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### 1ac – advantage

#### The advantage is Practitioners, or “NPs”:

#### Scope of Practice laws are anticompetitive barriers to autonomy for Nurse Practitioners

Smith 21 (Laura Barrie Smith, Health Policy Center, Urban Institute, Washington, District of Columbia, “The effect of nurse practitioner scope of practice laws on primary care delivery,” October 8th, 2021, <https://doi.org/10.1002/hec.4438)//NRG>

Like all health care providers, NPs are subject to considerable state-level regulation, and a key aspect of this regulation is their SOP. Most broadly, SOP dictates the range of procedures and services that NPs are legally allowed to perform. SOP laws also specify the degree of practice and prescriptive authority for NPs and outline requirements for collaborative practice agreements between NPs and physicians. Most collaborative practice agreements require physician review of NP patient charts. The agreements can also include practice protocols, require physician supervision, limit the number of NPs with whom each physician can have a collaborative practice agreement, and/or impose restrictions on NP prescriptive authority (Adams & Markowitz, 2018).

The American Academy of Nurse Practitioners considers a state to have “full practice authority” when NPs can legally practice and prescribe without any physician oversight and under the exclusive licensure authority of the state Board of Nursing (American Association of Nurse Practitioners, 2018c). As of 2020, 23 states and the District of Columbia grant NPs full practice authority. All other states maintain reduced or restricted authority (Phillips, 2020).

In 2011, an influential report by the National Academy of Medicine (formerly the Institute of Medicine) urged states to allow NPs to practice to the full extent of their training (Institute of Medicine, 2011). Since then, many research institutions, non-governmental organizations, and government agencies have advocated for states to relax their SOP laws in order to grant NP full practice authority (Adams & Markowitz, 2018; Buerhaus, 2018; Gilman & Koslov, 2014). A recent policy proposal from the Brookings Institution concisely summarized the problems with restrictive SOP laws, calling them “anticompetitive policy barriers” that “restrict competition, generate administrative burdens, and contribute to increased health-care costs, all while having no discoverable health benefits” (Adams & Markowitz, 2018). Following the National Academy's report, 12 states relaxed their NP SOP laws between 2011 and 2017 to increase NP practice authority (Figure 1). These relaxations of SOP laws eliminated requirements for collaborative agreements between NPs and physicians (sometimes following a limited, post-graduation period of collaboration/supervision), and abolished requirements for NP practice protocols if there were any.

Despite the momentum for relaxing SOP laws, considerable political resistance remains, particularly in southern states. Some legislators frame the debate over SOP as a professional turf war (Chesney & Duderstadt, 2017). Physician groups such as the American Medical Association and the American Academy of Family Physicians oppose full practice authority, and physician group political action committees have historically been successful in maintaining strict SOP laws (American Academy of Family Physicians, 2020). Political spending by physician interest groups is shown to be strongly correlated with restrictive SOP laws for NPs, while spending by hospital interest groups is shown to be correlated with NP autonomy (McMichael, 2017). While opponents of relaxed SOP laws cite concerns are about patient safety – emphasizing that NPs receive fewer years of formal education than physicians – evidence does not show that NP-provided care is unsafe for patients (American Academy of Family Physicians, n.d.; American Medical Association Advocacy Resource Center, 2017; McMichael et al., 2018).

#### The FTC can challenge State-Level SOP restrictions now – that fails due to immunity – cements the “physician-only” model

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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 independently 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

#### State action immunity blocks enforcement of anticompetitive practices sanctioned by incumbent interests – expanding prohibitions solves

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/

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 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.

#### The impact is massive – SOP restrictions block nurse-led clinics that expand access to 81 million people

Morgan 21 (Larissa, The Regulatory Review, “Law Reforms Promote Nurse-Managed Care,” September 1st, 2021, <https://www.theregreview.org/2021/09/01/morgan-law-reforms-promote-nurse-managed-care/)//NRG>

Advanced practice registered nurses lead nurse-managed clinics, which offer primary care and wellness services through partnerships with federally qualified health centers, academic institutions, nonprofits, and social services agencies. These clinics address the social determinants of health by increasing access to care and improving patient satisfaction, health outcomes, and behaviors that affect health. Hailed as “the future of primary care in the United States” by some health policy experts, nurse-led clinics support medically underserved populations, particularly in areas with a shortage of primary care physicians.

Nurse practitioners offer the same—and, on some metrics, better—quality of care than primary care physicians, while also providing cost savings to the U.S. health system.

For routine wellness visits, Medicare—the federal health insurance program for elderly U.S. residents and certain younger people—reimburses nurse practitioners at 85 percent the rate of doctors. Primary care from nurse practitioners is also less expensive for private insurers and patients who pay out-of-pocket. In addition to lower payments, nurse-managed care may decrease expensive emergency room visits by focusing on preventive services.

Nurse-led clinics were federally recognized as a health care delivery model following the passage of the Affordable Care Act (ACA). Although the ACA increased the number of Americans with health insurance, the supply of primary care physicians has remained insufficient to match the needs of the insured population.

To address this shortcoming, the ACA established a $50 million grant program to expand the financial capacity of safety net providers, such as nurse-led clinics. The federal government distributes funding under this program based on a number of factors, including the financial need of the safety net provider and other available funding at a state, local, and organizational level. To qualify for funding, nurse-led clinics must meet certain regulatory requirements. First, nurses must serve as the primary providers at such clinics where at least one advanced practice registered nurse works in a management capacity. Second, the nurse-led clinic must offer a full range of primary care and wellness services to all patients, regardless of their socioeconomic or insurance status. Finally, nurse-led clinics must create community advisory committees composed of patients to oversee the impact of the clinic and seek civic input.

Although some health policy experts have praised the ACA’s funding for nurse-managed clinics as “the beginning of a new era for nurse-led health care,” variability across state regulations in nurse practitioner practice authority creates barriers to expanding these clinics.

Specifically, states differ in the amount of authority they grant nurse-led clinics to practice without physician oversight. Many states require nurses to enter into collaborative practice agreements with physicians before they can practice independently. To gain full practice authority, some states require nurse practitioners to complete several thousand hours or, in some cases, years of training under the supervision of a physician. Other states extend physician oversight into operations of nurse-led clinics.

For example, in addition to mandating 4,000 hours of supervised practice, Alabama requires supervising physicians to visit nurse-led sites at least twice per year. For nurse practitioners who have yet to complete their mandatory supervised practice, a physician must oversee a minimum of 10 percent of their work at the clinic. Some medical experts argue that collaborative practice regulations are necessary to protect patient safety and quality of care. Other health experts, however, explain that—compounded with a growing insured and aging population—these regulations hinder health care for the 81 million Americans who lack access to a primary care physician. To keep up with these demands in Alabama, for example, the state would need to increase its number of primary care physicians by 23 percent over the next nine years.

In response to these mounting pressures for access to additional medical professionals, some states have changed their laws to grant nurse practitioners full practice authority. Following 22 other states’ existing laws, California recently passed legislation that permits nurse practitioners to practice independently starting in 2023. Currently, nurse practitioners in California are required to work under the direction of a physician, and to collaborate with the physician and the larger health system in which they operate to establish treatment and care practices.

This new state legislation does not completely abandon this partnership, but it does afford nurse practitioners more freedom. Under the new law, nurse practitioners must complete a three-year, supervised “transition to practice” period before they are eligible to operate clinics independently, similar to a regulatory model used in states such as Connecticut, Delaware, and Nebraska. Although the legislation permits nurse practitioners to offer primary care and some diagnostic services, they must refer patients to physicians when medical needs exceed the scope of their practice capacity. This new legislation has sparked debate in the medical community. Proponents of physician-based care argue that easing supervision could compromise patient health. To resolve physician shortages, the state should instead focus on increasing training and education of providers, suggests the California Medical Association. Advocates of full practice authority welcome the legislation as an opportunity to expand care to needy patients while promoting the development of new health care delivery models, such as nurse-managed clinics. As the shortage of medical workers has worsened during the coronavirus pandemic, other states—most recently, Massachusetts—have granted full practice authority to nurse practitioners as part of larger health care reform efforts.

States will likely continue to update their health care laws to address the systemic inequalities that have intensified amid the pandemic. With heightened awareness of the social determinants of health, disparities in access to care, and rising health care costs, nurse-led care appears to serve as one solution to the existing challenges faced by patients across the United States.

