind of antitrust scrutiny, minus a few narrow exceptions.

Thankfully, courts have somewhat pulled back on this doctrine in recent years. In 2015, in a case involving non-dentists who were offering inexpensive teeth-whitening services, the Supreme Court refused to extend this immunity to North Carolina’s state dental licensing board because it was not actively supervised by the government and was composed of self-interested market participants. This decision was a step in the right direction, although its holding was narrow and the Parker doctrine was left largely intact.

Excluding competitors and keeping new entrants out of the market without reason is anticompetitive and should be punished, even when given a state’s stamp of approval. With its laser focus on antitrust, Congress is well-suited to take up the mantle on this issue.

Congress should empower antitrust enforcers like the FTC and DOJ to bring suits against these collusive bodies for their blatantly anticompetitive conduct. It can do this by overturning the state action doctrine’s application to licensing boards and allowing courts to look behind the veil of these “governmental” boards to gauge meaningfully whether they are engaging in intentionally anticompetitive conduct.

#### Medicare and Medicare prove health Law is malleable on race.

Gaffney ‘15

et al; 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. “Racial injustice still rife in health care” – CNN - July 28, 2015 - #CutWithRJ – http://www.cnn.com/2015/07/28/opinions/das-gaffney-racial-injustice-health-care/

Racism mars the history of health care in America. For years, black patients were relegated to separate -- and appallingly unequal -- hospitals and wards. Many were simply denied medical attention, either "dumped" into the care of other facilities or turned away at the hospital door.

Fifty years ago this week, that started to change as Lyndon B. Johnson signed into law two programs -- Medicaid and Medicare -- that constituted real progress in the cause of health care justice. For one, these programs greatly expanded health care access for the elderly and the poor, of all races. Also, building on years of civil rights work and legal challenges, Medicare was wielded to finally end explicit hospital segregation; hospitals hoping to become certified for the program were required to comply with Title VI of the Civil Rights Act.

# 2AC

## federalism

#### 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.

## practitioners

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#### 2 – medical mistrust narratives advanced by the NEG may be warranted, BUT are ALSO are a driver of inequitable health outcomes – plan’s key to overcome mistrust and produce positive encounters that generate health equity

Heath 21 (Sara Heath, Managing Editor at Patient Engagement HIT, graduate of Assumption College, studied English and history, “Community-Based Care Access Next Step in Health Equity,” Patient Engagement HIT, 4-14-2021, https://patientengagementhit.com/news/community-based-care-access-next-step-in-health-equity)

Nurse practitioners could play a big role in expanding community-based care access, creating more health equity in healthcare services.

It’s time for healthcare to take the next step in health equity work.

Over the course of the past year, which brought with it the coronavirus pandemic and a national reckoning on race and racism, the industry has produced countless studies confirming the existence of racial health disparities. The data has piled up indicating that communities of color carried a disproportionate COVID-19 burden compared to their White peers, while racial health disparities in transplant care, maternity care, and breast cancer care have also come to the forefront.

And most experts agree this is a dark stain on US healthcare. Racial health disparities are not only morally wrong and the result of decades of institutional racism in the country, but they also carry with them a hefty price tag. An assessment of Texas alone showed that racial health disparities can run up costs of nearly $7.7 billion in excess costs and lost productivity, according to Episcopal Health Foundation.

But now that the industry has reached the consensus that it must overcome racial health disparities, it is time to start taking action. That action, according to Captain James Dickens, DNP, RN, FNP-BC, FAANP, a regional director for the American Association of Nurse Practitioners located in Texas, needs to focus on community, social determinants of health, and access to care.

“We have to look at the social determinants of health and one wants to recall the social determinants of health can be simplistically put as: where you eat, sleep, and play affects your health,” Dickens, who is also manager of the Survey Branch for the Centers for Medicare & Medicaid Services (CMS) told PatientEngagementHIT in an interview. “If you're living in a food desert, you don't have parks, safe streets, and the like, it tends to have detrimental effects on your health over a period of time.”

The challenge is, those social determinants of health, as well as the patient access to care that comes with them, have been seriously affected by implicit bias and race relations in the US, Dickens suggested.

Racist policies like redlining have resulted in communities of color living far away from quality healthcare, lacking access to safe housing, and missing out on neighborhoods with plenty of green space and access to nutritious food.

“Institutional racism is differential access to goods and services and opportunity based on race,” Dickens added, citing his colleague Dr. Camara Phyllis Jones, a former APHA president. “I wouldn't call it institutional racism necessarily, but I would call it differential access based on race, right? And then what do we have to do?”

“What organizations can do is be intentional in their work,” he answered.

For example, healthcare can take a leaf out of the tech industry’s book, Dickens suggested. After Silicon Valley confronted its homogenous workforce comprised mostly of White males, Dickens recalled many companies prioritized the hiring of qualified women and people of color.

Those companies had to be intentional about advancing diverse candidates through rounds of interviews, Dickens said, in a way that healthcare needs to be intentional about getting communities of color access to healthcare.

And nurses and nurse practitioners can play a big role in that. Physician shortages are a significant issue plaguing patient care access, especially in Texas, Dickens explained. In his home state, 237 of Texas’ 254 counties were designated in 2019 as health professional shortage areas (HPSAs).

“And if you want to do anything to change that, it's a great opportunity in the state of Texas legislature to increase access to care by eliminating artificial barriers for nurse practitioners in the state of Texas,” Dickens explained.

Those barriers, commonly known as scope of practice laws, dictate the extent to which advanced practice providers like nurse practitioners or physician assistants are able to deliver medicine independently.

In some states, scope of practice laws allow NPs and PAs to deliver certain types of medicine without physician supervision, while other states require physicians to sign off on NP or PA healthcare delivery.

“Most of the states during this public health emergency eliminated any barriers or collaboration with physician counterparts to allow nurse practitioners and PAs to see patients all over the state, which increased access to care,” Dickens noted. “In a lot of those counties that I identified as health professional shortage areas, there are no physicians in those counties. And so for a hospital or hospital system to deliver their support for a measure like this would be extremely helpful to eliminate barriers and access to care issues.”

But expanding scope of practice and creating more options for accessing care is only half the battle, Dickens acknowledged. Communities of color may be reticent to access care because the inequality they have faced in the past has eroded patient trust. To close that loop, Dickens said community-based healthcare is going to be important.

#### They must rejoin the plan by proving a unique opportunity cost – testing scenarios of policy changes does NOT compel debaters to defend the state – helps unlearn anti-black assumptions – AND empowers a necessary plurality of new ways of oppositional praxis – they’ve proposed no counter-framework for making a decision nor a stasis for disagreement, and their project to make this space “safe” from problematic representations is counter-productive

Splawinski 16 (A. Splawinski, University of Toronto, “The Internal Backlash of Contemporary Black Liberation,” Harvard Journal of African American Public Policy, 2015-2016, dml)

However, as external pressures complicate activist progression on the social scale, internal conflicts threaten collective identity and the ability to define, organize, and move towards a collective goal. This can be internally demonstrated through the radical/moderate dichotomy, a distinction attempting to reconcile those activists who operate within, as opposed to outside, the traditional political system. However, this ignores the means, ability, and education people might have. Respecting diverse tactics used to reach a similar goal is not only ethical, but also strategic. Short-term goals amid long-term objectives leave room for old-school activists who contend we could live outside of the system we are in, as well as the novice who does not know another system is even a possibility. Political scientist Janet Conway articulates that respecting how other activists engage with issues does not necessarily mean one would choose the same, or even agree with the usefulness or ethics of such an action; “rather, it holds that everyone has the right and the responsibility to identify their own thresholds of legitimate protest and to make their own political, strategical, and ethical choices, while also allowing others to do so free from public criticism or censure.”8 A different tactic does not necessarily make it wrong. These internal activist-group interactions can be seen in the qualification of #BlackLivesMatter and other Black activists being cited as nothing more than a “liberal distraction” by other Black liberationists. The article “#BlackLivesMatter: Black Liberation or Black Liberal Distraction” by Halima Hatimy states that #BlackLivesMatter is composed of Western “Black petit bourgeoisie.”9 I agree that addressing global anti-Blackness is necessary, and that activists should be criticized for not addressing anti-Blackness in non-Western countries or not being proper allies to those in non-Western countries. However, the notion we can stretch criticism to a place where we can say all of this is in vain is unfair. According to Hatimy, an honest effort on the part of the #BLM movement would call for the abolition of oppressive, racist, and capitalistic structures, and demand full social and economic equality, rather than state-implemented reforms and deliberate moves to work in the system. However, framing the movement this way ignores the justifications one may have for advocating for reform as opposed to abolition—one group sees abolition as a plan while the other sees it as a goal. Perhaps, as Judith Butler describes in Critically Queer, there is a kind of “necessary error” occurring here. Butler argues we cannot create the terms that represent our liberation from nothing, and we are responsible for the terms carrying the pain of social injury. “[Y]et, neither of those terms are as a result any less necessary to work and rework within political discourse.”10 Perhaps, even in its faults, there is something uniquely necessary about #BlackLivesMatter and similar Black activist groups, and the multiplicity of tactics used within and outside of these groups. The #BlackLivesMatter movement does not state an end goal of police reformation. Instead, it defines one of its primary goals as “(re)building the Black liberation movement,” explaining that Black poverty and the disproportionate number of Black individuals in prisons are manifestations of state violence.11 Though it is misleading to articulate the movment’s goals as otherwise, counter-movements constituently question the credibility of #BlackLivesMatter by doing so. Ironically, it appears the radical and moderate activists often have the same goal—Black liberation—yet they’ve chosen to employ varied means to achieve that goal. Strategies of the #BlackLivesMatter movement are often critiqued, citing its discussions of privilege, reform of the prison industrial complex, reform of police practice, or meetings with politicians, as a sign of moderation.12 Critics contend if activists were indeed radical, as Hatimy’s article states, they would primarily call for abolition, not reform. However, this presupposes the activists are choosing reform as an end in itself, rather than a means to an end. Unlearning a Eurocentric Worldview Activists, like the general public, are inundated with regulations of Black bodies. This extends from the streets where victims of police brutality lifelessly lie, to the halls of the classroom where Black skin and Black hair are wholly unwelcome. Black girls have been kicked out of school for their natural hair, and dark-skinned women have been barred from entering spaces due to their complexion.13 Further, dark-skinned individuals face a high risk of sometimes violent consequences due to their complexion. Some of these consequences include having lower chances of obtaining employment than their light-skinned counterparts, and even being sentenced to 12 percent more time behind bars for the same crime as compared to light-skinned individuals.14 These legacies of colonialism, slavery, and Jim Crow compound alarming statistics that also demonstrate an increased likelihood of Black Americans being unarmed when killed by the police.15 The intersection of sexuality, race, and place— in addition to the historical contexts of slavery, colonialism, and systematic discrimination—impedes activists’ ability to “unlearn,” or envision ways of being that are outside of dominant or mainstream thinking. The process of unlearning requires activists to move away from the status quo, to see above the examples society presents them and apply a critical lens to their very being. Activists have to grapple with colorism’s impact on the sociopolitical world, and/or why African American English vernacular is framed with negative connotation, similarly to the dichotomy between “good” and “bad” hair, for that which is more straight and silky vis-à-vis curly and coarse. In doing so, activists not only undergo a journey of self-acceptance, but also make political decisions in the process, which are political acts rooted in one’s worth, rebuking Eurocentric consumerist ideals that dictate a “preferred” look, action, or being that confirms to the admissible politics of respectability.16 Activists enter and progress through the unlearning process in different ways. At these varied stages, then, it is troublesome for groups to cast one another aside because of differing perspectives, particularly in terms of methodology. Being at different places in the unlearning process is the reality, and activist groups must accept that as fact. The “Problematic” Identity The radical/moderate divide illustrates a larger problem in activist spaces: activists imposing the all-encompassing “problematic” identity onto one another. The power-hungry and ego-latent activist industrial complex employs a problematic identity on dissenters, casting anyone in the group aside who says or does something not in perfect alignment with their arbitrarily set standard of “activism,” or what may be deemed “appropriate” by the group. Though many groups aim to create safe spaces in order to respect a diverse set of voices and experiences, these groups simultaneously conduct, create, and assert “problematic” identities, which essentially rebuke dissenting opinions and differing viewpoints from the group’s intra-space. By silencing or discrediting dissent, the activity of activism is twisted into an unattainable mold an individual can perfect, rather than existing as a transformative activity that an individual strives to perfect. Through this frame, the internal backlasher’s viewpoints, strategies, and opinions are right, while those of the “problematic” activist are wrong. While the “internal backlasher” may purport him or herself as being open to a variety of lived experiences, eventually the “problematic” activist will not be able to reconcile their feelings with this assumed standard, and may even be qualified as being in the “wrong” phase of unlearning. While it seems contradictory for social movements to operate like quasi-political parties, employing a similar “agree-with-me-or-leave” rhetoric, this phenomenon may help explain why activists aligning with radical or moderate ideologies view their means (and only their means) as the best or safest way to proceed. Rather than critique an off-norm perspective for foundational validity, it is more productive for these groups to explore the rationale behind their choices and examine the reasoning of the dissent for both weaknesses and strengths. Labeling “problematic” that which is “different” dismisses the individual realities of each activist. Through this, the “internal backlashers” refuse to consider their collective goal could be achieved in a number of ways. Rather than assuming rigid value judgments, activists should acknowledge the comfort, safety, and value in the multiplicity of strategies as they may stimulate new ways to think about and exist in Black political spaces. The intellectual entrepreneurship in activist spaces is unlike any other. The need to harmonize ideas and reconcile lived experiences with the cause at hand can only occur when individuals feel safe to fully participate. However, there are scenarios wherein those who are labeled “problematic” face adverse consequences. In “Why This Radical Activist is Disillusioned by the Toxic Culture of the Left,” author Bailey Lamon cites after being termed problematic, or being called out, some activists she knew allegedly lost jobs, relationships, and friends.17 Some felt so alienated they avoid attending certain events or going to specific community spaces. The mental distress of the isolated individuals has even led to suicide. The fear and isolation produced in supposed “safe spaces” not only has adverse consequences, but also stunts the crux of activist activity—the process of unlearning. If not properly mitigated, this could ultimately stall the collective progress of the greater movement. The Impact of Fear There is a fear surrounding activist spaces that functions within the boundaries of the state. In The New Jim Crow: Mass Incarceration in the Age of Colorblindness, lawyer and legal scholar Michelle Alexander carefully describes the waves of reform that did not end racism, but rather merely changed its form. From slavery, through the Jim Crow era, and into the war on drugs and mass incarceration, Alexander explains racism has never left us; it has only become subtler.18 The anxiety of operating within traditional boundaries of institutional politics stems from the idea that perhaps by using purely conventional means, racism will, once again, only change its form—not its quantity or impact. The historical trend of Black activist spaces operating within the confines of the state (either by choice or by force), positions the state as an indicator of morality and success. Yet, when we consider what it means to use the state as an indicator of success, we are reminded the state’s supposed inclusiveness just slightly changes the color of the hierarchy—it does not necessarily reflect day-to-day occurrences on the ground. Clarence Lusane’s What Color is Hegemony? illustrates a version of this by dissecting the appointments of Condoleezza Rice as National Security Advisor and Colin Powell as Secretary of State during the second George W. Bush term. Their appointments raised questions about race relations and the state, as well as the active participation of Black Americans as “high-level functionaries operating within spheres in which they can agree but cannot fundamentally determine.”19 Being an active shareholder in the government’s plan to use economic and military means to ensure a rival power never emerges is worrying, especially when economic and military policy often intertwines with racist and xenophobic ideals. Operating within conventional activist tactics (such as voting) upholds state power, and calling for legislative reform may do the same. However, it is not fair to say these tactics must act in isolation, or that they will forever perpetuate the very systems against which Black activists are fighting. There are ways to simultaneously operate inside and outside of conventional means. For instance, despite being ridiculed as a “miscreant” and an example of “one of the sanctimonious and self-aggrandizing activists [that make] a career out of the Black Lives Matter protests,”20 DeRay McKesson, once at the forefront of unconventional activism, is now running for mayor of Baltimore. When questioned about his intentions, McKesson has said he is not a politician and that a multi-faceted approach to activism is necessary: “It will always be important that people continue to push on the system from the outside. It will also be important that people make the changes that we know are necessary on the inside.”21 We could consider he might be wrong; however, we must also consider he very well may be right. Perhaps a multi-pronged approach to Black activism won’t always be necessary, perhaps it is not the way of the future. Nevertheless, perhaps it is necessary right now. Conclusion Though the use of the radical/moderate dichotomy is necessary to explain the varied tactics employed by activist groups, respecting diverse strategies is sometimes more than ethical—it can be tactical. Demanding perfection via censorship or the constant threat of isolation is not social justice. My argument is not that one should be forced to align with positions for which they fundamentally disagree. However, if the goal is Black liberation, a diverse set of strategies—dependent on varying levels of comfort, ability, knowledge, access, and belief—it should not define alienation. Rather, it should be holistically viewed, with due benefits incurred from each. We should analyze the pros and cons of all tactics, while also exploring the reasons why we choose to use them. Such internal critique is necessary for the future and progress of the Black activist space.

