**\*\*1AC**

**Adv One**

**Advantage One is Federalism**

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

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

**The FTC’s State Action Report**

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

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

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

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

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

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

III. DOCTRINAL CRITICISM

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

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

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

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

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

IV. PROPOSED SOLUTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**McGinnis 11**

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

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

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

**Wilson ‘13**

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

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

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

**Miller ‘12**

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

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

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

**Specter ‘12**

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

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

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

**Philp ‘14**

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

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

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

**Philp ‘14**

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

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

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

**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.

**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)

# 2ac

## Case

### Adv 1

**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.

**practitioners**

**2ac – practitioners turn**

**Here’s more ev from Carthon that – regardless of the variables – access is key. It’s a materiality add-on and disad to the Alt. Failure to do the Aff means unique modes of violence towards black populations.**

**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/

**Historically marginalized individuals**

“For historically marginalized individuals, including black and brown communities, low income communities, and residents living in medically underserved areas, a lack of **access** to primary care, preventive services, and mental health services is really **at the core** of many of the poor physical and health status disparities we see today,” she continued. “And the concern is that **s**cope **o**f **p**ractice restrictions contribute to that by impacting NPs’ ability to evaluate, diagnose or prescribe, or to work in the places they’re needed most.”

“We now **know** from a **growing number of studies** and reports that residents living in states with more restrictive nurse practitioner **SOP** **reg**ulation**s** have, on average, less access to health care, and longer wait times. The supply of nurse practitioners in those states is also actually lower.”

“The best way to utilize NPs,” **Carthon told the audience**, “is let them work to the top of their license, let them do what they’re trained to do. We have to reduce this **national patchwork** of different **s**cope **o**f **p**ractice restrictions that leads to such variations. From an equity perspective, we need to work more in coalition building with one another. As someone who’s been an NP for 20 years, I think we’ve been having these turf wars for far too long, and patients get no benefit from that.”

**The Hudson study is a subset of a larger parent study – over 98% of those participants identify s black, female, and lower-income.**

**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>

This sampling of participants largely reflects the demographic composition of the larger parent study. All participants self-identify as black, as did 98.5% of the parent study. Also consistent with the larger study, participants were mostly comprised of women and earned less than $30,000. This demographic make up of undereducated, lowr-income participants speaks directly to Dutta's (2008) conceptualization of structure, as participants' status demonstrates marginalization that potentially impedes their access to quality care.

**Black patients do resist bad diagnoses**

**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>

While there is a clear dearth of research concerning interactional resistance, our findings confirm existing previous findings. Our participants **did** indeed resist diagnoses that they deemed inappropriate (Stivers, 2005). Just as Ijas-Kallio, Ruusuvuori, and Perakyla's (2010) findings indicate, our participants also referenced their immediate symptoms, past symptoms and information provided during previous medical visits as resistance tactics when resisting the physician's recommended diagnosis. However, the resistance tactic of questioning the physician's competence is a new contribution to interactional resistance research. This tactic may be owed to a number of unique circumstances, specifically, the composition of this study's participants. Unlike Ijas-Kallio's study (2010), which consisted of Finnish patients in a primary setting, our participants are comprised of low-income black patients. The act of questioning a physician's competence is a clear resistance tactic, but is also indicates distrust. This finding is hardly surprising in light of the fact that this study's participants reported a high degree of previous perceived discrimination. Given the unique findings generated from this population, future research should examine the patterns of resistance that emerge from this and similar populations of minority and marginalized individuals.

**The issue is not one of CARE – it’s access. We blunt the critiques of care through Nurse Practitioner models advanced by Dr Carthon and others.**

**Patients will successfully exert agency – especially in instances of potential misdiagnosis**

**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>

As such, the interdependent relationship between culture and agency was clearly evident during observations of patient agency and resistance. Patients managed their presentation to the physician, carefully constructing their self-image in an effort to be positively perceived. Patients **were adept at enacting agency**, often surprisingly so. Participants routinely questioned the qualifications of their physicians, and closely monitored the physician's progress during the interaction in order to ensure that all the pertinent information was considered and processed during the construction of the diagnosis and treatment. Objections and interruptions were utilized to ensure that the adequate consideration was given to all of the key pieces involved during the identification of the diagnosis and treatment plan. Patients consistently asked questions of their physicians, clarifying information when needed and expressing their concern when the treatment plan did not resonate with their own expectations or desires. Patients worked as advocates in their own interests, displaying vigilance as they monitored the progression of the clinical interaction, as well as the physician's comprehension of their illness and related symptoms. Patient resistance represented this same process of advocation, as patients pressed physicians in an effort to ensure that they had received the most accurate, appropriate diagnosis and treatment plan. While patients were perhaps not always correct in their assertions, their actions are perhaps understandable given the context of a history of misdiagnoses and inadequate patient education. The link between enactment of agency as a result of cultural values are clearly shown in our findings.