**NPs are key – first is shortages – COVID highlights the pivotal role of SOP laws – shortages are classist and racist in nature**

**Heath 20** Sara - Managing Editor, Xtelligent Healthcare Media. Sara’s been writing about the healthcare industry since 2015. Sara's healthcare interests include patient-provider communication, patient engagement technology, and the social determinants of health. PatientEngagementHIT 7-20-2020 - https://patientengagementhit.com/news/why-nurse-practitioners-are-pivotal-in-health-equity-work

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Legal interventions are useful for challenging health disparities and contextualizing reform to address social determinants of health

Stipp & Smith 19 Karen Flint Stipp, MSW, PhD, is associate professor at Illinois State University School of Social Work. Trista Smith - Illinois State University. At the time of this writing, co-author Trista Smith was an MA student at Illinois State University’s School of Social Work and is currently an Adult Protective Service Case Manager at Prairie Council On Aging. This review internally quotes Dayna Bowen Matthew, a leader in public health who focuses on racial disparities in health care. Matthew joined the faculty at the University of Virginia in 2017. She is the author of the book Just Medicine: A Cure for Racial Inequality in American Health Care. Matthew previously served on the University of Colorado law faculty as a professor, vice dean and associate dean of academic affairs - "Review of Just Medicine: A Cure for Racial Inequality in American Health Care by Dayna Bowen Matthew” - Journal of Sociology & Social Welfare - Volume XLVI - Number 4 - December 2019 - #E&F – modified for language that may offend - https://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=4358&context=jssw

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

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

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

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

**Second is chronic illness – NPs empower access and collaboration between communities and health care systems – especially over chronic illness**

Breathett & Cortés 21 Dr. Khadijah Breathett is an Assistant Professor, as well as heart failure specialist in The Division of Cardiovascular Medicine, Sarver Heart Center, University of Arizona. Her research interests include reducing racial/ethnic and gender disparities in advanced heart failure and preventing those populations from developing advanced heart failure. Dr. Breathett has developed several outcomes and population studies as well as community interventions focused on reducing racial/ethnic and gender disparities in cardiovascular disease. Dr. Yamnia I. Cortés is Assistant Professor at the University of North Carolina at Chapel Hill (UNC-CH) School of Nursig. Dr Cortés leads an interdisciplinary program of research focused on 1) understanding sociocultural, environmental, and biological factors that impact midlife women’s health; 2) the interface between reproductive aging and cardiovascular disease risk; 3) interventions to promote cardiovascular health, particularly in Latinas. Methodologically, Dr. Cortés integrates approaches from biosocial research, epidemiology, behavioral medicine, and community engagement strategies. “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.

#### The aff is key – practitioner shortages hit the medically marginalized hardest

Sonenberg 17 (Andréa, PhD, WHNP, CNM-BC, Pace University New York, and Hillary J. Knepper MPA, PhD, Pace University New York, “Considering disparities: How do nurse practitioner regulatory policies, access to care, and health outcomes vary across four states?,” Nursing Outlook, Volume 65, Issue 2, March–April 2017, Pages 143-153, https://doi.org/10.1016/j.outlook.2016.10.005)//NRG

Introduction

Despite its position as a global economic leader, the U.S. health outcomes continue to lag behind many other less developed nations, whereas health disparities across U.S. subgroups have endured for decades (Docteur & Berenson, 2014). In a recent study, Salway et al. (2016) identify the imperative for greater study and understanding of the full implications of policy on health disparities. In rural communities and inner cities, access to primary care is particularly inadequate (Shin & Rosenbaum, 2012). Minority groups are disproportionately overrepresented among the uninsured (Agency for Healthcare Research and Quality, 2015, Murphy et al., 2015). Amplifying the effects of this access disparity, rates of chronic illnesses such as diabetes, kidney disease, and heart disease are disproportionately higher in minorities (Centers for Disease Control and Prevention, 2012, Flack, Fung, and Rogers, 2010). Cancer and heart disease mortality rates are higher for African Americans than Whites (Murphy et al., 2015). In the 2014 Commonwealth Fund report on 11 industrialized countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, and United States), the U.S. health care system ranks at the bottom in overall quality, cost-related access, and equity (Davis, Stremikis, Squires, & Schoen, 2014).

In the United States, two persistent problems contribute significantly to health disparities, the ability to pay for health care (largely, access to health insurance) and access to health care providers, with particular emphasis on primary care. When the Patient Protection and Affordable Care Act P.L. 111 to 148 (ACA) was enacted, more than 15% of Americans were uninsured and more than 20% were underinsured (Kaiser Family Foundation, H.J, 2012, Rovner, 2009, U.S. Census Bureau, 2011, U.S. Census Bureau, 2015). By 2015, the ACA has greatly expanded access to health care. However, it is estimated that 23 million Americans, 7% of its total population, will remain uninsured by 2019 (Institute of Medicine, 2010, Mays and Smith, 2011, Naylor and Kurtzman, 2010). At the same time, demand for primary care providers is anticipated to remain high, with shortages projected to exceed 40,000 (Bodenheimer and Pham, 2010, Cassidy, 2012, Health Resources and Services Administration et al., 2013, Jacobson and Jazowski, 2011, Marsh et al., 2012, Purnell et al., 2016).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Reversing SOP restrictions helps marginalized patients at the levels of cost and access – NP autonomy empirically reduces health inequities

Sonenberg 17 (Andréa, PhD, WHNP, CNM-BC, Pace University New York, and Hillary J. Knepper MPA, PhD, Pace University New York, “Considering disparities: How do nurse practitioner regulatory policies, access to care, and health outcomes vary across four states?,” Nursing Outlook, Volume 65, Issue 2, March–April 2017, Pages 143-153, https://doi.org/10.1016/j.outlook.2016.10.005)//NRG

One proposal to address the health care practitioner deficit is to maximize the utilization of Advanced Practice Registered Nurses (APRNs) (Auerbach et al., 2013a, Liu et al., 2014, Paradise et al., 2011, Reagan and Salsberry, 2013, Yee et al., 2013), a provider group that provides well-documented high-quality health care, often with improved outcomes at a lower cost (Buerhaus et al., 2015, DesRoches et al., 2013, O'Grady et al., 2012). Key standards for nurse-led health care include advanced practice certification and identification of, and access to care for, vulnerable populations (Chin, Lam, & Lo, 2011). The effectiveness of nurse practitioners (NPs) in primary health care provision is well supported in the literature (Grumbach et al., 2003, Hansen-Turton et al., 2010, Jacobson and Jazowski, 2011, Newhouse et al., 2011, Oliver et al., 2014, Reagan and Salsberry, 2013, Vonderheid et al., 2003). However, it is important to note that state policy may inhibit optimal NP practice and subsequently affect health outcomes (Knepper et al., 2015, Kuo et al., 2013, Lugo et al., 2007, Poghosyan et al., 2014, Sonenberg, 2010, Sonenberg et al., 2015). This article examines the key demographics, public and regulatory policies, health workforce capacity, and primary health outcomes of four states of the United States.

Background: Disparities Health Equity and Health Outcomes

Having just observed the 30th anniversary of the Heckler (1985) Report, it is important to note that although progress has been made with differences narrowing since 1985, significant health disparities continue to exist among U.S. morbidity and mortality rates. In 2013, White Americans had a mortality rate of 731 deaths per 100,000, whereas African Americans had a mortality rate of 860.8 per 100,000. Rates of obesity and diabetes deaths were also higher for American Blacks (72.7% and 38.4/100,000, respectively) than for Whites (62.8% and 19.4 per 100,000, respectively), as were the rates of asthma (16.6% Blacks and 14.1% Whites) (CDC, 2013). Health equity does not currently exist among the poor, racial minorities, or in rural communities (Purnell et al., 2016). The continuation of these health inequities promotes the evidence that structural racism persists, placing a significant burden on societal health, with the impact of socioeconomic disparities, institutional factors, and segregation affecting health care delivery and outcomes (Spalter-Rogh, Lowenthal, & Rubio, 2005). Hall and Fields (2013) call for continued improvements in education, training, and open communications to break down these structural barriers in nursing, whereas Matthew (2015) asserts that legal measures may be necessary complementary tools to improve socioeconomic and educational equity and break down structural racism in health care.

Disparities also exist between health outcomes of populations living in metropolitan centers versus rural areas. According to the Rural Health Reform Policy Research Center (Meit et al., 2014), the incidence of diabetes for Americans in rural areas is 10.9%, whereas it is 9.9% for urban Americans. “For the nation as a whole, age-adjusted activity limitation rates from 2010 to 2011 were lowest in fringe counties of large metro areas and highest in the most rural counties” (Meit et al., 2014, p. 60). Mortality rates related to ischemic heart disease are 206.5 for those living in areas without a metro center of >10,000, whereas for those residing in a large metro center, the mortality rate from the same cause is only 174.9. The life expectancy of rural Americans is two years less than for those living in urban centers (76.8 and 78.8 years, respectively) (Meit et al., 2014). Health equity, as defined by the U.S. HRSA Office on Health Equity, “is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality” (HRSA Office of Health Equity, 2016). Unfortunately, the lack of health equity is ubiquitous, with global advancements in socioeconomic quality of life indicators necessary if health equity is going to be achieved (Marmot & Allen, 2014).

Access to Care

Disparities also persist in access to care. In 2011, 15% of Medicaid registrants were White, whereas African Americans and Latinos comprised 32% and 30% of the Medicaid recipients, respectively (KFF, 2013a). The rates of uninsured were 13%, 21%, and 32%, respectively (KFF, 2013b). Although the rates of uninsured dropped from 24.6 to 15.9% for African Americans and from 40.3 to 33.2% for Latinos in the first quarter after the ACA began enrolling registrants, each group's uninsured rate remains far higher than that of American Whites (11.1%) (AHRQ, 2015). In all regions of the country, there is a lower percentage of residents of large fringe urban areas on Medicaid than those residing in nonmetropolitan areas (Meit et al., 2014). There were only 4,084 rural health clinics for 59,492,267 (19%) residents living in rural areas (U.S. Census Bureau, 2015). Throughout the country, there are greater numbers of all physicians and dentists (both generalists and specialists) in metropolitan regions than in nonmetropolitan regions (Meit et al., 2014). Interestingly, statistics for other nonphysician primary care providers were not reported by the Rural Health Reform Policy Research Center. Although, several researchers have discovered that a larger percentage of NPs practice in rural areas than other primary care providers (Grumbach et al., 2003; Newhouse et al., 2011), there is no database reporting percentage of NPs practicing in rural regions compared with metropolitan areas. Meanwhile, being poor and rural suppresses the number of NPs within communities (Reagan & Salsberry, 2013). In total, there are 59 million people living in designated primary care Health Provider Shortage Areas (HPSA) among which rural communities remain disproportionately overrepresented (Shin and Rosenbaum, 2012, Health Resources and Services Administration, 2015c). Chetty, O'Donnell, Blane, and Willems (2016) note the opportunity for primary care to improve health equity. As discussed in greater detail in the next section, NPs are delivering substantial primary care services, illustrating the potential for significant improvements in health equity. The Area Health Resource Files do report the statistic at the state and county level (HRSA, 2015a), the findings of which will be reported in the Results section of this article.