#### ( ) Alt fails and policy framework’s is valuable to learn *even if fiat’s not real.*

Bryant ‘12

(Levi Bryant is currently a Professor of Philosophy at Collin College. In addition to working as a professor, Bryant has also served as a Lacanian psychoanalyst. He received his Ph.D. from Loyola University in Chicago, Illinois, where he originally studied 'disclosedness' with the Heidegger scholar Thomas Sheehan. Bryant later changed his dissertation topic to the transcendental empiricism of Gilles Deleuze, “Critique of the Academic Left”, http://larvalsubjects.wordpress.com/2012/11/11/underpants-gnomes-a-critique-of-the-academic-left/)

Unfortunately, the academic left falls prey to its own form of abstraction. It’s good at carrying out critiques that denounce various social formations, yet very poor at proposing any sort of realistic constructions of alternatives. This because it thinks abstractly in its own way, ignoring how networks, assemblages, structures, or regimes of attraction would have to be remade to create a workable alternative. Here I’m reminded by the “underpants gnomes” depicted in South Park:¶ The underpants gnomes have a plan for achieving profit that goes like this:¶ Phase 1: Collect Underpants¶ Phase 2: ?¶ Phase 3: Profit!¶ They even have a catchy song to go with their work:¶ Well this is sadly how it often is with the academic left. Our plan seems to be as follows:¶ Phase 1: Ultra-Radical Critique¶ Phase 2: ?¶ Phase 3: Revolution and complete social transformation!¶ Our problem is that we seem perpetually stuck at phase 1 without ever explaining what is to be done at phase 2. Often the critiques articulated at phase 1 are right, but there are nonetheless all sorts of problems with those critiques nonetheless. In order to reach phase 3, we have to produce new collectives. In order for new collectives to be produced, people need to be able to hear and understand the critiques developed at phase 1. Yet this is where everything begins to fall apart. Even though these critiques are often right, we express them in ways that only an academic with a PhD in critical theory and post-structural theory can understand. How exactly is Adorno to produce an effect in the world if only PhD’s in the humanities can understand him? Who are these things for? We seem to always ignore these things and then look down our noses with disdain at the Naomi Kleins and David Graebers of the world. To make matters worse, we publish our work in expensive academic journals that only universities can afford, with presses that don’t have a wide distribution, and give our talks at expensive hotels at academic conferences attended only by other academics. Again, who are these things for? Is it an accident that so many activists look away from these things with contempt, thinking their more about an academic industry and tenure, than producing change in the world? If a tree falls in a forest and no one is there to hear it, it doesn’t make a sound! Seriously dudes and dudettes, what are you doing?¶ But finally, and worst of all, us Marxists and anarchists all too often act like assholes. We denounce others, we condemn them, we berate them for not engaging with the questions we want to engage with, and we vilify them when they don’t embrace every bit of the doxa that we endorse. We are every bit as off-putting and unpleasant as the fundamentalist minister or the priest of the inquisition (have people yet understood that Deleuze and Guattari’s Anti-Oedipus was a critique of the French communist party system and the Stalinist party system, and the horrific passions that arise out of parties and identifications in general?). This type of “revolutionary” is the greatest friend of the reactionary and capitalist because they do more to drive people into the embrace of reigning ideology than to undermine reigning ideology. These are the people that keep Rush Limbaugh in business. Well done!¶ But this isn’t where our most serious shortcomings lie. Our most serious shortcomings are to be found at phase 2. We almost never make concrete proposals for how things ought to be restructured, for what new material infrastructures and semiotic fields need to be produced, *and when we do*, our critique-intoxicated cynics and skeptics immediately jump in with an analysis of all the ways in which these things contain dirty secrets, ugly motives, and are doomed to fail. How, I wonder, are we to do anything at all when we have no concrete proposals? We live on a planet of 6 billion people. These 6 billion people are dependent on a certain network of production and distribution to meet the needs of their consumption. That network of production and distribution does involve the extraction of resources, the production of food, the maintenance of paths of transit and communication, the disposal of waste, the building of shelters, the distribution of medicines, etc., etc., etc.¶ What are your proposals? How will you meet these problems? How will you navigate the existing mediations or semiotic and material features of infrastructure? Marx and Lenin had proposals. Do you? Have you even explored the cartography of the problem? Today we are so intellectually bankrupt on these points that we even have theorists speaking of events and acts and talking about a return to the old socialist party systems, ignoring the horror they generated, their failures, and not even proposing ways of avoiding the repetition of these horrors in a new system of organization. Who among our critical theorists is thinking seriously about how to build a distribution and production system that is responsive to the needs of global consumption, avoiding the problems of planned economy, ie., who is doing this in a way that gets notice in our circles? Who is addressing the problems of micro-fascism that arise with party systems (there’s a reason that it was the Negri & Hardt contingent, not the Badiou contingent that has been the heart of the occupy movement). At least the ecologists are thinking about these things in these terms because, well, they think ecologically. Sadly we need something more, a melding of the ecologists, the Marxists, and the anarchists. We’re not getting it yet though, as far as I can tell. Indeed, folks seem attracted to yet another critical paradigm, Laruelle.¶ I would love, just for a moment, to hear a radical environmentalist talk about his ideal high school that would be academically sound. How would he provide for the energy needs of that school? How would he meet building codes in an environmentally sound way? How would she provide food for the students? What would be her plan for waste disposal? And most importantly, how would she navigate the school board, the state legislature, the federal government, and all the families of these students? What is your plan? What is your alternative? I think there are alternatives. I saw one that approached an alternative in Rotterdam. If you want to make a truly revolutionary contribution, this is where you should start. Why should anyone even bother listening to you if you aren’t proposing real plans? But we haven’t even gotten to that point. Instead we’re like underpants gnomes, saying “revolution is the answer!” without addressing any of the infrastructural questions of just how revolution is to be produced, what alternatives it would offer, and how we would concretely go about building those alternatives. Masturbation.¶ “Underpants gnome” deserves to be a category in critical theory; a sort of synonym for self-congratulatory masturbation. We need less critique not because critique isn’t important or necessary– it is –but because we know the critiques, we know the problems. We’re intoxicated with critique because it’s easy and safe. We best every opponent with critique. We occupy a position of moral superiority with critique. But do we really do anything with critique? What we need today, more than ever, is composition or carpentry. Everyone knows something is wrong. Everyone knows this system is destructive and stacked against them. Even the Tea Party knows something is wrong with the economic system, despite having the wrong economic theory. None of us, however, are proposing alternatives. Instead we prefer to shout and denounce. Good luck with that.

#### Disease Reps DON’T cause support for harsh health policy.

Saksena ‘11

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To understand the relationship between changes in media coverage of SARS and changes in public opinion, further correlation analyses were conducted. The three public opinion measures studied were willingness to support harsh public health measures, actual behavioral changes made, and recognition of SARS as a threat. Public opinion polls that asked people whether or not they were willing to support harsh public health measures such as quarantine were first conducted in April 2003 and repeated in May 2003. To examine the correlation between media frames and public opinion, news coverage data from the corresponding time period (March 16, 2003 to June 5, 2003) were included in the analysis. A 5-day interval was chosen to examine the changes over time in the two sets of data. The percentage of positive responses within the four frames of media coverage is shown in Figure 4.3(also see Appendix A4.6). There was no change in public opinion when the survey was repeated in May. As far as the media coverage is concerned, the biomedical ratio decreased from 0.53 to 0.37. The economic ratio showed a modest increase between April and May but then dropped to its original level of 0.11. The human rights and security ratios were very small and changed very little. These results show that changes in frames did not correlate with changes in public opinion. The overall support, however, for harsh measures such as quarantine and isolation was very high and stable at 95% during the sampled period. Thus, the total ratio of coverage with a focus on biomedical aspects and economic implications of the disease seems to have influenced public opinion. To examine the relationship between media coverage and public opinion data about actual behavioral changes made in response to SARS, a total of nine survey questions were analyzed. A table was constructed displaying mean ratios from media coverage and mean percentage of positive/negative responses in 5-day intervals (Appendix Table A4.7 and Figure 4.4). The questions asked respondents if they had taken any precautionary measures or made changes in their behavior to prevent SARS. For seven out of nine questions, the mean percentage of “yes” answers dropped from 12% to 8% between April and May when the surveys were administered. During the same time period, the biomedical ratio decreased from 0.53 to 0.37. The economic ratio first increased and then dropped to the original level of 0.11. The human rights and security ratios were very small and showed very little change. Changes in public opinion seemed to correspond to a decrease in biomedical news, as it was the dominant frame when the first round of survey questions was administered. Moreover, all nine questions were largely related to health and biomedical issues. It is reasonable to conclude, therefore, that the public response to these questions reflected the change in the biomedical ratio. To examine the relationship between media coverage and public perception of SARS as a threat, a table of mean ratios from media coverage and mean percentage of positive responses in the threat category at weekly intervals was constructed (Appendix Table A4.8). The Pearson correlation coefficient was computed for the first question in the “threat” category for the period between March 30 and May 24, 2003 because many surveys were administered during this period. None of the correlations was significant. The percentage of positive responses regarding worry over being exposed to SARS, however, had the highest correlation with the economic ratio. The level of worry showed a very small negative correlation with the biomedical frame (Table 4.7 and Figure 4.5). The above analysis did not reveal any significant correlation between changes in media coverage and public response to SARS. To determine if news coverage about SARS that focused on its impact on the United States had a higher correlation with the survey question assessing perception of the threat from SARS, Pearson correlation coefficients were computed ( see Appendix Table A4.9). None of the correlations were significant. The percentage of positive responses indicating the level of worry about being exposed to SARS, however, showed a small positive correlation with the biomedical frame (r = 0.2456) and the economic frame (r = 0.2267) and a small negative correlation with the human rights frame (Table 4.8 ). In this study, I assessed whether news coverage during and after the outbreak of SARS increased the anxiety of Americans about the disease and led to support for measures such as quarantine.22 In March and the beginning of April in 2003, the story was developing and being brought to the attention of the public. Extensive reporting about how SARS had affected various parts of the world evoked public concern about the disease, and this concern was evident in many surveys administered in April 2003. Onethird of the respondents were gravely concerned about the disease. The responses (willingness to support quarantine and perception of threat) did not change much between when the surveys were first administered in April 2003 and when they were repeated in May 2003.23 While high percentages of people were worried in May, the number of positive responses did not increase in May. The time period from April to May was one of “saturation coverage.” There was a steady decline both in news coverage and in public perception of threat of the disease after that time.