**k**

**2ac – fw**

**(\_\_) Framework: the role of the ballot is to determine desirability of the aff – prefer ballot roles where Affs access their impacts. Anything else moots the 1ac, means “impact calc is disguise,” and creates activists who are incapable of engaging with the state. Any role of the ballot they advance has to provide clear roles for both sides with roughly equal ground. Neg impact can’t be the lone criteria – it’s not ethical unless we consider the externalities of the Neg’s failing Alt.**

**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.

**2ac – perm**

**( ) Perm---do plan and all non-competitive parts of the alt –**

**Multiple net benefits to the perm:**

**1 – plan’s key to ALT efficacy – narrowing scope of practice laws is key empower effective community care – that’s 1ac Allen and Cortes**

**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**.

**Health Ks – No Link – 2AC**

**Their Ks of health, healthcare, and physicians don’t contextualize to NPs – there’s a distinction between medicine and nursing – their Ks are about “medical work” but NPs aren’t simply facsimiles for physicians. NPs provide “care work” that’s a transformative approach to the medical encounter that accounts for social and economic determinants of health outcomes**

**NPs professional norms are fundamentally different from physicians – their approach to care includes addressing social determinants and providing holistic care**

**Entman 20** [Liz Entman, Vanderbilt University Medical Center reporter, internally citing LaTonya J. Trotter, Assistant Professor of Sociology at Vanderbilt, 6-10-2020 https://news.vanderbilt.edu/2020/06/10/nurse-practitioners-practice-more-than-medicine/]

In More than Medicine: Nurse Practitioners and the Problems They Solve for Patients, Health Care Organizations, and the State, Trotter observed the work of a group of **n**urse **p**ractitioner**s** at a clinic that served 400 elderly African American patients with complex health problems and limited financial resources. What she realized was that NPs were not simply healthcare professionals capable of performing virtually all the same tasks as physicians, but they also worked to solve **many** other **non-medical challenges** their patients faced related to poverty. In many cases, these problems may have once been addressed through the public social safety net, but no longer are—or never have been.

“It’s not just a question of high demand and scarcity of providers that nurse practitioners can help bridge,” she said. “The problem is that the work NPs do tends to reflect a broader lack of coordinated health care by the state. In the United States, medical care is privately provided, but 75 percent of it is publicly funded. What I observed raises important questions about how government could reconsider what it means to fund health care.

Transforming the medical encounter

The nurse practitioners Trotter observed were **not solely focused on the medical challenges** their patients faced. They also ended up dealing with the dozens of other issues that impacted their ability to care for themselves, such as going **grocery shopping**, **keeping up with** their **homes** or **finding someone to help** a patient **with post-operative care.**

“Many of the problems health care organizations—and nurse practitioners especially—are tasked with solving aren’t just medical problems, but social ones,” Trotter said.

Utility players for their organizations

Trotter found that **n**urse **p**ractitioner**s** filled a number of roles that were not directly related to medical care. That could mean picking up administrative tasks, coordinating care with other providers and addressing customer service issues. Not only were they providing **holistic care to their patients,** she said, they were providing holistic care, in a way, to their employer. That willingness reflects a distinctly nursing perspective, Trotter said.

“Nurses really do feel that their roles are **different than physicians’**,” she said. “So they’re not always doing this extra work simply because they feel pressed into it, but because their **professional norms** orient them toward feeling that this is part of what it means to be a nurse. They’re much less likely to look at a task and say, ‘That’s not my job.’ They’re much more likely to do that work on behalf of their employer as well as their patients.”

**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.

**Agency disad – 2AC**

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

**Hudson ‘15**

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

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

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

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

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

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

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

**Theory**

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

**Gaffney ‘16**

Adam Gaffney, Instructor in Medicine at Harvard Medical School and a Pulmonary/critical care doctor. The author holds an MD from New York University and expressly identifies as an “advocate for Single-Payer” as the lead on the author’s Twitter handle. Internally quoting Damon Tweedy – the author of the book Black Man in a White Coat. Tweedy identifies as black and is a graduate of Duke University School of Medicine. He is an associate professor of psychiatry at Duke University School of Medicine and staff physician at the Durham Veteran Affairs Health System. Also internally quoting Dayna Bowen Matthew, a leader in public health who focuses on racial disparities in health care. Matthew identifies as a black female. Matthew joined the faculty at the University of Virginia in 2017. She is the author of the book Just Medicine: A Cure for Racial Inequality in American Health Care. Matthew previously served on the University of Colorado law faculty as a professor, vice dean and associate dean of academic affairs. “Is the Path to Racial Health Equity Paved with “Reparations”? The Politics of Health, Part II” – LA Review of Books - 3-7-2016 – #CutWithRJ - [https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/#](https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/)!