Nurse Practitioners

Addressing the Health Workforce Shortage

Healthy People 2020 is a national multidisciplinary collaborative effort to frame and usher efforts to improve population health through the development and implementation of population-based initiatives using an ecological and determinant-of-health approach (U.S. Department of Health and Human Services [USDHHS], 2015). The goals and framing of Healthy People 2020 are consistent with the 2012 Institute of Medicine, 2012a, Institute of Medicine, 2012b For the Public's Health: Investing in a Healthier Future Primary Care and Primary Care and Public Health: Exploring Integration to Improve Public Health, both of which stress the need to integrate the practices of primary care and public health. In a significant effort to address health inequality in the United States, the Patient Protection and Affordable Care Act (ACA) strives toward Healthy People 2020 goals (CDC, 2011) by improving access to care for greater numbers of Americans, while also reforming the approach to health care to be more focused on health promotion and illness prevention. Along these lines, the ACA provides myriad direct and indirect opportunities for nurses, with new payment structures and models of care delivery. Concomitantly, the IOM (2010) recommended transforming nursing education, practice, regulation, and leadership to improve population health, but regulatory barriers persist.

It is estimated that more than 65% of NPs work in primary care practices (American Association of Colleges of Nursing [AACN], 2015), with reforms enabling more independence. Massachusetts reformed its NP regulations in 2008 to improve patient access to primary care by passing a statute that recognized NPs as primary care providers (Ober & Craven, 2009). Furthermore, 2014 federal legislation improved access to NP services under the Public Health Service Act by allowing Medicaid billing by any appropriately licensed health care provider (AACN, 2015). Through a number of its provisions, the ACA calls for improved quality of care, the promotion of quality health outcomes, and improving access through an expanded primary care workforce, thereby increasing the demand for NPs in primary care (American Academy of Nursing, 2010, Fairman et al., 2011, Institute of Medicine, 2010, Patient Protection and Affordable Care Act, 2010).

Compared with physicians, NPs are more likely to deliver care to underserved populations (Grumbach et al., 2003; Hansen-Turton, Ware, and McClellan, 2010; Newhouse et al., 2011). Benefits of NP care include quality-of-care indicators similar to physicians (Jacobson & Jazowski, 2011) and improved patient compliance and knowledge (Keleher, Parker, Abdulwadud, & Francis, 2009), with NP patient satisfaction rates higher than those of physicians (Cassidy, 2012, Keleher et al., 2009, Newhouse et al., 2011). NPs deliver high-quality health care at a lower cost than physicians and with improved outcomes (Newhouse et al., 2011, Oliver et al., 2014).

Scope-of-Practice Regulations

The regulation of NP scope of practice (SOP) occurs at the state level. Each state assigns this purview to its Board of Nursing, Education, or Medicine. SOP law covers three areas: legal authority, prescriptive authority, and reimbursement (authority and rate) (Yee et al., 2013). Correlations among access to care, restrictive state regulatory policies, and health outcomes in vulnerable populations have been identified in the literature (DesRoches et al., 2013, Lugo et al., 2007, Knepper et al., 2015, Sonenberg, 2010, Sonenberg et al., 2015). Although the movement to modernize NP scope of practice (SOP) acts has gained momentum in recent years, only 23 states and the District of Columbia have succeeded at full NP practice independence. More favorable NP SOP regulations increased the number of Medicare beneficiaries accessing primary care (Kuo et al., 2013). This important finding provides evidence that one way to improve primary care access is to reduce NP SOP restrictions (Déry et al., 2015, Gadbois et al., 2014, Gilman and Koslov, 2014). A recent study identified the cost effectiveness and high-quality patient outcomes of NP primary care practice (Marshall et al., 2015), providing further evidence to support policy reform to increase primary care access. Existing evidence supports the association among restrictive NP SOP regulations, access to care, and compromised health outcomes (Pulcini et al., 2014, Sonenberg et al., 2015), as well as with increased direct and indirect costs of diabetes (Knepper et al., 2015), and warrants further research.

Research Methods

Study Aim

The context of this study is the persistent health care disparities across the United States within the climate of restrictive NP SOP regulations, which are documented to influence access to care and health outcomes. The purpose of this descriptive study is to explore the current NP SOP, access to primary care, and health outcomes of key chronic disease indicators—diabetes, hypertension, and obesity (Holt et al., 2015) in four states. The selected states were chosen because they represented the greatest disparity in two chronic disease health outcomes and the greatest difference in modernization of their NP SOP laws. As an exploratory study to identify all areas of disparities in determinants of health (DOH), this study did not aim to identify associations but was descriptive in nature. The study aimed to elucidate the wide range of DOH for which disparities exist. For example, characteristics such as ethnicity, age, unemployment, an urban-rural mix, physical activity, and so forth were explored. On the eve of the implementation of the ACA in 2010, the states with the worst health outcomes related to diabetes and hypertension, as well as the most restrictive NP SOP laws, were Alabama and Mississippi, whereas those with the best health outcomes and the least restrictive NP SOP laws were Colorado and Utah (American Journal of Nurse Practitioners [AANP], 2011; CDC, 2012).

Conceptual Framework

The theoretical foundation of this study is laid by a few seminal theories that frame policy reform efforts. Gaus (1947) developed his social ecology theory to explain the influence of environmental context on public policy, suggesting that people, places, and resources contribute to how public policies evolve. Phelan, Link, and Tehranifar (2010) developed their theory of fundamental causes to explain the impact of context and socioeconomic disparity as it relates to disparities in access to care and poorer health outcomes; in their view, simply understanding the nature of disease and prevention is inadequate to improve health outcomes. Szreter and Woolcock (2004) introduced “linking” social capital theory to consider the impact of power differentials and network relationships on population health, with particular implications for relations between the state and society.

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

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

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.

#### Fourth, agency – healthcare access is key to it for patient medical choices

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

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

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

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

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

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

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

The Patient Role

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

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

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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.

#### Access outweighs – even within their framework – it’s a form of violence against disadvantaged populations

DesRoches et. al. 13 (Catherine M, Associate Professor of Medicine at Harvard Medical School, PhD in Health Policy from Brandeis University, Jennifer Perloff, PhD in Health Policy from Brandeis University, Karen Donelan, Harvard University, School of Public Health, Sc.D., Lisa I. Iezzoni, MD, MSc. Professor of Medicine, Harvard Medical School, and Peter Buerhaus, PhD, RN, FAAN, Montana State University, “Using Medicare data to assess nurse practitioner–provided care,” Nursing Outlook, Volume 61, Issue 6, November–December 2013, Pages 400-407, https://doi.org/10.1016/j.outlook.2013.05.005)//NRG

Perhaps the most important difference between NP and primary care physician practice is the profile of the typical beneficiary assigned to each type of clinician. Beneficiaries assigned to NPs were, on average, more likely than those assigned to a primary care physician to be younger, nonwhite, female, dually eligible for Medicare and Medicaid, and to have qualified for Medicare benefits because of a disability. These results suggest that NPs are more likely than primary care physicians to care for certain disadvantaged populations.

### 1ac – plan

#### The United States Federal Government should significantly increase prohibitions on anticompetitive business practices by the private sector shielded by application of the state action immunity doctrine.

### 1ac – solvency

#### NPs are inherently transformative and their history of reform proves solvency

\*FPA = full practice authority, something that SOP laws restrict

Brunelle 21 (Rebecca, pediatric nurse practitioner with experience in telephone triage, pediatric critical care, and pediatric cardiology, “5 Reasons Nurse Practitioners Need to Advocate for Full Practice Authority,” August 20th, 2021, https://online.marymount.edu/blog/full-practice-authority-for-nurse-practitioners)//NRG

NPs Are Advocates for Change

Nurses and NPs consistently advocate for patients’ rights and for increased access to care. The American Nursing Association (ANA) emphasizes the important role of advocacy in nursing. According to the ANA, “Advocacy is a pillar of nursing. Nurses instinctively advocate for their patients, in their workplace, and in their communities; but legislative and political advocacy is no less important to advancing the profession and patient care.”

Echoing the need for political advocacy to advance the profession, NPs have taken their passion for improving patient care to the policy level. A recent study published in the Journal of the American Association of Nurse Practitioners highlights how changes in the health care market, like the passage of the Affordable Care Act in 2010, have been leveraged to increase FPA for NPs. Between 2011 and 2016, eight states passed full practice authority legislation for NPs, which is an eight-fold increase from the previous 10 years.