#### Masco thesis presumes identifying danger justifies violent responses in its wake. That methodology is suspect.

Zimmerman – *reviewing Masco* - ‘15

Vera Zimmerman has served as a research analyst at the Hudson Institute. Her scholarship has been published in World Politics Review. The author is currently a graduate student of political science in the Department of Public and International Affairs at George Mason University. Article Title “Book Review: The Theater of Operations: National Security Affect from the Cold War to the War on Terror. By Joseph Masco Durham and London: Duke University Press” – May 23rd, 2015 – available at: https://verair.wordpress.com/2015/05/23/the-theater-of-operations-national-security-affect-from-the-cold-war-to-the-war-on-terror-by-joseph-masco-durham-and-london-duke-university-press-2014/

Masco asserts that U.S. superpower depends on the ability of the state to monopolize a discourse of danger, but he doesn’t discuss how the United States succeeded in doing that. Masco could have developed his argument by tracing how the United States was able to use its soft power to mobilize like-minded states to agree with U.S. hegemony on WOT. It will be interesting to trace the U.S. internalization of fear and terror. He could have examined how allies responded to U.S. domestic mobilization of its population and whether other states imitated U.S. emotional management projects to mobilize their own populations. This would boost his argument that the U.S. was able to project its power on the global scale. In Theatre of Operations, Masco makes a compelling argument about the creation of the unrestrained theater of operations via domestication of fear and terror carried over from the Cold War days. His anthropological study reveals the extent to which a democracy is willing to use fear to assure the core principle of the social contract, defined by Hobbes as the exchange of public obedience for collective security. A democracy that chooses to be preoccupied with security risks to forgo core democratic values resulting in the lack of transparency, restriction of free flow of information, and negligence of non-military threats—no less threatening than nuclear terrorism. Making criticism of U.S. actions the main focus of the book, however, Masco’s interpretations are not properly balanced and sometimes appear biased. Still, reading Masco’s insight of the purpose of U.S. actions in the post-9/11 context offers opportunities to think critically about the effects of 9/11 emotional reprogramming of society and state of emergencies in U.S. history.

#### Ahuja’s too sweeping – making a historical observation, NOT prescriptive – AND doesn’t deny case outweighs

Kenney 17 (Martha Kenney, Assistant Professor, Women and Gender Studies, San Francisco State University, “Review of Bioinsecurities: Disease Interventions, Empire, and the Government of Species by Neel Ahuja,” Feminist Formations, 29(1), Spring 2017, <https://muse.jhu.edu/article/658650/pdf>)

Although Ahuja provides a necessary critique of colonial and imperial public health discourses and policies, where Bioinsecurities falls short is in offering imaginative alternatives to “dominant forms of state vision and media assemblages” (201). In order to critique common sense public health logics, Ahuja chooses to suspend “normative judgements about the threats posed by viruses and bacteria” (11). Thus, throughout the book he refers to the illness and death caused by infectious disease as “bodily transitions” and writes about the “queer potentials of contact” with microbes (27). Although I understand the reasons he would want to avoid dominant discourses about transnational epidemics, ignoring the suffering caused by infectious disease seems out of place in this otherwise exacting analysis of state violence. As Ahuja himself shows, vulnerability to illness and medical neglect can also be the result of imperialism, colonialism, and global capitalism. Although it is important not to stigmatize debility and to learn to live with mortality, it seems dangerous to conflate bodily transitions that are life making and bodily transitions that are death dealing. And because infectious diseases like smallpox and HIV/AIDS have been so deadly, it feels necessary not to dismiss every effort to treat and eradicate illness as inherently imperialist. Although humanitarian medical projects can also be murderous (see also Stevenson 2014), I do not think we can afford to be cynical—or only cynical— about public health and medical care writ large. In the alarmist coverage of Zika with accompanying images of brown-skinned babies with small heads, the one thing that has been lost is the babies themselves. The hypervisibility of these infants reveals a pervasive ableism that continuously bemoans their disability, but is not curious about their lives. Most state policies around Zika have been about prevention and securitization; I have not read any that are explicitly about care for those already born (beyond screening for impairment). Care is a tricky term, because, as Ahuja illustrates, care can be violent, paternalistic, and in the service of empire. However, not all practices of care are equally violent; it is important for scholars to develop the critical and creative capacities to differentiate. In this way, the histories Ahuja offers in Bioinsecurities can help us to move away from the default mode of racialized panic toward more critical discourses and practices of care in the context of epidemics that cross borders and harm unevenly.

#### Particularly, does NOT contextualize to our non-communicable disease impacts – where absence of any scenario for global spread defangs militarized responses – only helps desecuritize already-circulating pandemic discourses

Fidler 16 (David P. Fidler, Professor of Law at Indiana University School of Law, one of the world's leading experts in international law and infectious diseases and has published widely in this area, including International Law and Infectious Diseases (1999), “A Pathology Of Public Health Securitism: Approaching Pandemics as Security Threats,” in *Governing Global Health: Challenge, Response, Innovation*, 4-22-2016, Routledge, p.41-64)