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

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

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

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

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

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

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

2. Black doctors: Discrimination within the profession

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

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

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

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

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

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

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

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

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

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

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

3. Jim Crow medicine: Past and present

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

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

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

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

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

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

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

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

4. Health equity and health system universalism

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

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

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

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

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

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

**A2: alt**

**Their Gumbs survival and mothering ev spins Aff.**

**Gumbs has a specific meaning of “survival” – “dismantling Cap”. The Aff is OBVIOUSLY in that direction.**

**Gumbs 10**

Alexis Gumbs; Ph. D Duke University, “**We can learn to mother ourselves, the queer survival of black feminism 1968-1996**,” p. 104-5

My engagement with the term “survival” in the work of these two radical Black feminist authors is an attempt to reactivate the hope that our survival will obliterate the violent hegemonic narratives that make a radical, leftist, queer Black feminism necessary. In this chapter I read Jordan and Lorde, respectively, in order to examine the linguistic context in which the term survival becomes necessary and the poetic intervention through which the meaning of survival can shift. Drawing on this multiplicity and the queer temporality in the word survival, I use survival here to imagine a futuristic relationship in the present that does NOT presuppose the reproduction of that present in the future. Thus I find the word survival generative and evocative to describe the praxis of Black feminists who imagined that their practices, incompatible with the world reproduced by the dominant narrative of their time, would survive as traces in a future beyond their agency. The situations of this dissertation, both the situation of the radical Black feminists that responded to post-civil rights backlash and an anti-welfare imperialist state, and the situation of the threatened knowledge project that this dissertation attempts to achieve, require a rigorous and hopeful redefinition of survival. If (queer/Black) mothering, the other key term of this dissertation, marks the production of rival meanings for Black life and rival social forms that affirm and perpetuate criminalized existence, survival is that process, and possibility that queer Black mothering produces. June Jordan and Audre Lorde, co-mothers of this project and the primary theorists featured in this dissertation, had much to say about survival. They each use the term survival in a manner that intervenes into the dominant meaning of survival, which the Oxford English Dictionary shows us is rooted in a tradition through which power and property systems outlive death through inheritance. Both Jordan and Lorde insist that the type of “survival” that they are interested is in direct contradiction to capitalist systems of wealth and power and the bodily and embodied domination that those systems rationalize. They draw on the definition of survival that emphasizes life after a disaster, and the disaster that these authors hope their words will survive is the emergent neoliberal capitalist order they witnessed in their lifetimes. The queer survival of Black feminism draws on an anthropological definition of survival, that cultural/spiritual practice that continues to exist even after the system in which it was made meaningful, no longer does, making another meaning possible.

**Gumbs Alt fails – it departs a system, but prescribes nothing after. The squo emerges – renders their O not unique.**

**Griffin ‘12**

REVIEW OF GUMBS – Sarah Mantilla Griffin is a mother and a literary critic. She holds a Ph.D. in English from the University of Pennsylvania and a B.A. with honors in American Studies from Stanford University. Her research primarily focuses on African-American literature, with special interests in women’s writing, black feminist theory, and sound theory. Review of “101 Things That Are Not True About The Most Famous Black Women Alive” by Alexis Pauline Gumbs – Feminist Wire – Dec 19th – http://thefeministwire.com/2012/12/book-review-101-things-that-are-not-true-about-the-most-famous-black-women-alive/

Despite her efforts, Gumbs does not fully **escape the bind** of truth. By presenting what is not true, she provides the poetic equivalent to a photographic negative, which leaves space for a positive image to be constructed. **This negative space**, however, is outlined by the claims of the untruth and thus **has its limits**. If they are definitively untrue, then her statements hold the opposite truths within them. These inner truths directly contradict prevailing images **but are no less defining**. The untruths are, in their own ways, statements of fact and therefore inflexible. Although Gumbs’s untruths offer new avenues for thinking about these women, **they rigidly define the boundaries of this thinking.** In this way, Gumbs may, at times, reproduce the type of strictures that the collection aims to disrupt. These constraints reorient discourse around these women, but occasionally leave conspicuous gaps in the conversations. Notably near-absent are moments of critique. Constructive criticism deriving from a place of, as Gumbs puts it, “loving black women,” could have deepened the impact of the poems by further expanding the possibilities for thinking and speaking about the most famous black women alive, while still creating distance from typical evaluations of these women.

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#### Comprehensive studies are aff – their links are assertions from physicians groups

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]

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.