The Expanding Role of Nurse Practitioners NPs’ scope of practice is still significantly limited in some states despite the fact that NPs are an essential part of the U.S. health care system and have been providing affordable, safe, and quality health care to millions of patients since the 1960’s.. The ability of nurse practitioners to work independently and provide the best care to their patients increases when they are granted full practice authority.

Policies that increase the autonomy of NPs are well founded and improve patients’ access to care. A recent systemic review published in the Journal of Evidence Based Nursing indicates that patients are more satisfied with the care they receive from NPs versus physicians. This may be because NPs tend to have a longer consultation time and do a more thorough investigation of the patient’s chief complaint. Furthermore, the systemic review indicated that there is no decrease in health outcomes when patients are cared for by NPs.

Nurse Practitioners Deserve Full Practice Authority NPs consistently demonstrate their worth in the health care market. Patients are more satisfied with the level of care provided and health care costs are lower in markets in which NPs have FPA. These statistics are not surprising given the rigor of NP education programs. The AANP policy statement on FPA clearly outlines why NPs should be granted FPA throughout the U.S.: NPs are required to meet national education standards. Prior to practicing, NPs are required to obtain national certification in their specialty. The NP model of care encourages collaboration among disciplines. NPs are held accountable for the quality of care that they provide by their state board of nursing and the public. Nurse in blue scrubs putting on gloves Advocating for Nationwide Full Practice Authority NPs need to advocate for expanding FPA privileges in the remaining 27 states in which their scope of practice is limited. There are five key ways that expanding FPA privileges benefits the U.S. health care market. It increases patients’ ability to access care. It results in more choices in the health care market. It creates a more efficient health care system. It lowers health care costs. It Increases job satisfaction among NPs.

NPs fill a critical role in the U.S. health care system. They tend to serve in underserved areas, drive down the cost of health care, and provide phenomenal care. Multiple studies have demonstrated the benefits of FPA for NPs. Furthermore, states that restrict NPs’ scope of practice have a higher shortage of primary care providers and lower standings on national health metrics. Increasing the number of states that offer FPA to NPs improves patient care and advances the profession of NPs.

#### Michigan is front and center in the crisis of SOP restrictions and advocating positive reform for NP autonomy is in line with localized politics of expanding health access

Jacek et. al. 21 (Michigan Council of Nurse Practitioners based in Okemos, MI, Authors: Grace A. Jacek, DNP, APRN, FNP-BC, Barbara C. Jaquith, DNP, APRN, PNP-BC, FNP-BC, Ann P. Sheehan, DNP, APRN, PNP-C, Denise Soltow Hershey, PhD, APRN, FNP – BC, “Improving Access to Health Care in Michigan through Full Practice Authority for Nurse Practitioners: Legislative Task Force White Paper,” February 19th, 2021, <https://cdn.ymaws.com/micnp.org/resource/resmgr/legislation/final_white_paper_2021.pdf)//NRG>

Michigan is facing a healthcare provider shortage. It is estimated that by 2025 Michigan will need approximately 1000 primary care providers (United States Health Resources and Services Administration [HRSA], 2016). This is compounded by the fact that many residents of Michigan do not have reasonable geographic access to a regular healthcare provider. Michigan nurse practitioners (NPs) are committed to the health and well-being of the residents of the state of Michigan. Patients cared for by NPs have fewer unnecessary emergency department visits, reduced hospital admissions and readmissions within 30 days, receive regular preventive health screening, and are more compliant with recommended treatments.

NPs are licensed professional practitioners, educated at the master’s or doctoral levels, and “practice at the highest level of professional nursing practice” (American Association of Nurse Practitioners [AANP], 2015). Several decades of data demonstrate that NPs with full practice authority (FPA) increase access to safe, high-quality, cost-effective care; while facilitating flexible, innovative healthcare business models (Dill, et al., 2013; Leach et al., 2018). FPA is the legal permission of a professional to be able to practice to the full extent of their education, training, and certification. Twenty three states have FPA for NPs to facilitate access to health care. Michigan is considered one of the 12 most restrictive states for NP practice, requiring NPs to practice under supervision of physicians. Access to care is hindered in Michigan, by unnecessary, restrictive legal statutes that do not recognize NPs’ education, training, and certification. This limits NPs’ ability to practice in the communities where physicians are not working.

Michigan Council of Nurse Practitioners (MICNP) recommends that lifting restrictions on NP scope of practice is a prudent decision to facilitate access to care. NPs improve access to health care by increasing the health care workforce capacity of fully qualified professional providers who are available to care for patients in diverse care settings. MICNP calls for Michigan legislators to modernize statutes to adopt and authorize FPA inclusive of full prescriptive authority for NPs in all healthcare settings, permanently. This will make NP practice in Michigan current with evolving national standards of care 3 and improve Michigan residents’ access to affordable health care. This reflects Governor Whitmer’s health care priorities which focus on making health care more affordable; expanding access to health care; improving health care quality; and investing in public health.

Introduction/Background Michigan is facing a healthcare provider shortage; it is estimated that by 2025 Michigan will need approximately 1000 primary care providers (HRSA, 2016). Michigan nurse practitioners (NPs) are committed to the health and well-being of the residents of the state of Michigan. As board certified professionals, NPs support innovative healthcare delivery models that provide health systems the flexibility to implement processes that maximize effectiveness with efficiency to improve access to care and the overall patient experience. The success of Michigan’s health care system to adequately respond to health care needs and provide access to care for residents depends on health care providers being able to practice to the full extent of their education, training, and certification. NPs are licensed professional practitioners, educated at the master’s or doctoral levels, and “practice at the highest level of professional nursing practice” (American Association of Nurse Practitioners [AANP], 2015). NPs integrate the nursing model of care-emphasizing health, wellness, disease prevention and early intervention to prevent complications, including patient education, advocacy, and population health, when caring for their patients. NPs, as a profession, have more than five decades of expertise within diverse clinical settings in both rural and urban communities. These clinical settings include primary care, specialty care, acute care (inpatient/ ED/ urgent care) and long-term care settings (residential facilities/ hospice).

AANP (2019) issued the following statement about NP scope of practice (SOP): "As licensed, independent practitioners, NPs practice autonomously and in coordination with health care professionals and other individuals. NPs provide a wide range of health care services including the diagnosis and management of acute, chronic, and complex health problems, health promotion, disease prevention, health education, and counseling to individuals, families, groups, and communities. NPs serve as health care researchers, interdisciplinary consultants, and patient advocates". Twenty-three states, the District of Columbia and two territories have full practice authority (FPA) for NPs to facilitate access to health care. FPA is the legal permission of a professional to be able to practice to the full extent of their education, training, and certification. AANP (2020) defines FPA as legal authorization of NPs to “evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments - including prescribing medications and controlled substances- under the exclusive license authority of the state board of nursing”, without the requirement of physician supervision.

Several decades of data demonstrate that NPs with FPA increase access to safe, high-quality, costeffective care; while facilitating flexible, innovative healthcare business models (Dill, et al., 2013; Leach et al., 2018). NPs mitigate health disparities by improving access to care and quality of care. Patients cared for by NPs have fewer unnecessary emergency department visits, reduced hospital admissions and readmissions within 30 days, receive regular preventive health screening, and are more compliant with recommended treatments than those cared for by other health care providers (Dill, et al., 2013; Leach et al., 2018). Collectively, these patient behaviors contribute to lower health care costs, overall, as problems are identified early and complications are avoided or minimized (Martin-Misener et al., 2015; Neff, et al., 2018; Newhouse et al., 2011; Phillips & Bazemore, 2010; Sonenberg & Knepper, 2017; Xue, et al., 2016). In 2018, $44.5 billion was saved in Medicare spending in 3,143 counties in the United States (U.S.) in which NPs have FPA. It is recommended to require NP patient encounters to not be billed for services under “incident to” billing. The Commission estimates the Medicare program will reduce spending by $50 – 250 million in the first year and by $1 – 5 billion over a 5-year period (Medicare Payment and Advisory Commission [Medpac], 2019). Cost of clinic visits in states with restricted NP practice averaged the highest in the U.S. (Chattopadhyay & Zangaro, 2019). Studies have also shown NPs are more likely to practice in rural and health care shortage areas and are more likely to provide primary care (Westat, 2015). NPs working in critical care settings have demonstrated reductions in the number of inpatient days (length of stay), shortened time to consultation and treatment, improved mortality, improved patient satisfaction, and cost reductions (Jennings et al. 2015; Woo et al., 2017). It has been noted that NPs are cost effective, provide savings to patients, insurance payers, health systems and society (taxpayers) (Chattopadhyay & Zangaro, 2019; Martin & Alexander, 2019; Poghosyan et al., 2019). Additionally, in states with full NP practice authority, patients received more health education services from NPs as compared to other providers.