Paradigm Aggregation: Public Health Securitism and Public Health Governance The emergence of public health securitism has produced paradigm aggregation rather than a paradigm shift. Post-securitisation public health governance involves three frameworks that converge to produce the political, economic, and moral context in which public health policy operates. The sea change that public health securitism represents is best viewed in light of security considerations entering into a governance context previously oriented by concerns involving economic considerations and aspirations grounded in concepts of human dignity. As historians of international health diplomacy have made clear, international cooperation on public health originated in the concerns of the European great powers with the economic burdens their trade and commerce suffered through the application of disparate, uncoordinated, and often irrational national quarantine systems (Goodman 1971; Howard-Jones 1950. 1975). The threat of the international spread of communicable diseases was thus constructed predominantly as a threat to the economic opportunities that trade and commerce provided states. This template dominated how states approached international health cooperation in the first century of such cooperation. The focus of international health efforts slowly drifted away from national economic self-interest as humanitarian concerns about health in other countries gradually emerged prior to World War II. The establishment of the WHO in 1948 accelerated this trend because the organisation directed most of its energies toward trying to improve public health in developing countries (Pannenborg 1979). Animating this concern with health conditions in poor countries was the vision for health proclaimed in the preamble of the WHO constitution (WHO 1994). The idea that the enjoyment of the highest attainable standard of health was a fundamental human right was central to this vision. The humanitarian and rights-bascd framework taking shape through WHO activities was connected to efforts in development being pushed by developing countries in the aftermath of decolonisation. The Declaration of Alma-Ata in 1978, which launched the Health for All by the Year 2000 initiative, captured the convergence of humanitarianism, the right to health, and the new thinking on development (International Conference on Primary Health Care 1978). The declaration reaffirmed the right to health, asserted that health inequalities between developed and developing countries were unacceptable, and linked health for all to the economic and social development strategies found in the so-called New International Economic Order (NIEO). The emergence of linkages between security and public health since 1995 adds yet another governance template to the economic-based and human dignity based frameworks that prevailed in earlier periods. Some concerns expressed about the securitisation of public health involved fears that security-based attitudes are eclipsing or subordinating the human dignity template that prevailed in international health governance from the WHO's establishment. As explored below, the securitisation process docs create tensions with the human dignity agenda; but this process has not been a zero-sum game among the economic, human dignity, and security templates of public health governance. Without question, security-based arguments have contributed to a new emphasis on the material self-interests of states with respect to public health governance. These arguments resonate with the original governance template for international health cooperation that reflected the economic concerns of the great powers. The security-related perspectives also help highlight the increasing economic costs that countries face from the globalisation of disease, especially with respect to their export interests. With disease rising as a threat to the state’s material power and wellbeing, states have started to engage public health governance with more intensity. Human dignity has not, however, dropped off the agenda. The securitisation process has included security concepts, especially human security, that conceive of security more broadly than the traditional narrow emphasis on the material power and interests of states. In addition, one of the dominant themes of the securitisation process has been that international cooperation and the national and global involvement of non-state actors are essential in public health governance to achieve security, whether the concept of security in question is narrow or broad. The commonalities of the strategies required to engage in successful public health governance in the early 21st century allow the economic, human dignity, and security templates to coexist, held together by the epidemiological requirements of addressing diseases effectively in an intensely globalising environment. Pathology of Public Health Securitism Understanding that public health securitism has taken public health governance into a post-securitisation phase is important, but it is not sufficient for comprehending the seminal nature of this change in attitudes, strategies, and tactics concerning public health governance. This section provides a pathology of public health securitism, or an exploration of the causes, processes, and consequences of this important development in public health governance.1 This brief examination supports the belief that security-based arguments have utility for public health policy. Causes The rise of public health securitism has many causes. But cutting across these causes is the realisation that the danger presented by diseases to states, peoples, and individuals has increased in the last decades of the 20th century- and early stages of the 21st century. The Oxford English Dictionary defines security as ‘the condition of being protected from or not exposed to danger\*. The trend toward using security-based thinking and concepts in a time of increasing disease danger makes sense, at a basic level. The key to understanding the causes of public health securitism involves the scrutiny of the reasons why diseases are more dangerous in the early part of the 21st century than they were in the post-World War II period. Analyses of communicable disease emergence provide insight into the increasing dangers these diseases present. In its well-known report, the U.S. Institute of Medicine's C ommittee on Microbial Threats to Health in the 21st Century identified 13 factors that produce microbial dangers for the U.S. and other countries (see Tabic 4-1) (Smolinski, Hamburg, and Lederberg 2003). Similarly, public health experts argue that dramatic changes in patterns of product consumption, stimulated [[TABLE 1 OMITTED]] by the globalisation of trade and lifestyle choices, significantly increase risks to health, as evidenced by growing pandemics of chronic diseases related to tobacco use and obesity (Beaglehole and Yach 2003). Increasing risks and dangers from diseases arise in an environment in which public health governance has proved ill equipped to respond. The turn to security-based arguments involves the perception that the human dignity and economic templates that prevailed in earlier historical periods are insufficient bases, on their own, for the kind of robust governance required in the early 21st century. With disease dangers rising, the rallying cries of the right to health and Health For All no longer carry the weight they previously did. Framing disease dangers in terms of security has proven to be attractive across political and ideological spectrums as an approach that can motivate states and communities to strengthen national and global public health. Processes In order to understand how the belief that security-related arguments could provide policy traction for public health governance developed as rapidly and strongly it is necessary to look at various processes through which this transformation occurred. These processes can be divided into practical, tactical, and strategic categories. At the practical level, many people concerned about growing disease dangers in a context of weak to non-existent public health capabilities used every argument available to raise policy attention about this governance challenge. Thus, security-based arguments were intermingled with economic rationales and appeals to humanitarian impulses in a melange that reflected a call for urgent action rather than a desire for theoretical coherency. At the tactical level, there have been modifications made to accommodate public health concerns in traditional security concepts and practices. Thinking on U.S. national security attempted to graft public health into its priorities. This grafting process involved two aspects. First, the traditional Cold War definition of national security as security against the military power and potential military- violence from other states began to look anachronistic when the U.S. felt threatened by potential violence from non-state actors, notably terrorists. Although national security was still defined in terms of threats of exogenous violence, the range of potential actors that could pose a security threat expanded in light of the terrorist threat. Part of that terrorist threat involved the possible use of bioweapons against the U.S., a threat that came to pass with the anthrax attacks of October 2001. This threat against the U.S. meant that the quality of public health systems in the U.S. and in other countries grew in national security importance. Second, the post-Cold War period also encouraged policy makers and policy thinkers to question the narrow perspective on U.S. national security that prevailed during the long conflict with the Soviet Union. This questioning involved experts analysing whether U.S. national security policy should consider transnational phenomena, such as environmental degradation and communicable diseases, as threats to the material power, interests, and well-being of the United States. Part of ihis approach posited whether naturally occurring communicable diseases could directly cause such material damage to the U.S. as to be a threat akin to a violent attack. Another facet of this outlook focussed on how transnational phenomena might present indirect national security problems for the United States. Could, for example, environmental degradation or communicable diseases contribute to the violent destabilisation of important countries or regions and thus damage U.S. interests and power overseas? At the strategic level, the process involved fundamentally rethinking the concept of security. Here, the rapid development of human security as a rival to the traditional, state-centric perspectives on security is the most important innovation. Human security's focus on the individual as the core subject of security policy opened more space in security thinking for public health issues. The tactical process described above allowed public health to have some national security significance, but the centre of policy attention remained the security of the nation-state in terms of its material power. Human security challenged the assumptions of the traditional national security template and thus created greater possibilities for states and the international community to consider public health more seriously as a security issue. These practical, tactical, and strategic processes do not mesh into each other to produce a harmonised process that generated public health securitism. Each individually contributed to the politics that has gradually led to public health securitism’s emergence. The messiness of the processes is one reason why public health governance faces some unfinished business in its post-securitisation phase. Consequences The last element of the pathology of public health securitism concerns its consequences. One consequence has already been highlighted — the aggregation of templates informing public health governance. This aggregation is not without competition and friction. The increased dangers that diseases present have reconnected the security and economic self-interests of states with public health governance. This reality has created tension with the governance template focussed on human dignity, with its concerns about the right to health and equitable social and economic development. At one level, these tensions merely indicate that public health governance is returning to normality in international relations. Most issues involving international politics and foreign policy experience friction between interest-based approaches and value-based approaches. Public health governance after World War II witnessed the withering of great power interest in international disease control and prevention largely because these states enjoyed steadily improving national public health outcomes. International health activities devolved to the ‘low politics' of ‘mere humanitarian ism’ in international relations, allowing the human dignity template to appear dominant in the ethos of international health cooperation. The securitisation of public health has made what appeared to be a fundamental transformation look more like a transitory mirage. The consequences of the securitisation of public health are not. however, exclusively about the potential fragmentation of public health governance into a rivalry between interests and values. The epidemiological requirements of addressing mounting disease dangers do not change according to whether an interest-based approach or a value-based perspective dominates. Surveillance remains critical under the framework of either public health securitism or human dignity. Vaccines and antibiotics do not change their physiological effects depending on whether the impetus behind their use is based on security or rights. Thus the nature of public health governance allows a degree of convergence between interest-centric and value-centric perspectives on solutions to disease dangers. This convergence of interests and values forces both sides of the debate to think about public health security in depth. Thinking of disease threats as security dangers requires understanding not only disease-specific epidemiology but also the broader determinants of disease dangers. Public health securitism does not, by definition, imply that concern with the social determinants of health is jettisoned because security becomes an organising policy framework. Seeing diseases as security dangers actually forces interest-based approaches to appreciate the depth of the policy needs required to address disease dangers. Where public health securitism has its greatest consequences for public health governance is in the area of priority setting. The attractiveness of security-related arguments Hows from the priority policy attention that security threats arc perceived to receive. The process of securitisation was a proccss of prioritisation in public health governance. This dynamic helps explain why virtually everybody has jumped on the security bandwagon since 1995. Like the various processes that produced public health securitism, the bandwagoning did not represent a coherent sorting out of priorities but rather a pluralistic endeavour that privileged security arguments without producing policy coherency on prioritisation. Л theme in the untidy bandwagoning process concerns priority setting between communicable and non-communicable diseases. Security-based arguments tend to cluster around communicable diseases. National security concerns identified bioweapons as the threat, especially those that might use contagious pathogens. The international security discourse has also centred on communicable diseases, as illustrated by the UNSC's work on HIV/AIDS. Initiatives informed by the concept of human security have gravitated toward communicable disease dangers, as evidenced by the focus on communicable disease problems in the Millennium Development Goals (MDGs) (WHO 2006a). Public health securitism need not be restricted to communicable disease problems. Rather, the securitisation of public health governance makes it more difficult to elevate many non-communicable disease problems. The nature of some of the leading problems, such as tobacco-related diseases and obesity, makes the effort to use security-based arguments more difficult both in a conceptual sense and in terms of common sense. A similar difficulty arises with respect to tobacco-related and obesity-related diseases and the human rights framework because the spread of such non-communicable diseases requires, in most cases, voluntary participation in behaviour that is bad for one’s own immediate health and the health of others. The difficulties experienced within the security and human rights frameworks perhaps explain the efforts made to cast non-communicable diseases as material burdens on the economic interests of countries and corporations. I'nfinished Business: Toward Greater Analytical Rigour in the Relationship between Security and Public Health Thus the dawn of the post-securitisation phase for public health governance does not mean that public health securitism has produced a clear and coherent consensus on the relationship between security and public health. Public health securitism has proved to be a powerful but promiscuous idea that will not disappear any time soon from the landscape of public health governance. The pathology of public health securitism points to some unfinished business, especially with respect to bringing more analytical clarity to the identification of security problems within public health governance. There are four different ways to bring order to the process of identifying what public health problems pose security threats. Each of these frameworks shares the common goal of providing parameters for deciding what public health concerns should be labelled security threats and given the policy priority such threats require. These four contribute to more rigorous analysis of the security-public health relationship. Вioweapons Framework Traditional notions of security have been based on the violence paradigm — the threat of exogenous violence against the state, its military power, or its people (Princeton Project on National Security 2005). The violence paradigm continues to have significant power because I) threats of violence clearly fall within any definition of security and 2) states have to remain vigilant against potential violent threats. The bioweapons framework maintains that securitisation of public health should only involve public health’s relationship to the identification of, and responses to, bioweapons threats. This approach produces a very narrow perspective because it rejects treating, for example, naturally occurring communicable diseases as security concerns. The legitimacy of the bioweapons framework depends on the appropriateness of relying on the violence paradigm as the exclusive basis for thinking about security nationally or internationally. This framework is parsimonious and provides clear direction in terms of how public health governance should be securitised. Although some actions taken to improve security against biowcapons violence have general public health benefits (such as surveillance), these positive externalities for public health governance are not the intended security objective. The bioweapons framework is unlikely to carry the day in the post-securitisation phase of public health governance. It recommends a drastic retrenchment in public health sccuritism that essentially throws every other perspective on security off the securitisation bandwagon. More fundamentally, this perspective rejects the broader thrust of the securitisation of public health governance — that disease dangers of multiple varieties have emerged that threaten individuals, populations, the state, and the international community. The ‘back to the future' approach counselled by the bioweapons framework does not respond to the globalisation of disease threats that public health governance must address. Communicable Disease Framew ork A second approach involves limiting securitisation to communicable diseases. As noted earlier, the securitisation of public health governance has gravitated toward communicable diseases as the most prominent dangers to public health in the early 21st century. Limiting public health securitism to communicable diseases would also provide a bright-line rule for distinguishing what public health problems should be accorded security status. With such a limitation in place, securitising public health could focus on what communicable diseases are sufficiently dangerous to warrant heightened governance attention. Unlike the bioweapons framework, the communicable disease approach does not exclude looking at communicable disease problems through security perspectives that arc broader than the violence paradigm. The communicable disease framework may, however, be under-inclusive in terms of disease threats and over-inclusive in terms of concepts of security. The choice to exclude all non-communicable disease threats from public health securitisation neglects the acute dangers that can be posed by some such diseases. International legal regimes in trade and environmental protection have long recognised that pollutants and contaminants can pose extraordinary dangers to public health and should be prevented, protected against, and, if necessary, controlled. For example, states have used international law to address transboundary pollution generally and transboundary pollution caused by industrial or nuclear accidents specifically (Bimie and Boyle 2002). To leave these types of situations outside an understanding of public health's relationship with security appears arbitrary in light of all the diplomatic activity and international law devoted to dangerous non-communicable disease threats. In terms of concepts of security, the communicable disease framework might be over-inclusive because the framework docs not contain any parameters for determining which communicable disease problems deserve security status and which do not. Not all communicable diseases should be considered security threats. Some methodology is required for determining when a communicable disease becomes a security threat. The communicable disease framework does not provide this methodology. Without such a methodology, the concept of security could bccomc little more than a rhetorical device used to bring more policy attention to a wide variety of communicable diseases. Decision Tree Frameworks A more sophisticated approach to bringing some conceptual order to the relationship between security and public health has appeared in decision tree frameworks. These break the question of a public health issue as a security threat into a series of factors that lead analysis to specific conclusions. Decision tree frameworks have appeared in the scholarship of Henry Feldbaum and Kelley Lee (2004) and of Colin Mclnnes (2004), as well as in the approach used by the WHO (2005) in the new International Health Regulations (IHR[2005J) adopted in May 2005. The work of Feldbaum and Lee and of Mclnnes focusses on the need to improve analytical approaches to deciding what health problems are global health security issues. Figure 4-1 provides the beldbaum-Lee decision tree, and Figure 4-2 provides the Mclnnes decision tree. Both construct a way to determine whether a health issue is a risk to the individual national security threat or is a global health security issue. The decision trees allow their analytical frameworks to be applied to bioweapons, communicable diseases, or non-communicable diseases. Unlike the communicable disease framework, the