States that are highest in health rankings have NP FPA laws (see Appendix A). The United Health Foundation (UHF), American’s Health Ranking Report, is an annual snapshot of over 30 measures reported out as a composite index score. States are ranked in order of best outcomes. Michigan ranks 32nd and has restricted NP practice authority. As compared to other states, in 2019, Michigan underperformed in the following core measures, ranked by order of severity: smoking, frequent physical distress, cardiovascular deaths, frequent mental distress, obesity, infant mortality, cancer deaths, preventable hospitalizations, drug deaths, premature deaths, diabetes, excessive drinking, pertussis, childhood immunizations, and physical inactivity (UHF, 2020). NPs have master’s or doctoral degrees in advanced practice nursing from universities that meet national accreditation standards for nursing curriculum. NPs pass competency exams for national board certification in their areas of expertise. Board certifications indicate specialized advanced-practice education in caring for specific patient populations. For primary care NPs, practice populations include family practice, adult/geriatrics, pediatrics, psychiatric mental health, or womens’ health. Additionally, there are NPs who specialize in acute care and populations such as adults, pediatrics, neonatal, psychiatric, or emergency. It is important to note that prior to entry into an NP program, candidates have already earned a baccalaureate degree, and have passed state licensure examination as professional registered nurses (RNs).

Statement of the Problem Michigan has 138,155 actively licensed registered nurses (RNs) as of March 2020 (Michigan Department of Licensing and Regulatory Affairs [LARA], 2020), with 11,708 (8.4%) of those RNs additionally holding specialty certification. Seventy-three percent or 8,602 of the RNs who hold specialty certification in Michigan are listed as NPs (6.2% of total RNs). Michigan recognizes the NP as an advanced practice registered nurse (APRN) in statute 2016 PA 499 (in effect in April 2017). Michigan is considered one of the 12 most restrictive states for NP practice, requiring NPs to practice under supervision of a physician. Currently NPs do not have a defined SOP in statute in the state of Michigan (Patel, Petermann & Mark, 2019; Michigan Public Health Code [PHC], 1978/2017).

Patient access to care is hindered in Michigan, by unnecessary, restrictive legal statutes that do not authorize NPs to have FPA. Access to health care involves more than just a geographic component. Health care is accessible when it is available (timely, near to home), appropriate (evidence-based for the condition and measured by health outcomes; given in the appropriate healthcare setting: primary, specialty, long term, or acute care), affordable (cost effective, efficient), and accountable to patients, as evidenced by provider education, training and certification. This is consistent with Governor Whitmer’s health care priorities which focus on: making health care more affordable; expanding access to health care; improving health care quality; and investing in public health (Mich.gov, 2021). According to Hart, Ferguson & Amiri (2020), states with restrictive NP scope of practice laws experience: 1) reduced overall access to care, 2) increased cost of care with no appreciable increase in quality, and 3) stifling of healthcare organizations due to fewer options for innovative business models that respond to market conditions.

#### Our analysis foregrounds the contextual interactions between epidemiological patterns in communities of syndemic disadvantage – COVID proves it’s the only way to create a morally better world

Jecker 21 (Nancy Jecker is an Professor of Bioethics and Humanities at the University of Washington School of Medicine, Department of Bioethics and Caesar Atuire, Professor of bioethics, University of Ghana, “Out of Africa: A Solidarity-Based Approach to Vaccine Allocation,” Hastings Center Report 51, no. 3 (2021): 27-36, via my phl 453 prof lol, DOI: 10.1002/hast.1250 edited for readability in [brackets]) MULCH

Does a solidaristic approach demand that we abolish a global system where countries vie for vaccines and buy them directly from manufacturers? Our answer is that even if a morally best world required this, the world we live in is far from that ideal. Our aim should be a morally better world [that]. A morally better world shows awareness of the syndemic[s] nature of the Covid-19 threat and acts in solidarity. It prods rich nations to join global alliances, like COVAX, and to share a portion of their doses. It places moral constraints on bilateral agreements that COVAX-participating nations strike on the side by requiring transparency. A better world nudges wealthy nations toward joint agreements that help, rather than hinder, global efforts. Examples are agreements that generate new vaccine candidates and grant COVAX firstrefusal rights and agreements that increase vaccine knowledge and share standardized technical and clinical data. A better world must do more.

While COVAX has secured agreements for 2 billion doses of Covid-19 vaccines in 2021, those agreements meet just 20 percent of the vaccine needs of participating countries, leaving 80 percent of people in participating countries unprotected. Current forecasts show that, at the current rate, there will not be enough vaccines to cover the world’s population until 2023 or 2024.34 A better world is reflected in a proposed international treaty committing nations to undertake coordinated efforts to improve global pandemic preparedness. The proposal, set forth by the WHO and leaders of nations, calls on all countries to “seize this opportunity and come together” for a common good “in the spirit of solidarity and cooperation.”35

Criteria for Global Distribution

Once global health alliances like COVAX have vaccines to distribute, what criteria should they use? A syndemic and solidaristic approach aims to win the global race against Covid-19 together and therefore focuses strategically on how the lethality of the crisis results from a confluence of factors and on how to shut down viral pathways. For this reason, it prioritizes vaccines for populations with relevant co-occurring diseases and with salient social, economic, and cultural vulnerabilities known to invite viral spread. First, prioritizing LMICs, which have less ability to obtain vaccines, should figure prominently in global distribution. From a syndemic standpoint, this criterion shuts down viral pathways that SARS-CoV-2 can otherwise exploit, while from a solidarity standpoint, it extends a hand to members of a group who would otherwise lag and moves the whole group closer to the finish line. Next, prioritizing people at high risk of infection is warranted because people vulnerable to disease are more likely to offer a pathway for spread of the SARS-CoV-2 virus than those at lesser risk. From the perspective of solidarity, when my group, which is all humanity, is at high risk of infection, then I remain at risk, too, because I exist as part of that group, not by choice, but as a given. Finally, people at high risk of severe disease and death merit priority from a syndemic perspective because if they contract the virus, they will be sicker for an extended period, giving the SARS-CoV-2 virus more time for viral evolution and withinhost mutation. This can exacerbate the syndemic by exposing others to highly mutated, potentially dangerous strains of virus shed late in the course of the disease.36 Ethically, safeguarding people at high risk of severe disease and death reflects a sense of ubuntu, the value that underpins solidarity. The ethic of ubuntu bids each member of a group to respect the dignity of every other.

#### Government policy is much better than an untouched market

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Although health equity was not a part of seventeenth-century political discourse, Montesquieu accurately captured the conflict that surrounds the concept today. In theory, people are born with equal potential for healthy lives, yet the minute their lives begin, a confluence of factors render some people immensely more likely than others to have the capability to lead healthy lives. These disparities in individuals' capabilities to achieve good health raise important social justice questions--What obligation does society have to take measures to reduce health disparities based on race or ethnicity, socioeconomic status (SES), gender, sexual orientation, education, disability, and other factors, particularly where behavioral risk factors are a contributing factor to disease? Stated differently, how much “choice” do individualstruly possess regarding their health, and what can and should government do to address the societal influences that negatively impact health status?

Routinely, society looks at an individual health outcome and ascribes the result to modifiable lifestyle choices, good or bad, with the implicit assumption that people who are healthy deserve praise for their responsible choices and those who are not deserve at least partial blame for failing to act in ways that would improve their health. However, this personal responsibility framework fails at a population level. It is well-documented that there is a socioeconomic gradient to health, in which individuals are likely to be healthier as their socioeconomic status increases. But no serious scholar ascribes population level socioeconomic health disparities to the superior willpower of the wealthy in making healthy lifestyle choices. Similarly, there is a persistent racial and ethnic component to health that is not explained by other factors, pursuant to which certain racial and ethnic groups are more likely to have worse health outcomes than others. But no one argues that African-Americans have worse health outcomes on average than whites because African-Americans are not as motivated as whites to protect their health. There is no basis for making such population-wide generalities about motivation regarding health behavior. Yet in the face of these widespread and presumptively inequitable disparities, the law has done little. This paper argues that coercive legal mechanisms are an essential element of eliminating health disparities and achieving health equity. Moreover, the paper argues that Healthy People 2020 (HP 2020), which is the nation's “master blueprint for health” and explicitly seeks to achieve health equity, has not fully incorporated the principles of health equity in the formulation of its objectives and indicators because HP 2020 fails to recognize the varying distributive effects of policies that could achieve population health targets. To truly incorporate the principles of health equity, HP 2020 should advocate for those demonstrably effective coercive legal mechanisms that would both achieve its population health objectives and reduce health disparities.

The federal government has monitored health disparities in one form or another since at least 1985 and has advocated for the elimination of health disparities since at least 2000, with the release of the Healthy People 2010 goals. However, decisive action on the reduction of disparities has been lacking, and, on average, disparities have not improved over at least the past fifteen years. Although health equity is a mainstay of health law and policy discourse, the concept has not had a significant role in mainstream political discussions. As it is commonly understood, health equity exists when “all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health.” There are strong philosophical and social justice reasons that support government action to reduce disparities--among them are human rights principles of equality underlying the right to health; Nussbaum's theory of health as an essential human capability necessary to fully function in life; Amartya Sen's theory of the capability for health as an instrumental human freedom; and principles of equality and nondiscrimination among people based on characteristics such as SES, race or ethnicity, gender, sexual orientation, religion, disability, rural/urban geography, and other characteristics historically linked to discriminatory treatment.

The question, then, is, What means are both necessary and effective for reducing health disparities and achieving health equity? It is here that distributive consequences of policies become important, leading to the conclusion that coercive legal mechanisms such as direct regulation and taxation are essential to a serious strategy to reduce disparities. While coercive legal mechanisms are not suited to solve every problem and must always be balanced against concern for personal liberties and principles of autonomy, there are many instances in which coercive legal mechanisms are demonstrably the most effective way of reducing health disparities and improving population health. Unfortunately, when discussing these mechanisms, advocates are often cowed by advocates of “personal choice” into watering down interventions to the point that the likely result is--even with an improvement in population health--no change or a worsening in health disparities. This approach is problematic from a health equity standpoint, given that health equity by its nature requires the elimination of health disparities associated with social disadvantage.

The U.S. government has made the achievement of health equity and the elimination of health disparities a national priority in HP 2020, recognizing the importance of working toward the realization of health equity. Every ten years since 1979, the Department of Health and Human Services (HHS) issues new “Healthy People” nationwide health goals for the forthcoming decade, the most recent of which are HP 2020. The essential aim of the Healthy People project (the Project) is to establish national health priorities by setting targets for improvement of health across a broad spectrum of topics, ranging from access to health services to environmental health to more discrete diseases such as cancer and heart disease and, for the first time in HP 2020, including the social determinants of health. In some instances, HP 2020 advocates the adoption of specific coercive legal mechanisms that would both further a population health goal and reduce disparities--for example, passage of smoke-free legislation would both reduce overall population exposure to secondhand smoke and more strongly affect disadvantaged groups (who have higher rates of smoking and are more likely to work in places where smoking is permitted), thereby resulting in a reduction in the disparity in rates of exposure to secondhand smoke. This advocacy is laudable. However, in most instances, HP 2020 chooses to set broad, population-based targets for health measures without expressing a preference between means of achieving those targets, as in the case of access to health insurance coverage, where HP 2020 sets a target of 100% coverage without acknowledging the obvious--that there is no evidence that anything other than a coercive legal mechanism is a realistic way to achieve that goal.

The determination of which coercive legal mechanisms HP 2020 supports appears to be made not on the ground of epidemiological evidence of a policy's effectiveness; rather, HP 2020 seems to be willing to advocate for direct regulation only in areas that are relatively politically uncontroversial, such as helmet laws and certain tobacco control measures. This paper argues that a **true** internalization of the principles of **health equity** **requires** that HP 2020 acknowledge the predictably different distributive consequences of various policy interventions and urge the adoption of those coercive legal mechanisms that are demonstrably effective in reducing health disparities. Without such a framework under which to operate, the likely result is that, even if overall population health improves, health disparities will widen between the most vulnerable population groups and the already advantaged, or remain essentially stagnant, as they did under HP 2010.

More broadly, this paper argues that health equity demands the use of coercive legal mechanisms in certain circumstances given the existence of current disparities and the evidence of effectiveness of direct regulation as compared to its alternatives. This is true for a number of reasons, including that purely voluntary policy initiatives often result in little impact on the most vulnerable populations (e.g., in the case of trans fat initiatives, discussed infra Part III.B.3), and because market-based initiatives have failed to adequately account for the health needs of certain population groups (as in the case of access to health services, discussed infra Part III.B.1). Only with a candid assessment and acceptance of the critical role that coercive legal mechanisms play in furthering population health can progress be made toward the achievement of the HP 2020 goals and ultimately, health equity. Part II of this paper discusses health equity in the U.S. and how HP 2020 incorporates health equity into its goals. Part III discusses the importance of law in public health and health equity and uses specific HP 2020 goals and objectives as examples of the essential role of coercive legal mechanisms in achieving those goals while also furthering health equity. Part IV proposes certain additional legal mechanisms that could inform selection of strategies for achieving the HP 2020 goals and health equity, including the use of a “health in all policies” approach to government, the use of health impact assessments in policymaking, and the use of various indices to measure the effects of various policies and assess progress toward disparities reduction.

#### Incumbent forces call for an untouched market – loss of access places *millions at risk*

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

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

The consequences of ACA repeal would be dire:

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

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

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

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

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

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

1. 20 million fewer Americans are uninsured

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

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

2. The ACA protects people with preexisting conditions from discrimination

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

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

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

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

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

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

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

#### Restrictive SOP specifically causes practitioner burnout

Smith 21 (Laura Barrie Smith, Health Policy Center, Urban Institute, Washington, District of Columbia, “The effect of nurse practitioner scope of practice laws on primary care delivery,” October 8th, 2021, <https://doi.org/10.1002/hec.4438)//NRG>

Together, these findings imply that relaxing SOP laws may lead to a decrease in costs, an increase in transparency, and no increases in low-value care provision – overall, a value gain. Primary care practices and the NPs and physicians they employ may see additional benefits from relaxed SOP. First, relaxed SOP laws may improve professional satisfaction for NPs; survey data indicate that NPs who feel their skills are being fully utilized also report significantly higher job satisfaction (Athey et al., 2016). Second, by allowing NPs to practice at the top of their license, relaxing NP SOP laws may alleviate growing concerns about primary care physician shortages and burnout (Bodenheimer & Smith, 2013; Linzer et al., 2009, 2017) – particularly as team-based models of care delivery prove promising in primary care (Pany et al., 2021). Finally, as value-based payment models gain popularity (Muhlestein et al., 2017), relaxed SOP laws will enable primary care practices to increase the value of the care they provide by employing NPs with the authority to practice and bill independently.

#### Studies confirm SOP laws costs many lives *per day* *per State*. Solvency is *empirical* and the *impact is significant*.

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Nurse practitioners (NP) are well-trained health care personnel for primary, acute, and specialty care in the US. However, 32 states have restrictions on their scope of practice 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 scope of practice 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 scope of practice 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 scope of practice 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 scope of practice

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 evidence that granting NPs independent authority has contributed to a reduction in COVID-19 deaths.

# 2AC

## Case

### 2ac – at: hot spotting link – Krupar and Ehlers

#### Their card for reference. MSU = Blue.

Krupar and Ehlers 16 (Shiloh and Nadine, Krupar is a geographer and assistant professor of culture and politics at the Georgetown University and Ehlers is a Sociology and Social Policy professor at the University of Sydney, Biofutures: Race and the governance of Health, Vol. 35 (2) <http://journals.sagepub.com/doi/pdf/10.1177/0263775816654475>, accessed 6/7/17)

The contradictions and racialized hazards of biomedical targeting are further illustrated in our second case study on medical hot spotting**. Medical hot spotting refers to ‘‘a** problem solving **technique that targets the most expensive problems or in-need people by allocating resources to specific problem areas as revealed by** the **data’’** (Ratigan, 2011; also Hu et al., 2012). It endeavors to reorganize health governance according to the economic logic of cost efficiency by targeting populations that are ‘‘high utilizers’’—that incur high costs—in the U.S. health care system. The practice began in Camden, New Jersey, an economically depressed community across the Delaware River from Philadelphia. Following the collapse of its industrial base and decades of disinvestment, Camden effectively became a container of poverty within a deeply racialized region, with declining interior infrastructure and minimal access to outlying areas where services were being elevated.16 The city of Camden today hosts a slew of toxic industries, from incinerators that burn Philadelphia’s trash to pharmaceuticals manufacturing. The city’s housing and infrastructure are largely unsafe or abandoned, and the population (77,000) is per capita one of the poorest in the nation (U.S. Census Bureau, n.d.). In 2006 the medium household income in Camden City was $18,007, the lowest of all U.S. communities with populations over 65,000, and 52% of the city’s residents lived in poverty (Fahim, 2006; Poverty Research Institute, 2007). These figures become particularly telling in light of the racial demographics of the city: According to the 2010 census, half of the city’s residents were black or African American and more than a third of the residents were Latino (U.S. Census Bureau, n.d.). Widespread industrial contamination, poverty, and escalated violent crime all have contributed to a dire public health problem in Camden. With 29.5% of the population unable to afford prescription drugs, the city’s residents clearly experience disproportionate levels of ill health (CamConnect, 2008). **The innovations of medical hot spotting emerged in this racialized context as a means to lower exorbitant health care spending on the medically indigent by coordinating intensive outpatient care for complex high-needs patients**.17 The practice involves locating costly users of the health care system and targeting them for more effective, preemptive care in order to cut down on the number of medical crises requiring expensive treatments and rehospitalizations. To achieve this, medical hot spotting applies policing strategies to health care, namely, the methods of tracking and mapping of crime statistics to direct police to ‘‘hot spots’’ of criminal activity. The medical application of this police technology uses medical data to identify populations that are high utilizers or ‘‘superusers’’ of the health care system, i.e. patients who use health care resources at abnormally high rates. Medical hot **spotting in Camden revealed that 1% of patients were driving 30% of medical costs and that people with the highest medical costs and the greatest number of emergency room visits were usually receiving the worst care** (Bronski, 2012). One single public housing development was alone responsible for $12 million in health care costs from 2002 to 2008 (Bush, 2012). High utilizers of health care in Camden visited overburdened local clinics; they were uninsured or otherwise remiss about seeing a primary care doctor for preventive care, were on welfare and otherwise poor, and were purportedly making detrimental lifestyle choices with little capacity for change (Bronski, 2012). **By targeting these concentrated zones of high utilizers through spatial data analysis, medical hot spotting seeks to organize and tailor care management through numerous techniques that restructure the organization, delivery, accountability, and doctor–patient relations of health care, from interdisciplinary teamwork to house calls and behavioral modification techniques** (focused on an individual patient for up to six months) (Aetna Foundation, 2013). A promising aspect of medical hot spotting, then, is to alleviate health inequities, through stabilizing both the medical conditions and social environment of patients as a means to health. This might entail health and wellness promotion and psychosocial counseling, helping patients apply for government assistance programs, securing better housing or temporary shelter, and adapting to home life after hospital discharge (Blair, n.d.; Frontline, 2011). From its Camden origins, medical hot spotting has gained traction across the health care system. Similar practices are now at work in places such as Trenton, Newark, West Philadelphia, York, Scranton, Allentown, the Bronx and Queens, Atlantic City, Boston, Anchorage, Chicago, Seattle, and Las Vegas (Gawande, 2011a, 2011b).18 Such health care reforms and experimentations are needed social projects, which, we argue, are inherently racial projects. The well-documented institutional racism of biomedicine, and persistent forms of structural racism that underpin U.S. society and produce differential vulnerabilities to illness and disease, are part of what universal access to health care endeavors to address and even rectify.19 Yet ‘‘race’’ remains topically out of bounds in discussions about medical hot spotting. Our contribution, then, is to consider the racialized operations and potentially inequitable and endangering effects of medical hot spotting as a relatively new practice of targeted health interventions. While BiDil might be said to ontologize blackness as a corporeal truth for market accumulation, **the neoliberal logics and spatial technologies of medical hot spotting work to ontologize racialized spaces—they ontologize structural racism as space, as transparent/self-evident, race-neutral, dehistoricized, undialectical space. Regardless of the intentions behind medical hot spotting, it potentially supports intensified racial dominance under the auspices of improved health administration and biosecurity.** We explore, here, three dystopic dimensions on the horizon of U.S. health care reform that rationalize antiblackness through intensifying forms of monitoring and containing costs. Such consideration is timely given the mounting popularity of medical hot spotting under the banner: ‘‘when treating patients like criminals make sense’’ (Williams, 2011; also Duggan, 2003; Omi, 2010).