decision trees include a methodology for deciding whether a given problem is a security threat and what type of security threat it represents. In the IHR(2005). a decision instrument guides states parties in determining what disease events may constitute a ‘public health emergency of international concern\* for the purposes of notifying the WHO (sec Figure 4-3). Public health emergencies of international concern arc not defined in the 1HR(2005) as security threats, but the concept of a public health emergency of international concern is not far removed from identifying dangerous disease events as security problems. According to the WHO, for example, the IIIR(2005) is a core component of its strategy to improve global health security (Fidler 2005). Like the academic decision trees, the IHR(2005) decision instrument applies to communicable and non-communicable disease events (whether intentionally caused, accidental, or naturally occurring) and thus avoids the under-inclusiveness of the bioweapons and communicable disease frameworks. These decision tree approaches share the common elements of identifying acute health risks that cause, or have the potential to cause, high levels of morbidity and mortality as either security threats or public health emergencies of international concern. The Feldbaum-Lee decision tree expressly lays out these factors as securitisation criteria. The IHR(2005) is concerned with emergency situations, which clearly includes acute, high-impact disease events. The Mclnnes decision tree centres on extreme events, which appear to be defined as acute disease risks that post a threat of significant death and illness. If adopted as the key variables for securitising public health problems, the acute and high morbidity and mortality factors eliminate most non-communicable diseases that cause high levels of morbidity and mortality through chronic but not acute disease. For example, radioactive pollution from a nuclear reactor accident. such as Chernobyl, could not be defined as a security issue because the potential high morbidity and mortality would, beyond the immediate accident site, develop chronically over years rather than acutely over days. Feldbaum and Lee (2004) argue, however, that tobacco-related diseases are acute threats that cause significant morbidity and mortality. They also argue that childhood obesity does not become securitised because it is not an acute health risk. Both tobacco-related and obesity-related diseases are chronic not acute health risks, as those concepts are understood by epidemiologists. Why tobacco but not obesity gets included in the Feldbaum-Lee securitisation process is not clear. The common approach discernable from the decision trees raises questions about what constitutes an acute threat. From an epidemiological perspective, some communicable diseases, such as HIV/AIDS and tuberculosis (ТВ), damage health [[FIGURE 1 OMITTED]] over lengthy periods of time, more akin to a chronic disease than an acute infection, such as influenza, severe acute respiratory syndrome (SAKS), or haemorrhagic fever viruses (such as Ebola and Marburg). HIV/AIDS produces high levels of morbidity and mortality but not through physiological means that fit the traditional notion of an acute infection. In fact, the non-acute nature of HIV infection is part of what has made AIDS such a global public health problem. Loosening the acute factor to open up securitisation to more non-communicable disease problems and to address infections that arc chronic may, however, produce a one-branch decision tree that securitises public health problems that generate high levels of morbidity and mortality. Such a move risks equating security with public health rather than creating a framework for prioritising some public health problems as security threats. Epidemiological Elasticity Approach Another approach to identifying which public health problems constitute security issues involves assessing the level of danger posed by health risks by determining the propensity of the risks to spread and cause damage in human populations, or the [[FIGURES 2 AND 3 OMITTED]] epidemiological elasticity (epi-elasticity) of a public health threat. Л public health risk would have a high epi-elasticity if the risk demonstrates mobility within human populations and crcates adverse material impact for societies. Public health risks that exhibit high cpi-clasticity would be candidates for security consideration. Assessing the mobility of a public health risk would involve determining the means of transmission of the risk (for example, pathogen, pest, product, or pollutant), the speed with which the risk moves in human populations, and the geographical reach of the risk's mobility. The decision tree approaches showed interest in whether health risks were mobile, as illustrated by the attention paid to whether a risk was capable of cross-border, trans-border, or intra-border spread. But the spread capability of a risk only served to distinguish whether the risk was a national security issue or a global health security issue in the Feldbaum-Lee and Mclnnes decision trees. Mobility was not, therefore, a factor in deciding whether a risk was a security concern. The epi-elasticity approach makes mobility a central securitisation factor. Assessing the material impact of a public health risk would involve determining the morbidity and mortality, the economic costs, and other adverse material effects (for instance, reduction in military capabilities, fear generated in societies) actually or potentially caused by the risk. The idea is to calculate the damage the risk poses to societies. The decision trees were interested in limited aspects of material damage, namely whether a risk threatened high or low morbidity and mortality. The Feldbaum-Lee decision tree does not accommodate a low morbidity or mortality risk that otherwise causes, or threatens to cause, enormous material damage to affected countries, such as a limited bioweapons attack with a non-contagious pathogen. The Mclnnes decision tree might accommodate such a risk within the concept of an extreme risk, but without a more precise definition of extreme, such accommodation is guesswork. The epi-elasticity approach expressly broadens the impact analysis in securitisation beyond morbidity and mortality statistics to include other forms of material damage to populations. Assessments of a public health risk’s mobility and potential for material damage will involve consideration of other important factors. One such factor is the means of response available to be brought to bear against the risk, such as surveillance and intervention capabilities. The existence or non-existence of public health infrastructure can affect the mobility of a public health risk and the material damage it can inflict on a population. For example, a population universally vaccinated against a highly mobile, contagious pathogen will not, in all likelihood, suffer high morbidity and mortality from that pathogen's spread. The vaccine the means of response has a material impact 011 the epi-elasticity of the pathogen’s overall risk to public health. Another factor that flows into both mobility and material impact is the mutability of the public health risk, or its ability or potential to change, or be changed, as it enters human populations or in response to intervention efforts. The most obvious example of the importance of mutability is the development of antimicrobial resistance in communicable pathogens, such as malaria and ТВ, which make resistant microbes more dangerous public health risks because the propensity to spread and to cause damage is enhanced. The mutability factor is not. however, limited to communicable diseases. The routes by which non-communicable disease vectors affect human populations can change, or be changed, in response to public health interventions. Raising taxes and increasing regulatory burdens on tobacco and alcohol, for example, may produce an increase in smuggling and other forms of illicit trade. The cpi-elasticity approach is not a decision tree because the assessment of the mobility and material impact factors produces an objective picture of the level of danger the public health risk poses. Concluding that a risk has a high epi-elasticity does not mean that it is automatically a security problem. The epi-elasticity approach leaves open a margin of discretion in the securitisation process because, as Mclnnes (2004) argued, how security is defined in most situations involves both objective and subjective considerations. This outcome is really no different from the definitional choices that have to be made in the decision tree approaches, such as whether a public health risk is acute or extreme. However, the epi-elasticity approach’s focus on mobility and material damage provides a more robust methodology for using empirical data to aid the determination through the securitisation process of what public health problems should be prioritised as security threats. Three Pandemics: HIV/AIDS, Pandemic Influenza, and Tobacco-Related Diseases The rise of public health concern about pandemics provides an interesting lens through which to look at public health securitism, its pathology, and its unfinished business. The three pandemics involving HIV/AIDS, influenza, and tobacco-related diseases provide rich case studies for analysing the belief that public health can be improved through the use of security-based policies. Collectively, the developments related to these pandemics support the argument that public health governance has entered a post-securitisation phase. Public health securitism appears with respect to the policy discourse on each pandemic, illustrating the power of this policy belief today in public health and other circles. The pandemics also help illustrate the various parts of the pathology of public health securitism and underscore the importance of greater analytical rigour in the relationship between security and public health. Pandemics and Public Health Securitism The ubiquity of thinking about public health problems in terms of security that has developed since 1995 owes much to the re-emergence of pandemic and potentially pandemic diseases. The threat of global disease as a public health concern diminished during the post-World War II period, particularly with respect to developed countries that dramatically reduced their vulnerability to communicable diseases. In addition, for much of this period, increased morbidity and mortality caused by non-communicable diseases remained largely a rich country concern and thus did not have global implications. The re-emergence of pandemic potential for communicable diseases and the emergence of pandemic possibilities for non-communicable diseases since 1995 arc directly conncctcd to the fundamental cause behind the rise of public health securitism — the awareness that the dangers presented by diseases have significantly increased from the local to the global level. Pandemics arc not, by definition, dangerous because whether a disease is dangerous involves other considerations. But pandemics can be dangerous, and mounting concerns about the dangers to public health posed by pandemics involving HIV/AIDS, influenza, and tobacco-related diseases have stimulated policy to gravitate toward security-based arguments as a strategy to motivate public health governance on these global disease threats. The pandemic threat has acted as a counterweight to the bioweapons threat's tendency to produce narrow conceptions of the relationship between security and public health. But for the threat of pandemic communicable diseases, it is unlikely that the U.S. would have been willing to move the security-public health relationship beyond bioweapons. The grim progress of the HIV AIDS pandemic and the emergence of conditions conducive to communicable disease pandemics have contributed to shattering the complacency many developed countries exhibited toward public health in the post World War II period. The rise of pandemic threats also supported the use of different kinds of security arguments in discourse about how to deal with these dangers. Pandemics provided a background against which concepts of national, international, and human security could be advanced and debated. The HIV/AIDS pandemic proved particularly powerful in attracting diverse security-related arguments in policy and academic debates about how to respond to this crisis. The continued use of these types of arguments in the frenzy of interest around avian influenza and its potential to trigger a global pandemic has reinforced the prominence of security-based thinking with respect to pandemic disease. These observations suggest that the emergence and threat of pandemics have materially contributed to the securitisation of public health governance. This development is cold comfort because it means that diseases have emerged as global dangers for which past governance frameworks have proved inadequate. The security approach prioritises pandemic preparedness and response over other public health needs and aspirations. Securitisation Claims and the Three Pandemics The growth in the threat posed by pandemics generally also raises issues explored above concerning the identification of public health threats as security problems. Are the HIV/AIDS pandemic, the feared influenza pandemic, and the pandemic of tobacco-relatcd diseases all security threats? The hardest to analyse in response to this question is the pandemic of tobacco-related diseases. Experts have frequently securitised the HIV/AIDS pandemic and the anticipated influenza pandemic. Security-based arguments are not as frequently made with respect to the global spread of tobacco-related diseases. As already argued, part of the unfinished business of public health securitism involves the development of greater analytical rigour in the relationship between security and public health. Application of the various frameworks described earlier to the three pandemics at issue here underscores the need for such rigour. Clearly, none of these three pandemics ranks as a security threat under the biowcapons framework because none involves the intentional use of disease as a weapon. This conclusion merely reinforces the under-inclusivcness and narrowness of the bioweapons approach to the securitisation of public health problems. The communicable disease framework would cover HIV/AIDS and pandemic influenza but not the pandemic of tobacco-related diseases. Given the actual and anticipated scale of the death and illness caused globally by tobacco consumption, the exclusion of this pandemic entirely on the basis that it involves non-communicable diseases does not seem analytically justifiable. The various decision tree approaches produce important questions that cast some doubt on their utility. Although the IHR(2005) clearly applies to events involving sources of non-communicable diseases, no one has argued that the concept of a public health emergency of international concern would apply in any context to the continued spread of HIV/AIDS or tobacco-related diseases.2 Such continued spread of these established pandemics would not be considered unusual or unexpected within the meaning of the IIIR(2005). This situation might change with respect to HIV/AIDS if, for example, multi-drug resistant strains of HIV/AIDS began circulating globally, thus significantly imperilling the efficacy of antiretroviral treatment (ART) efforts. Under the Feldbaum-Lce and Mclnnes decision trees, pandemic influenza would be the only pandemic of the three under consideration here to merit dear security status. For HIV/AIDS to be securitised under these decision trees, it would have to be considered either an acute disease (Feldbaum and Lee 2004) or an extreme disease event (Mclnnes 2004). As mentioned earlier, whether HIV/AIDS is an acute infection is questionable. The problem faced by the 'acute health impact’ factor in the Feldbaum-Lee decision tree is stretching ‘acute\* to cover both pandemic influenza and HIV/AIDS, which stand at opposite ends of acuteness in epidemiological terms. Feldbaum and Lee stretch the concept further, in fact, in arguing that tobacco-related diseases should be securitised, which must mean Feldbaum and Lee think they have acute health impact; this again strains epidemiological credulity. In terms of the Mclnnes decision tree, HIV/AIDS and tobacco-related diseases would have to be perceived to be extreme health risks to be securitised pandemics. Aggregate morbidity and mortality statistics are not sufficient to achieve extreme status because, under that approach, tobacco-related diseases would be more extreme as a health risk than HIV/AIDS. The heavy securitisation of the HIV/AIDS pandemic and the lack of security-related claims for tobacco-related diseases reinforcc this conclusion. The Mclnnes decision tree, furthermore, seems to exclude tobacco-related diseases as security threats altogether because it is hard to argue that their spread over the course of decades constitutes an extreme health risk in the same way pandemic influenza. As with the concept of acute in the Feldbaum-Lee decision tree, ihc Mclnnes decision tree raises ihe question of whether the term ‘extreme’ needs to be defined more objectively. Both decision trees easily accommodate pandemic influenza, but they have both difficulty with HIV/AIDS, even though it is an intensively securitised pandemic. In contrast to the awkward application of the decision trees to the HIV/AIDS and tobacco-related disease pandemics, the cpi-elasticity approach assesses the level of danger presented by public health risks according to their respective propensities to spread and cause damage to human populations and societies. The mobility and material impact factors apply equally to all three pandemics, so the epi-elasticity approach does not exclude any pandemic for not satisfying a decision tree factor. This approach assesses the level of danger each of the pandemics presents, and policy makers can more objectively assess whether each pandemic poses a sufficient danger to warrant securitisation at the national or global level. An epi-elasticity analysis of the three pandemics would lead to the conclusion that pandemic influenza would have the highest epi-elasticity and thus be the most dangerous public health risk of the three. This outcome means that pandemic influenza’s combined mobility and material impact factors exceed those of HIV/AIDS and tobacco-related diseases. The next highest epi-elasticity would belong to HIV/AIDS, with tobacco-related diseases being third in terms of the level of danger posed to public health. In terms of the mobility factor, pandemic influenza would exhibit mobility greater than the mobility of HIV or tobacco products. As an airborne virus, pandemic influenza’s means of transmission is more efficient than that of HIV or tobacco products. Pandemic influenza would also have very high mobility because of the speed of virus transmission between humans and the potential of the virus to reach every corner of the earth very rapidly. HIV and tobacco products have also demonstrated impressive mobility locally, regionally, and globally in their respective spread and penetration of human populations. In terms of material impact, pandemic influenza again would threaten to damage populations and societies on a scale and speed that HIV/AIDS and tobacco-related diseases could not currently generate. Projections about the impact of pandemic influenza often discuss the scale of morbidity and mortality, the economic harm, and the political and social disruption pandemic influenza could cause in both rich and poor countries (Russell 2005). The global handwringing about the lack of preparedness for pandemic influenza demonstrates that an adequate means of response is currently lacking. Prospects for mitigating the material impact of pandemic influenza are, at present, not good. As between HIV/AIDS and tobacco-related diseases, HIV/AIDS is more dangerous in terms of its material impact in populations and societies. The morbidity and mortality and economic costs created by tobacco-related diseases are enormous in terms of aggregate numbers (WHO 2006b). But no one has argued that tobacco’s material impact on societies has the potential to destabilise entire countries, decimate political elites and productive-age labour forces, harm peacekeeping efforts, and create legions of orphans, as IIIV/AIDS is now doing in sub-Saharan Africa (Garrett 2005). Nor does contracting a tobacco-rclated disease involve the economic, social, and psychological costs associated historically with the stigma of HIV/AIDS. There is also the ability of HIV to mutate in ways that may render existing ART ineffective and defeat attempts to create a vaccine. The means of response available for preventing tobacco-related diseases is, on the whole, easicrandchcaperthan HIV/AIDS prevention and control strategies. Thus the overall propensity of HIV/AIDS to cause material damage to a population is greater than that of tobacco. This rough attempt to establish the level of danger these three pandemics respectively pose correlates with the way securitisation processes have unfolded. The epi-elasticity analysis supports the securitisation of pandemic influenza and HIV/AIDS because their combined mobility and material impact factors make them more dangerous risks than tobacco-related diseases. Thus pandemic influenza and HIV/AIDS deserve the public health governance priority that securitisation processes have accorded them as dangerous threats. Although the epi-elasticity analysis does not rank tobacco-related diseases as a security threat, this approach acknowledges the possibility that a non-communicable disease could represent such a threat because of its mobility and material impact on the health of populations. In fact, the epi-elasticity of tobacco-related diseases may be higher than some communicable diseases, which helps underscore the emphasis that public health authorities nationally and globally have been placing on the importance of more vigorous action against tobacco consumption. Conclusion With respect to the war on terrorism, some have expressed the hope that one day terrorism will again be treated as a law enforcement problem rather than a threat to national security. Some in public health may long for the day when disease risks are again treated as public health problems rather than security threats. Desecuritisation would signal that the disease dangers that stimulated linkages between security and public health had been reduced. Ironically, the only way to desecuritise public health might be to increase political interest and policy attention on public health through securitisation. This reasoning supports this chapter's emphasis on the strength of securitism in public health governance today and the continuing importance of this policy belief in the future. The pathology of public health securitism outlined in this chapter also highlights another reason why securitisation will not fade away any time soon as a feature of public health governance. Securitisation of public health has provided for convergences of narrow and broad conceptions of security and of interest-based and value-based approaches to health and security. In other words, the securitisation of public health creates a two-way street conceptually because it not only brings security into public health but also causes public health to inform security. The basis for a much deeper and broader governance transformation is now under construction in the post-securitisation phase of public health governance.