First, medical hot spotting mobilizes a national imagination of scarce health care dollars and advances a world defined by relationships of cost that fuel racial enmities.20 The abstraction of this cost grid disregards the ‘‘richness’’ of space—the social–spatial relationships that contribute to high-cost usage of health care, and it circumscribes subjectivity within the market. Managing medical care for cost containment disregards the structural reasons for ill health by giving epistemological primacy to cost relations.21 There are countless examples of this circulating in the media: ‘‘there’s a small segment that is burning through 20 percent of our society’s wealth at a massive rate’’ or ‘‘because U.S. hospitals give billions of uncompensated care to the uninsured and under-insured each year, they pass costs along to insured users’’ (Bush, 2012; Sealover, 2012).22 In the context of austerity policies and widespread panic about the overtaxed U.S. health care system, ‘‘cost efficiency’’ amplifies a racist antagonism between those who are worthy of scarce resources—an imagined community of deserving Americans, i.e. white, suburban, healthy families—set against the despicable, leeching ‘‘high utilizers,’’ i.e. a category that serves as proxy for racialized others. The call to locate the super-user 1% marshals racism via the powerful rhetoric of statistics and unfair burden. We may see ‘‘high utilizer’’ join ‘‘welfare queen’’ and ‘‘gangbanger’’ in the pantheon of demonized subjects for ‘‘endangering our national health care budget and the health of worthy citizens who are not bringing health problems on themselves’’ (Herndon, 2005: 132**). Medical hot spotting, ostensibly supports the idea that hot spots are a threat to the nation and, by locating them, facilitates the transfer of blame and placement of responsibility on those who are already disadvantaged and disenfranchised, i.e. those that inhabit these spaces**. The super-user is identified and ‘‘found’’ through hot spot delineation, where the inhabitants-as-threat inhabit the space-as-threat, and vice versa. This is particularly deleterious to African Americans, who have received significantly less adequate care than white Americans in the U.S., due to a host of financial, organizational, and social barriers (Bhopal, 1998). The historically accumulated suffering of the black body has meant African Americans are at increased risk for acute and chronic diseases, epidemics, such as HIV/ AIDS and mental illness (Whiteis, 1997: 229). Yet the risks of black life in America are eclipsed by racialized subjectivities that stratify the population and justify the harmful impacts of neoliberalization experienced disproportionately within racialized communities (Roberts and Mahtani, 2010: 249; Wilson, 2006). The operation of targeting the 1% super-users enacts a deeply structural logic of anti-blackness in America, equating race—specifically blackness—with the antithesis of the ideal neoliberal citizen—as inherently vulnerable, risky, wasteful, unable to be self-sufficient or healthy, as a burden to the nation.

**Second, medical hot spotting promotes** self-care in the absence of social welfare**, and thus contributes to a feedback loop of racial domination. Lack of health is attributed to** personal failure**, rather than the structural positioning of African Americans outside of the populace, and the aggregation of these failures is mapped in space for the purposes of surveillance, anticipation of risk, and containment**.23 While autonomy and empowerment to make oneself be healthy are laudable goals, the neoliberal imperative to ‘‘self-care’’ undercuts the promise of social reform by enlisting the nation’s costliest health care consumers to participate in preventive care—a process that relegates racially coded economic, social–environmental disadvantage to the private and personal spheres (Davis, 2007: 349).24 Neoliberal self-care asserts that individuals are solely in charge of their health and should adjust their behavior to achieve optimal health; individuals that fail to do so are ‘‘bad,’’ deviant, or even pathological subjects, despite any structural issues that might preclude good health. Under neoliberal logics, African Americans are enlisted to self-care—to participate as consumers of preventive care—yet any inability to do so is relegated to a private issue or racially grouped failure within a supposedly colorblind meritocracy enabled by the free market. Thus, medical hot spotting potentially resecures anti-blackness through requiring blacks to take on selfresponsibility as if it were race transcendent. The practice seeks to intervene in the daily care of three categories of patients—the mentally ill, medically fragile elderly, and patients that are described as ‘‘socially disintegrated,’’ i.e. ‘‘those who tend not to engage in self-care, have few family resources and display dependent personalities’’ (Bush, 2012: 32). The category of ‘‘socially disintegrated’’ seemingly offers an opportunity to examine the race-specific biopolitics of health—how poor health, institutional racism, and the epistemology of anti-blackness are ontologically enmeshed. Anecdotal evidence and a short documentary about medical hot spotting demonstrate that medical hot spotting does attempt to expand health care into social, environmental arenas, and to cultivate social infrastructure and stability through caregiving (Frontline, 2011). Such efforts, however, are undermined by the behaviorist emphasis, which medicalizes urban marginality. The sorting out of the so-called socially disintegrated—those who fail at/to self-care—from productive citizens allows for race to be understood as a marker of risky or dysfunctional social behaviors—rather than an indicator of racialized knowledge and experiences that make one more vulnerable (Herndon, 2005: 132; Monahan and Wall, 2007: 163). **Medical hot spotting signals a shift in health governance toward potentially more aggressive in/voluntary programs that target individual behavior and mandate personal responsibility, just as the state is** withdrawing institutional supports **that are necessary to shoulder illness, unemployment, indigence, and so forth** (Wacquant, 2010: 218). The practice could progress in the direction of racially sorting and segmenting health care to support moralizing behavioral workfare in the context of austerity.

Third, medical hot spotting risks spatially ontologizing historical geographies of racial domination—urban renewal, redlining in housing and mortgage industries, environmental racism—as simply geodemographic ‘‘facts’’ on a map. From crime mapping and policing, medical hot spotting borrowed technologies (namely CompStat) that collect and use spatial data to model, monitor, and control criminal behaviors. First instituted by then New York City Police Commissioner William Bratton in the mid-1990s, ‘‘crime hot spotting’’ generates digital cartographic representations of high-crime areas by linking statistical information such as crime type and occurrence with zip code and neighborhood (Kelling and Bratton, 1998; Propen, 2006: 135). Police are then able to target anticipated high-crime spaces, by spatially customizing surveillance (Williams, 2011). Similarly, medical hot spotting integrates GIS data and demographic techniques that target problem spaces and populations through spatial profiling.25 Such geosurveillance is the logical outcome of the militarized interpretation of residents as risk factors that need to be logged, mapped, and understood in a calculative statistical manner. Medical hot spotting secures target fields of information, spatial data, and geographical identification of high-risk people and spaces for the purposes of biosecurity, i.e. managing health for the optimization of the population. The auditing process—the geographical processing of medical metadata—generates a racially stratified datascape of expectations that basically reproduces ‘‘what we already know.’’ The spatial ontology at work in this targeting operation stipulates that where you are reveals who you are, as collected and assessed by marketers, governments, the police, or clinics (Kaplan, 2006: 697). Racialized spaces and bodies become ontologized as knowable, measurable geo-tags and data of a population—even when medical hot spotting does not explicitly involve racial profiling. In other words, medical hot spotting ontologizes structural racism in/as space. Medical hot spotting’s application of GIS demonstrates a political rationality that calls forth surveillant uses of technology in the observation of spaces and populations, transforming governing into a field of perception (Propen, 2006: 136). The geosurveillant technologies that inform medical hot spotting arguably mobilize the ghetto as a preemptive way of seeing, of knowing as containing (Loyd, 2014: 30; Wacquant, 2002). Thus, establishing medical hot spots may serve as a teleological spatial containment technique for the management of poverty and marginality. Targeting the medically indigent 1% could result in ‘‘coordinated care camps’’ that punitively quarantine racialized segments of the population by restricting access to specialized medicine and experts. Stricter definitions of medical necessity may be instituted within hot spots to decrease opportunities to receive a particular test or treatment (a twisted reversal of current profit-seeking methods that overprescribe to the poor).