#### The ALT absolutely does NOT solve this link – Beller later clarified

Beller 20 (Jonathan Beller, Professor of Humanities and Media Studies and co-founder of the Graduate Program in Media Studies at Pratt Institute, member of the Social Text editorial collective, PhD Duke University, “Jonathan Beller: ‘From the World Computer to Post-Capitalist Economic Media?’,” free public lecture hosted by ICA Miami, 2020, <https://icamiami.org/video/jonathan-beller/>) [38:46-51:16] \*manually transcribed by Kevin McCaffrey

So, only a direct engagement with the computational colonization of the life-world through a reprogramming and remaking of the material processes of abstraction that constitute real abstraction can secure victory, in the form of a definitive step out of and away from racial capitalism, for the progressive movements of our times. Now I realize that’s a large claim, and maybe one that people would want to argue with. Such a definitive movement requires an occupation and decolonization of information, and therefore of computation, and therefore of money. Only through a remaking of social relations at the molecular level of their calculus, informed by struggle against oppression, can the beauty of living and the fugitive legacies of creativity, community, and care prevail.

So I’ve gone on for, I guess, 40, 45 minutes now. I think I’ll just say a few words about economic media, and then we can open up a conversation, if that’s possible.

But, I think one of the things that I want to try to make as clear as I can, is that economic media already exists. We’re already in a situation in which the forms of media that we think of as being separated, for example, monetary media, right, and financial instruments, and communications media, are actually working on a continuum, and are beginning to share many, many features with one another. People use Venmo, recognize that there’s a social media dimension to that, right, but more than that, the banking system, its institutions, the credit scoring system, these mediate relationships among people, and they use social indices in order to evaluate people’s risks and make loans. So they’re functioning as a way not only of measuring financial risk, but it’s directly translated to forms of social difference. Likewise, in monetary media, I mean, sorry, communications media, are nothing but extensions of monetization strategies, right, attempts to capture value from the social metabolism, and to convert that social creativity, the creativity that potentially could belong to us, or to all of us, to shareholders and to owners, to basically privatize, capture and privatize our collective product. And so when you think about the internet, what you has was you had the promise of democratization, by the horizontalization of communication and the breaking down of barriers to publication, but the retention of property relations, right, which is a fascist structure, where the masses get not the right but the chance to represent themselves. And so we can all represent ourselves on social media, we can all communicate with one another, and even if our values are profoundly anti-capitalist, or we work for social justice, or we work for reparations, if our work is about a praxis of liberation, mutual care, all these really important things, which are not only seriously offered but are not to be devalued, or dismissed in any way, one of the aspects of that is that they become content for news systems, for computational media, and produce value for them, which is actually functions antithetically to what their desire is. So, that’s what I mean by sort of thinking about the protocols of a financial, or economic logic, as underpinning the protocols of our semiotic situation, and needing to redesign those.

This is where the talk’s going to get a little weird, I’m not going to go on for too long, we can talk about it in the Q&A if we want to, but this is actually one of my interests in cryptocurrencies, which I have a long list of problems with, and disclaimers about, I won’t go too deeply into them but I just want to make it as clear as possible, and you may or may not believe me, but I have no interest in crypto-bros, and the libertarian aspects of Bitcoin and many of the cryptocurrencies that are around that I’m really repelled by.

However, I’m not dismissive of it, because I see it as a development in the capacities for abstraction and the way in which monetary systems are platformed, and that makes a huge difference, because money, whether it’s platformed as gold, or later on, sovereign monies by nation states, it’s linked to social relations and community, plus behavior, which is protocolized by those communities. If you think about the [unintelligible] dollar retains its value, it retains its value because the US can guarantee a secure space for capitalism, through, or has been able to, through legal strategies, through policing, through militarization, through ownership, and everything that comes along with it. So to own dollars is not only just to have money, in a completely abstract sense, it’s actually denominated in the platform, so that it’s an investment in the US, it’s an investment in US hegemony, it’s a way of validating US hegemony. And when you see the communitarian aspect of that, even in this negative light, you can start to think of what it would mean to platform currency on other communities, and with different aspirations. I can say this as clearly as I can, hopefully that was relatively clear, in part because of the innovations of Bitcoin, and beyond, because they were able to platform money and monetary systems, what we think of as institutions, on computational protocols which were distributed, verifiable, and secure, through encryption. This is a really interesting development, because it changes the rules, and who controls the game, in a way, the thing that’s, so Bitcoin and its community of users is making a wager on a protocol, and as I said, it’s primarily libertarian, and it believes in individual sovereignty, and wants to, as they say, disintermediate the state, right, you get rid of central banks, who can make random decisions about issuing trillions of dollars, right, Bitcoin issuance follows a very strict protocol and exchanges mediated by a consensus mechanism which some people say is a new kind of social contract. Maybe that’s too detailed to go into right now, but like I said, the rules of the game change, the rules of issuance, the rules for provisioning of liquidity, all these things are design features now, and the Bitcoin platform, its value is the result of the perception of the viability of that project. And it’s important to say it that way, because if you think about the attention economy, and this perceptual dimension of what Bitcoin is, the affect to the narrative of what Bitcoin is supposed to do creates its value. It is an extension, and kind of an elaboration of attention economy, in the same way that cinema captures certain kinds of values, certain computations, by creating celebrities. Now, people’s attention is creating these currencies, these monetary structures, and the relationship between the form of that attention and the protocol is very, very interesting, although, as I say, limited. And, I’ll try to say one more thing about why I think it’s so limited. In the same way as I talk about Hayek and money as a, capitalism as a computer, which translated everything into a single signal, the signal of the price, and a price system, what you have there is a kind of information collapse, right, all the richness and robustness of social life all the other possible ways of creating meaning, are marginalized and reduced to noise, by the power of the price signal, right, so it becomes monologic, it becomes a monologue. Bitcoin seems like it’s committing a kind of heresy, because it says, no, you don’t have to have national currencies to do this, you can actually platform something on computation, but Bitcoin’s big problem, as I understand it, is that it’s another monologue, right, that there’s no subtlety, because it just collapses all the signals of attention, all the community dimensions that I mentioned, which give it its value, into a single narrative, about Bitcoin emergence. So you might disintermediate the banks, and the states, to some extent, but there’s nothing in that system, that language and that protocol, which can address inequality, which can allow other values, beyond Bitcoin itself, to persist. So Bitcoin is like a medium which can communicate quantities of Bitcoin. And that’s it. And because it does it securely, and in a very interesting way, it’s quite powerful. And, I think this is where I’ll end for now, it’s kind of like photography in 1842, or cinema in 1896, 1898, it’s at the very beginnings of what it might be, you couldn’t have imagined, well [unintelligible] thinks you could have imagined, but it would have been difficult to imagine from photography, the kinds of cinema that we have, or the emergence of VR, and computation, and sort of legacy technologies for these kinds of representation, and likewise from early cinema, you couldn’t have imagined, sort of the robust, complex, affective techniques which developed out of that and became profoundly expressive.

So, if it were possible that crypto as a medium in the strong sense, could become far more expressive than it is, but allow those values to persist, not just as exchange value, but as qualitative value, so as to persist economically, to create liquidity for people who are part of various communities, then you could have communities dedicated to, either specific projects, I mean, kind of crudely, for example, abolition, or reparations, something like that, who work together to finance themselves in a sustainable way and develop that project, but, looking forward another 10 years, you could have far more complex forms of economic endeavor, which would allow for qualitative value to be registered in an economic substrate. And I think that’s a huge project, it’s a very difficult one to even begin to conceptualize, but it’s something that bears a lot of thinking, because, I feel that the sort of checkmate of postmodernism, and the checkmate, until now, of imagination by the sort of enclosure and foreclosure of it by capitalism is relegated as to making culture and just leaving the economic aspect up for grabs, saying well fuck it, we can’t really do anything about the economy, so let’s just make radical cultural form, but we know where that leads, maybe it does really important things, not to minimize, kind of community creation, a sort of shift in the demographics of enfranchisement, which is an extremely important part of that, but if people are competing for slices of the capitalist pie, we’re still reproducing global inequality. And I think we can do better than that, and I think we really owe it to ourselves and to the world that haunts us, to do better than that.

#### Their frame is wrong, crushes agency, and cynicism wrecks the alt.

McCarthy 15 – Jesse McCarthy, PhD Candidate in English at Princeton, BA from Amhearst College, Writer for Dissent, The Point, and The Nation, now Professor of English at Harvard University, “Why Does Ta-Nehisi Coates Say Less Than He Knows?”, The Nation, 11-15, https://www.thenation.com/article/why-does-ta-nehisi-coates-say-less-than-he-knows/

Consider, for example, his use of “the Dream” or “Dreamers” as shorthand for the white suburban pastoral of “perfect houses with nice lawns.” For Coates, “the Dream” is an ideal maintained at the expense of black lives, insofar as those who live in it refuse to acknowledge the institutional racism that has been instrumental in the creation of such ideals and the maintenance of their exclusiv­ity. It’s easy to understand what Coates means by “the Dream,” especially since for a long time it has been transmitted, as he acknowledges, through daytime television. But why indulge this fiction in the first place? The neoliberal financialization of the economy that began with the Reagan Revolution, and that has devastated black neighborhoods and gutted the organized working class across the nation, certainly didn’t spare people of other races and cultures. Why not admit that there are vast stretches of entrenched white poverty (representing nearly 40 percent of all welfare “handouts,” incidentally)? Why not remind people that the dark side of “the Dream” is the ongoing heroin epidemic ravaging predominantly white middle-class families, or the spread of meth across rural lower-class white communities, where lives are being destroyed as well? Why not attack outright the myth of an ideal white community—­which exists nowhere—­instead of using it as a rhetorical crutch?

Why not attack outright the myth of an ideal white community—­which exists nowhere—­instead of using it as a rhetorical crutch?

Another crutch is Coates’s evocation of environmental disaster toward the end of the book: “It is the flight from us that sent them sprawling into the subdivided woods. And the methods of transport through these new subdivisions, across the sprawl, is the automobile, the noose around the neck of the earth, and ultimately, the Dreamers themselves.” Using an image of lynching to describe something as abstract as climate change strikes me as contrived, if not inappropriate (and I share Coates’s opinion about the environment and the car). It’s hard to believe this language is addressed to his son; perhaps it’s meant to appeal to readers familiar with Elizabeth Kolbert’s writings on climate change and human extinction. At times, hyperbole leads Coates to throw down bolts that sting where they should, but elsewhere it results in an exhaustion of metaphor.

What gets obscured by Coates’s metaphoric handles is class; yet there’s no story about race in America that can afford to ignore the realities of class interest. Voting blacks, many of them staunchly middle class, supported Clinton’s “tough on crime” measures in the 1990s. Maryland’s Prince George’s County—which, as Coates points out, has a reputation for police corruption and brutality—is also one of the richest majority-black counties in the nation. That doesn’t make racism a less important factor in the killing of Prince Jones. But is the larger pattern attributed to the PG County police force also in each case a matter of black-on-black racism—or is there a class bias at work as well, with the county’s well-to-do inhabitants sending a message that certain blacks don’t belong in the enclave they’ve carved out for themselves? Coates tells his son that some “theories” of law and order came up “even in the mouths of black people,” but he drops the matter without further explanation. It’s a false choice to pit color against class in determining racial inequality; both are essential to understanding social relations. But by skating over the realities of class politics instead of endeavoring to explain their complexity, one can end up undermining the case for structural racism instead of demonstrating it.

One of the frustrations of Between the World and Me is that Coates says less than he knows. In his reparations essay, incisive prose demolishes myths and displays the material and moral consequences of political crimes that are hiding in plain sight. I simply do not believe that his readers, black or white, require the cloudy metaphor of “the Dreamers” to grasp his argument, or can’t confront head-on the realities of class antagonism or the pernicious violence of colorism and sexism. If people really are “dreaming,” the way to wake them up can’t be to feed them clichés and narratives in which they have no agency, in which history is largely a catastrophe that has already happened, and all they can do now is watch the ship go down.

I also take issue with Coates’s repeated suggestion that black folks are at the mercy of forces they will never be able to shape. “The fact of history is that black people have not—probably no people have ever—liberated themselves strictly through their own efforts,” he writes. There’s no question that historical forces are compacted and impossible to disentangle, but this statement is surely uncharitable to Toussaint L’Ouverture and the Haitian Revolution; to the Jamaican Maroons; to the Quilombos in Brazil; to the ANC in South Africa; to Amílcar Cabral in Guinea-Bissau; to Madison Washington’s commandeering of the Creole; to Harriet Tubman, who freed herself and her family and went back for countless others; and to all the individuals and organizations, secular, religious, and militant, that banded together and broke Jim Crow in the American South. But despite this air of dismissal, Coates isn’t a quietist; he’s a pessimist. He believes in struggle while maintaining a paradoxical skepticism about its effectiveness. He tells his son, Samori—named for a military hero who resisted French colonial expansion in West Africa—that he must struggle, “not because it assures you victory, but because it assures you an honorable and sane life.” This is wonderfully put, but I would observe that most black people are already struggling. This summer, concerned parents undertook a hunger strike just to protect a local high school in Chicago. The question is how to empower that struggle, against whom to direct it, with what allies, by what means, and with what vision of society before us?

There is a real need today for writing that shatters people’s cynicism and perceived impotence, for the grain of truth that brings them back to politics, where so much ground has been ceded. The American prison archipelago is a nimble and ruthless adversary with enormous power. It is an instrument of profit, and the Corrections Corporation of America intends to keep it that way. Taser International, the company that promises to put body cameras on cops, also makes a handsome profit selling the devices to “light up” noncompliant traffic offenders. Coates says in this book that these forces “are the product of democratic will,” what he calls “majoritarian bandits.” This strikes me as implausible. They are the product of complacency and demagoguery and the hollowing out of democratic institutions and our political culture, not its malicious expression. The gutting of the Voting Rights Act was carried out through right-wing judicial activism, subverting the will of both the Senate and the House. The Ku Klux Klan, which originated in the post–Civil War struggle to overthrow the biracial governments of Reconstruction and restore white supremacy in the South, has never been an expression of democratic will, but rather a weapon for suppressing and intimidating democratic power at the ballot. The forces of white supremacy, in league with great wealth, have always feared true democracy, because they know they are outnumbered.

Coates writes at one point that “‘White America’ is a syndicate arrayed to protect its exclusive power to dominate and control our bodies.” But doesn’t this mistake the symptom for the cause? It would be more true to say that “White America” is a syndicate arrayed to protect powerful oligarchic profit, and that it has always been able and eager to do so by exploiting anti-black racism to harvest the enormous benefits of a labor force stripped of human rights and dignity. If you believe that “White America” really is dedicated to white power for its own sake, that it seeks the domination of black bodies almost as a blood sport, then how can you even begin to dismantle such a massive structure of evil? If this vision is true, then Coates’s pessimism is indeed justified. But what if it is instead the case that white supremacy is merely a servant—as well as the original grease of laissez-faire capitalism, an arrangement of political economy in which everything is up for sale, including human beings, and which at the inception of the modern European world provided the mercantilists with the international market’s original “liquidity”? If you recognize this—that we are still bound to the illusion that it’s reasonable to live as if everything can be bought and sold, with the profits producing their own justification and all human and environmental costs relegated, at best, to an afterthought—then you can also identify an all-too-human structure of interest that can be actively fought and denounced for its abuses, greed, and fraudulent promises.

**Racial capitalism oversimplifies.**

**Walzer, 20**—editor emeritus of Dissent Magazine (Michael, “A Note on Racial Capitalism,” <https://www.dissentmagazine.org/online_articles/a-note-on-racial-capitalism>, dml)

I have been **puzzled** for many months by the appearance of the phrase “**racial capitalism**” in the left press (see, for example, the article by K. Sabeel Rahman in the Summer 2020 issue of Dissent). What does it mean?

Perhaps the adjective “racial” is simply an ordinary qualifying adjective. Racial capitalism is **one kind** of capitalism, and then there **must be other kinds**, requiring other adjectives. Here in the United States we have a kind of capitalism where the majority of exploited workers or a majority of the most exploited workers are people of color. The underclass and the reserve army are defined both racially and economically. Of course, no leftist writer would be indifferent to the exploitation of white workers, who might still make up the majority of the American workforce—and who are certainly the majority of exploited workers in Europe. The point of the adjective, then, is simply to focus our attention, for good reasons, on non-white workers. But is the exploitation of these workers a **necessary feature** of American capitalism?

The phrase “racial capitalism” leaves us **unclear** about whether the hierarchical location of non-white workers is determined by **race** or by **capitalism** or by the two **somehow working together**. To begin to answer that question, we need to look at some examples of non-racial capitalism.

The form of capitalism sponsored by the **Chinese** communists is **obviously non-racial**. Though the exploited workers are, in Western terminology, people of color, Western terminology is **out of place** here. If the Chinese imported white workers to take on the most menial jobs, that might make Chinese capitalism “racial,” but no such importations have been reported. The predatory version of capitalism that prevails in Putin’s **Russia** is **also non-racial**. It may be that Muslims are among the most exploited workers in Russia, but they are mostly **Caucasian** (some of them the original Caucasians), so we would have to talk about religious capitalism—where Orthodox Christians, not white people, are the privileged group. But no one is doing that. I have no statistics, but from what I read about China and Russia, I doubt that the rate of exploitation is higher in the United States, in racial capitalism, than it is in those two countries, where capitalism is non-racial. Capitalism “works” **with** and **without** a **racialized underclass** and **reserve army**.

But is that right? The adjective “racial” sometimes makes a **much stronger** claim: it isn’t a qualifying but rather a definitional adjective. Capitalism is **necessarily**, **inherently**, **racist**. Forget about China and Russia, which are capitalist latecomers. Western capitalism is the prototypical version, and it has been **racist from day one** (if we can agree on day one)—**always** and **forever** racist. Does this mean that Manchester in 1844, as Engels described it, where all the exploited workers were white, wasn’t capitalist? No, for those workers were producing fabrics from cotton raised and harvested by Black slaves in the American South.

That’s true enough, but I am **not** sure it is **sufficient** for an argument about **necessity**. Consider a **counterfactual** possibility: had **no Black slaves** been available, the recruitment of **Irish workers** would have started **much earlier** than it did. The rise of capitalism **would not have been halted** had the slave trade never begun.

But the Manchester/Southern plantation example suggests what we all now know: capitalism is a global economic system, and it depends on the exploitation of people of color around the world. Here, however, it seems **clear** that the **key issue** is **exploitation**, **not racism**. Given global demography, the **majority** of workers in **any** global economy will be **people of color**. Even in a democratically or social democratically regulated global system, the majority of workers and the majority of managers—the underclass and the overclass—will be non-white. Indeed, it would be the **refusal** of any transnational corporation to hire people of color that would rightly be called **racist**. (In the Pennsylvania town where I grew up, the local steel company did not hire, and therefore did not exploit, Jews or Black people. I suppose that this is also an example of racial capitalism.)

All this suggests that capitalism and racism have to be analyzed **separately**. They overlap **sometimes**, as they do today in the United States. But the overlap is **circumstantial**, **not necessary**. The two phenomena are **distinct**. They don’t rise and fall together. Each one, for different reasons, requires severe criticism and sustained opposition. Many years ago, socialist writers argued that the triumph of the working class would liberate women, Jews, Black people, and everyone else. Separate political struggles against sexism, anti-Semitism, or racism were unnecessary—indeed they were a distraction from the all-important class war. Today some people on the left seem to believe that the end of racism will bring with it the downfall of capitalism. Both these theories are wrong.

Overthrowing racism will **still leave us with capitalism**; overthrowing capitalism will **still leave us with racism**. Putting the adjective and noun together gives us a **false sense** of the relationship between the two phenomena.

#### The alt’s Deleuze themes is full of contradiction, doesn’t solve anti-blackness, and methodologically flawed

Snediker 16 *REVIEW OF THEIR CULP BOOK* - Timothy Snediker is an Assistant Editor for the Journal for Cultural and Religious Theory. The author holds an M.A. Religious Studies, University of Denver. And a B.A. in Religious Studies & Creative Writing from the University of Central Arkansas. Review of Culp, Andrew. Dark Deleuze (Forerunners: Ideas First). Minneapolis: University of Minnesota Press, 2016. ISBN 10:1517901332 Paperback, e-book. 90 pages. Originally Posted at JCRT. Modified for language that potentially offends - August 4,2016 and also available at: http://www.academia.edu/27536621/Review\_-\_Dark\_Deleuze\_Andrew\_Culp\_

For several decades there has been a general consensus among readers of Gilles Deleuze: the influential French philosopher was, is, and will be a thinker of affirmation, joy, and plenitude. Notwithstanding the fact that Deleuze himself insisted on this very profile, a certain alternative current has arisen in recent scholarship on Deleuze. There has developed—to the dismay, one supposes, of Deleuze's orthodox readers—a vision [perspective] of the infamous philosopher of difference and desire that directly antagonizes the beatitudes of affirmative politics, ontologies of plenitude, and the 'canon of joy' associated with Deleuze: a darker, destructive and more macabre Deleuze. To pick a few examples just from 2016: Aaron Schuster's The Trouble With Pleasure explores the thorny relationship of Deleuze and psychoanalysis, particularly the rift between Deleuze and Lacan, with an explicit view toward a more negative Deleuze by raising the negativity of the complaint to an ontological register. Daniel Colluciello Barber's article, entitled, "The Creation of Non-Being." published in Rhizomes 29, finds in the late Deleuze a partisan of noncommunication, negativity and destruction, and decisively links these admittedly occulted Deleuzian proclivities to the afro-pessimist project. Finally, Andrew Culp's Dark Deleuze—the subject of this review—is a sort of manifesto for the 'negative reading' of Deleuze,

and makes up in intensity and polemic what it lacks in length and breadth. My aim here is not only to summarize the contents of this small, dense volume, but also to attempt to place it in the context of contemporary political struggles, to which Deleuze is perhaps more important than ever. In order to characterize the aim of Dark Deleuze, one should perhaps quote the author on his own intentions, and the oppositions he wishes to establish: Culp puts forth a Deleuze characterized not by naive affirmation, but rather by "revolutionary negativity in a world characterized by compulsory happiness, decentralized control, and overexposure" (2). In other words, and true to Deleuzian method, Culp wishes to render Deleuze a problem for thought—to understand the "rapport between Deleuze's thought and our time" as a "puzzle for us to solve," rather than a mere tradition to replicate or embellish (4). The guiding motif of Dark Deleuze is nothing other than a hatred for, and desire to destroy, the world as such. Culp imagines a "Death of the World" that follows on the death of God and the death of Man, completing the three-fold project of revolutionary negativity, with a view towards the abolition of the state and the advent of full communism. Much of the legwork Culp performs in Dark Deleuze is split between his (non-)apologies to orthodox Deleuzians with regards to his heterodox reading of a Deleuzian negativity, and the "series of contraries" he lays out in rapid succession—more akin to footnotes to Deleuze rather than fully-fledged concepts—which are aimed at articulating and intensifying a hatred for the world, and calling for its destruction. No doubt, many readers of Dark Deleuze are Deleuzians themselves, and so the talk of the death of the world will appear as less of a shock and more of an index of an internecine debate. An infamous Deleuzianism reads as follows: "We need reasons to believe in this world" (Cinema 2: The Time-Image," 172). Against the realist reading of Deleuze, where 'belief in the world' is meant to signify the need for a re-connection to the world as it is, Culp reads through and past Deleuze, such that one should only believe in the world inasmuch as one desires grounds to destroy it—the 'world' must be understood not only as a mass, social hallucination, but as a transcendental illusion. Seasoned readers of Deleuze will recognize, in each of these contraries (or "nondialectical negations," as Culp describes them), concepts that have caused no small consternation for Deleuze scholarship. The dangers of reading Deleuze tend to often coincide with the boons of reading Deleuze. Since Deleuze's thought is rarely systematic and almost always an intervention into one debate or another, he often appears to hesitate between seemingly opposed concepts, such as cut and fold, interruption and flow, univocity and equivocity, and so on. Decisively, Culp sees [considers] this not as a weakness in Deleuze's thought, but one of its great strengths—namely, the ability to adapt, strategize and act in thought. Thought becomes a life, irreducible to life in general or even to "bare life."1 In other words: thought becomes, or is in itself, politics. Hence the wisdom of his admonishment at the outset of the text: "there is something absolutely essential in [Deleuze's] work, but it would be best not to take it at face value" (4). Deleuzians at large would do well to take heed of this advice. I won't waste the reader's time cataloging my agreements and disagreements with each of Culp's contraries—they deserve to be rigorously evaluated one by one— but it is clear that Culp has done his homework, and that his heterodoxy is genuine. Of note are the critiques of procedural democracy (41-43), the searing takedown of Nick Land's accelerationist project (44-48), and the pervasive emphasis on the powers of the outside (56-59). The section on the subject and the genesis of subjectivity from shame, misery and disgust as much as wonder and freedom, is exemplary of the possibility of a radical politics that dispenses with guilt and innocence as primary categories, ensconced as these latter are in a Christian-capitalist libidinal economy (26-29). As a volume, Dark Deleuze has many weaknesses, some of which Culp ably addresses in a concluding prolepsis: the book is too short, the arguments move much too quickly, the author ignores Deleuze's own prescriptions, and so on and so forth. So be it, Culp seems to say, with a malevolent grin (65). In spite of the perversity and carelessness perceived in Dark Deleuzehy the partisans of joy, Culp insists that in order to be faithful to Deleuze one must, in a very specific sense endorsed by Deleuze himself, betray the master. Dark Deleuze is Culp's philosophical and political 'buggery' of Deleuze, a desperate attempt to escape a desperate situation, in which Deleuze does indeed, or has indeed, become the "ideologist of late capitalism"2 At the end of the day, Dark Deleuze is an important contribution to Deleuze scholarship—and to radical political thought. The 'negative' turn toward a 'sad Deleuze' is, against the partisans of the 'canon of joy,' perhaps perfectly untimely, and the call for a conspiratorial communism characterized by a renewed political struggle that resolutely jettisons liberal platitudes about connectivity and tolerance is a welcome alternative to the banality of what currently passes for 'resistance' to capitalism. Culp is absolutely correct to leave behind the naive, joyous Deleuze of mizomatic connections and networks of flows of desire (all of which was radical in the 1970s, but, alas, no longer) and to affirm instead the destructive darkness at the heart of Deleuze's philosophical project, folded into so many of the prefixes of key Deleuzian terms, de-, a-, in, and non-. Nevertheless, the book's most obvious—and damning—flaw is the omission of any reference to afro-pessimism, the assorted authors of which have been advocating the death, or the end, of the world—using precisely this language and reliance on negativity—for approximately a decade.31 note in passing that Culp, judging from his fascinating discussion of Dark Deleuze here with Alexander Galloway, is well-aware of the afro-pessimists. Suffice it to say that the omission of such important source material from the monograph is troubling, not to mention familiar. In the last instance, Dark Deleuze remains white—all too white.

# 1AR

## Case

**They misread Hudson- she is writing a criticism of the violently essentialized trope of the passive black patient and supports the aff – proves we are not pathologizing**

**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).

**Hudson found that black patients will get doctors to change their practices – or, they’ll shift to new ones.**

**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>

These findings clearly demonstrate that black patients experience a disparity in healthcare quality, and our participants consistently spoke to these observations of disparity during the interaction. It is interesting to note, **however**, that our participants not only were aware of and noticed these differences, but they also shared these observations with their treating physicians. These shared observations are clearly agentive and are conveyed in order to let the physician know that they are dissatisfied with a type of treatment **and that they do not wish to repeat the experience.**

As the literature demonstrates, it is not uncommon for black patients to receive substandard care. What is noteworthy, however, is that the participants in our study were **unabashed in enacting their agency** in order to share their grievances, dissatisfaction and observations with their physicians. As Lim, Tan and Goh (1998) note, patients' complaints are indicative of patient dissatisfaction and point to the need for healthcare personnel to give greater attention to service dimensions such as wait time, professional skill, patient expectations and conduct. As the participants demonstrated, complaints serve as agentive acts that function strategically in an attempt to improve the outcome of the interaction.

## K

**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 concentration**s 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.

#### They misread Beller – his argument’s that the digital platforms through which all communication and radical advocacy – including this debate, AND their ALT – are mediated, accumulate value at a material – NOT discursive – level through attention economies that structure the unconscious irrespective of the message

--MSU = BLUE

**Beller, 18** (Jonathan Beller, Professor of Humanities and Media Studies and Director of the Graduate Program in Media Studies at Pratt Institute, “Prosthetics of Whiteness: Drone Psychosis,” in The Message is Murder, Pluto Press, 2018)

Medea Benjamin in Drone Warfare: Killing By Remote Control, shows clearly how drone warfare is an effort to emasculate the enemy.19 The observation grafts the psychologistics of the drone directly in line with the cinematic gaze. She also cites a 2003 Department of Defense computer program designed to show the human cost of an attack.” “The dead show up as blob-like images, resembling squashed insects, which is why the program was called ‘Bugsplat.’ Bugsplat also became the “in-house” slang referring to drone deaths.”20 The automation that renders targets castrated or as vermin as a means to annihilation and thus also as a means to corporate/imperial subjectivity damages, as Benjamin points out, not just the thousands or tens of thousands of specific targets—whether defined by “personality,” “signature,” or “collateral damage”—but millions of Palestinians, Syrians, Somalians, and others for whom the fabric of life and time is destroyed. This destruction feeds back in the public relations calculus as volatility, and is used to further legitimate and financialize the drone vector. The cybernetics of machines, including industrial machines, photographic technologies, cinema, computation and drones has been in a feedback loop with the bios for centuries. The technical and logistical dimensions have been and remain inseparable from **racial capitalism**. In Control, Franklin says of Kittler’s cold technological determinism: After all, Kittler, whose technological a priori is in this book [Control] deformed into a subjective point of view that is intelligible as a double of that attributable to capital itself [a deformation I, as the author of Message, am sympathetic with], equates the displacement of the subject by the computer with a conflation of targeting and programmability or self-steering: ‘bees are projectiles, and humans, cruise missiles,’ Kittler writes, because ‘one is given objective data on angles and distances by a dance, the other a command of free will.’ What is critical about this claim is that its **ballistic conceptualization of** **sociality** rests on historical conditions under which ‘[e]lectronics … replaces discourse, and programmability replaces free will.’ **Sociality**, from an epistemic position that grounds the control era, **can be understood only as targeting** under the continued impression of free will—a conceptual frame underscored by the fact that the terms reticle (gun sight) and network share a root in the Latin reticulum, ‘net.’21 Franklin sums up, “**Under the control episteme, targeting**, the practice from which Weiner first developed the concepts of control and steering and which, for Kittler, equates to the conflation of free will and programmability—**becomes the horizon for all possibility**.”22 Because all systems (computation, financialization, **visualization**, **militarization**, **national borders** and migration, **racialization**, **aestheticization**, etc.) tend toward and are shaped by the logic of **financialized digitization**, subjectivity within these programs relies on the instantiation of targets (iconic or blurred as necessary). It is, as an experience, only to be found, or at least is primarily found, in the various positions organized by the **logistics of an annihilating gaze**. In this way **subjectivity has itself become a program for murder**; **it renders a subject programmed for murder with all outsides configured as zones of noisy crisis populated by targets.** This neo-liberal, cybernetic **subjectification** **through** active **annihilation** of the outsider is one real, if unconscious meaning of digital “convergence.” **Computational capital instantiates its fractal subjects or dividuals as cruise missiles and all externalities as targets**: the first person shooter game become world. Thus alongside the regular games or risk management, **we have war games**, war porn, food porn, fashion porn, news porn, reality porn, and regular porn. In fact, this is the regular fare, a sick tableau of degraded crap, and it is all part of the attention economy, where everything we look at is emptied of essence and stuffed with psychotic emphasis in an effort to help everyone keep reality at bay in the half-light of the digital imaginary that is **simulation**. This all-consuming production by mediated sensual labor organized by the dead labor of information is an always on expropriation of the libido and the sensual that might otherwise have been turned to other uses (love, sensuality, poetry, community, caring, erotic forms that redefine a relationship to violence by receding from it). The **libidinal expropriation** and reconfiguration characteristic of what is nothing short of **fractal fascism** in a network of dividualized nodes **functions at a variety of levels**, from the ratification of a particular screen image thorough to the game, blog, show, channel, platform or interface and all of their advertisers, shareholders, banks, militaries, and states. We man our dividualizing peepholes as best we can (**for who among us is really a man, and given the terms, who would want to be?),** cutting up worlds in accord with an algorithmic function beyond our ken, **while the bodies pile up** to a height equaled only by that of the profits. The engineering of **fractal fascism bundles** modes of **attention** by means of computerized systems of content delivery, value extraction and metrics of account. Platform “users” become conscious and unconscious organs of this vast automaton. We have, in short, the programmatic simulation of reality, the virtual mise-en-scène of all looking, without the guarantee of **any real event** beyond that orchestrated by the inexorable logic of advertising and **value extraction**. **The logistics and** indeed **pathologistics of these increasingly formalized algorithmic processes preserve the basic annihilation-function of the gaze as operationalized in relation to race, gender and would-be intersubjective formations, but adds a new layer of fungibility that allows for the targeting of potentially anyone, anytime, anywhere with the proviso that the likelihood of a person being targeted is subject to prior encodings of their profile, their digitized identity**. That our thoughts and perceptions are **programmed**, accumulated, and capitalized in relation to these fundamentally weaponized programs for race, gender and financialization, **testifies to the automation and expropriation of the general intellect by racial capitalism**. The overwhelming of the intellect by means of the algorithmic discrete **state machine** is the situation, and the irony that it was “humans,” who programmed the machines, **does nothing to return sovereignty in any meaningful form.** Racial capitalism achieves further autonomy and impunity by means of computational automation. To be meaningful, that is to say in radical sense “political,” sovereignty would have to diverge from the programmatic leveraged accumulation of value and its corollary murder, but few seem capable of offering a new way of organizing things—the white sovereignty of what **Benjamin Bratton** and others refer to as “**the stack**” maintains its stranglehold.23 The general intellect, distributed across **media platforms** and automated in various apparatuses, is not just part of the means of production in the industrial sense, that is, in the sense understood by traditional capitalists; **it is the means of production of sense perception and knowledg**e. **Neither is it an ideal or an immaterial formation**. It is itself distributed among the bodies and machines that constitute the socio-historical domain—the sociality of machines. The general intellect has been rendered as forms of sensuality that are themselves sites for value production that include modes of subjectivity at once fully automated and **fully virtual**. They are virtual in the sense that the referent that would anchor the subject in question—is strictly speaking **a non-entity**, that is, a computational entity, **a simulation**. **Subjectivity is a contingent instantiation**, **a plug-in (**and always was), but the mediatic matrix of its materialization, exceeds the pre-individual linguistic world detected by Freud, Lacan, structural linguistics and poststructuralism, as its local conditions of production and reproduction have been overtaken and absorbed computation. **The unconscious is structured like a language**: a computer language, and that language is **built on racial violence**.

#### BUT, he’s wrong – the computational unconscious theory reductively obscures reflexive agency that solves the link

Fuchs 17 Christian Fuchs is Professor and the Director of the Communication and Media Research Institute, University of Winchester, Social Media a Critical Introduction, pp 89-90

One problem regarding Manuel Castells's (2009) book Communication Power is that he tends to use rather technocratic language for describing networks and communication power- social networks, technological networks and techno-social networks are all described with the same categories and metaphors that originate in computer science and computer technol- ogy: program. meta-programmers. switches. switchers. configuration. inter-operability, pro- tocols, network standards, network components, kernel, program code and so on. I have no doubt that Castells does not intend to conflate the difference between social and technologi- cal networks. He has argued in the past, for example, that social networks are a "networking fonn of social organization" and that information technology is the "material basis" for the "pervasive expansion" of social networks (Castells 2010. 500). But even if the terminology that Manuel Castells now tends to employ is only under- stood in a metaphorical sense, it is a problem that he describes society and social systems in technological and computational terms so that the dijferentia specifica of society in comparison to computers and computer networks - that society is based on humans, reflexive and self-conscious beings that have cultural norms, anticipative thinking, and a certain freedom of action that computers do not have - gets lost. It is no surprise that, based on the frequent employment of such metaphors, Castclls (2009, 45) considers Bruno Latour's actor network theory as brilliant. It is important that one distinguishes the qualities of social networks from the qualities of technological networks and identifies the emergent qualities of techno-social networks such as the lnternet (Fuchs 2008a, 12 I-147). Castells acknowledges that there is a "parallel with software language" (Castells 2009. 48) in his terminology, but he does not give reasons why he uses these parallels or why he thinks such parallels are useful. Obviously society is shaped by computers, but it is not a computer itself, so there is, in my opinion, simply no need for such a technological conflationism. Computer metaphors of society can, just like biological metaphors of society, become dangerous under certain circumstances so, in my opinion, it is best not to start to categorically conflate the qualitative difference between society and technology. Technology is part of society and society creates, produces and reproduces technology. Society is more than just technology and has emergent qualities that stem from the synergetical interactions of human beings. Technology is one of many results of the productive societal interactions of human beings. It therefore has qualities that are, on the one hand, specifically societal but, on the other hand, different from the qualities of other products of society. It is a common aspect of social and technological networks that there are nodes and interactions in all networks. One should not forget the important task of differentiating between the various emergent qualities that technological networks and social networks have - emergent qualities that interact when these two kinds of networks are combined in the form of techno-social networks such as the lntemet so that meta-emergent techno-social qualities appear.