---their card ends---

Basically, medical hot spotting allows for—even rationalizes—racially segmented care, by further entrenching social borders and spatial segregations. In other words, minority communities might experience medical hot spotting as an intensified form of medical redlining: That is, “spatially customized care” as a means to ration medical resources and health care. Given the twin neoliberal imperatives of cost containment and self-care, it is not a stretch to see medical hot spotting even develop into a remote-sensored care delivery system that somatically surveils the high utilizers of health care through cost-saving home monitoring and positions bodies as nodes within a network of physiological, behavioral, and locational data connected to command centers (Graham, 2011: 99). The geosurveillant technologies of medical hot spotting reveal that health promotion and disease prevention involve increasingly militarized preemption, concentrated on preknown spaces of failure as analytic objects that can be surveilled at a distance (Mitchell, 2009: 254).26 Whether through self-responsibilization of risk or ontologizing structural racism in space, medical hot spotting reveals the future of a race-specific biopolitics of health that rationalizes and defends anti-black biosecurity as race-neutral technology.27

### at: maxwell + bellcourt

#### addressing shortages is decolonial

Wong et. al. 21 (Sarah H.M. Wong, Medical Student at UCL London, Faye Gishen, consultant physician in palliative medicine and Associate Head of the MBBS (Medicine) at UCL, London, Amali U. Lokugamage, consultant obstetrician and gynaecologist and Honorary Associate Professor at UCL, London, “‘Decolonising the Medical Curriculum‘: Humanising medicine through epistemic pluralism, cultural safety and critical consciousness,” London Review of Education, May 19th, 2021, DOI: 10.14324/LRE.19.1.16)//NRG

The term ‘decolonising’ has lent itself to multiple definitions throughout history, but in its recent resurgence within higher education, it refers broadly to a movement to: (1) recognise how forces of colonialism, empire and racism (and other forms of discrimination, such as sexism, racism, heteronormativity and ableism) have shaped the systems in which we participate every day; and (2) offer alternative ways of thinking about the world, re-centring perspectives of populations historically oppressed and marginalised by these forces (Bhambra et al., 2018: 18). This is the framework we adopt in this article to consider what forms of knowledge and ways of knowing must be prioritised in efforts to decolonise the medical curriculum. The decolonial outlook sheds light on power imbalances within systems, institutions and interactions, and prompts exploration of how power can be redistributed to achieve intersectional equity. In the context of medicine, it may be used to examine how health systems that have inadvertently served to ostracise and even dehumanise segments of society can be reimagined, to cater to the needs of the whole patient population (Gishen and Lokugamage, 2019; Lokugamage et al., 2020a).

#### ) solves misdiagnosis and nurse respect – NPs are patient advocates

Trotter 18 (LaTonya, sociologist at Vanderbilt University, “’I’m Not a Doctor. I’m a Nurse’: Reparative Boundary-Work in Nurse Practitioner Education,” July 15th, 2018, https://journals.sagepub.com/doi/10.1177/2329496518783683)//NRG

Similar invocations were embedded in informal stories. Faculty sometimes leavened the hours of didactic material with accounts from their own practice. Rachel Steele, MSN, CRNP, shared such a story. She described a woman who had come into her office, ‘for something small; like a cold.’ During the encounter, the woman reported that she had been experiencing a recurrent pain in her chest. The woman had recently been to see her parents’ cardiologist, the one who had treated both her parents for myocardial infarctions (MIs). Rachel emphasized ‘both parents for MIs’ by raising her voice slightly and opening her eyes a little wider. The signal was unambiguous: this was important to Rachel and should be important to us. But it seemingly was not important to the cardiologist. According to the patient, the cardiologist had ordered a stress test, but it had come back normal. ‘Based on that test,’ Rachel told us, ‘he told her she was crazy. The pain was all in her head, and she should go home and get a life.’ A few days later, Rachel got a phone call. The woman was having chest pains. Rachel told her to go to the hospital ER while she called ahead and ‘told them to please, please cath her,’ referring to a diagnostic procedure that images the heart and blood vessels. Catheterization revealed that one of the woman’s arteries was 90 percent blocked. Rachel could not explain why the stress test was normal, but she explicitly located the diagnostic error within the narrow vision of the cardiologist. ‘The doctors were just looking at the tests and not the whole picture. They weren’t listening to the patient. With her family history? Heart doctors look at the heart, lung doctors look at the lungs, but the job of the nurse practitioner is to look at the whole person.’ Clinicians of all stripes share stories of the time they “had a hunch” that something was wrong. But what Rachel emphasized was neither luck nor intuition but the skills necessary to be a good NP. Rachel listened to the patient instead of telling her to “go home and get a life.” She paid attention to the whole person rather than relying solely on diagnostic tests. Nursing’s emphasis on whole person care was reworked into an NP strategy of action for the exam room.

Whole person care required one to not only pay attention to what happened in a singular encounter. One had to know the patient. Relationships with patients appeared often in clinical decision-making narratives. In one lecture on acute respiratory infections, guest lecturer Suzanne Weathers, MPH, CRNP, discussed treatment options for community-acquired pneumonia. She explained that one of the key decisions they will need to make is whether treatment should be provided at home or in the hospital. ‘We’re moving away,’ she warned, ‘from pure “gut” decision making.’ To make this point, she demonstrated a severity index calculator that was designed to take the guesswork out of treatment setting. ‘However, you also need to evaluate the context of the patient.’ And she began to tell a story.

Suzanne described seeing a 78-year-old woman who had been her patient for years. The woman presented with pneumonia. According to the guidelines, the age of the patient indicated hospital treatment. The patient was opposed; she had a cat she did not want to leave alone. Suzanne decided to treat the patient at home. She knew that the woman had a support network that could alert her to any changes in mental functioning. She also called the patient daily. As Suzanne finished her story, a student raised her hand: ‘What if you didn’t know her and she didn’t want to go to the hospital?’ Suzanne paused before answering: ‘Well, nobody wants to go to the hospital. But if she had just walked into my office and I hadn’t seen her before? I would have sent her to the hospital.’ Without knowing the patient, an algorithm limited provider discretion. Because Suzanne knew her patient, she was able to provide whole person care.

Other stories directly addressed the clinical importance of relationships. Steve, the case informed us, was a 28-year-old Caucasian male complaining of chronic back pain. He had been in a car accident six years ago, but the pain never went away. He requests a prescription for Percocet, a combination of a narcotic and an over-the-counter pain reliever. He tells you that his last doctor refused to renew the prescription. Steve was presented as “an ethical” rather than clinical case. The ethical dilemma was primarily that Steve was instantly recognizable as a drug-seeking patient. Despite this recognition, the conversation began with an assertion of complexity. Jenna believed this was “a sticky situation.” ‘Perhaps he is addicted to Percocet. But addiction is a medical condition that needs to be addressed.’ Matt counters, ‘But this is Steve’s first visit; it’s probably not the time to bring up drug addiction. He’d never come back.’ Matt, half seriously and half in jest, suggested giving Steve a prescription for 10 pills and making a follow-up appointment to see whether they could come up with a different plan for treating his pain. The instructor reminds them of their responsibility for the evidence. ‘Is Percocet indicated for this kind of pain? For back pain?’ There is agreement that no, according to the guidelines, Percocet is not indicated. ‘But,’ the instructor adds, ‘Matt is right about one thing. This is a dilemma of the first visit. How do you go forward with someone where you don’t have a relationship but would like to build one?’ The relationship between the provider and patient became the crucial point on which the discussion hinged. Published guidelines provide clear limits for pharmacological treatment of back pain. However, addressing Steve’s needs was more complicated than ushering him out of the office. The primary strategy for managing this complexity revolved around the possibility of future relationship. The skill of the NP would be gauged by whether or not Steve returned.

Remaking Relationships: Physician Recognition

The construction of NP skill is not only an internal matter; it requires cultural work on the physician side of the boundary. NPs define their new relationship to physicians as collaborative. Collaboration invokes mutuality in that it requires that physicians recognize NP expertise. It is questionable how much influence this ideal has on physician action. However, there was room to work on narrated physicians in NP educational accounts. When physicians appeared, they were congenial colleagues who respected the NP’s expertise. Lecturing NPs would routinely cast the physicians with whom they worked as coworkers to whom they turned for advice. However, they would also tell stories in which physicians did the same.

In one example, we listened to guest lecturer Catherine Brady, MSN, CRNP, deliver a lecture about urology. As with most speakers, she embedded stories about her professional orientation within the didactic content. For Catherine, the line between physician and NP expertise was hard and bright. ‘I tell patients before I even do the exam, “I’m going to examine you to see if I can treat you as a nurse. I’m not a urologist; I’m not a doctor. So if I see something that’s out of my league, I’m going to have you see someone else.”’ Catherine was unusual in voicing explicit deference to medical knowledge, but she was not unusual in telling stories with a physician presence. As Catherine delivered a lecture about urinary incontinence, she described a case from her own practice.

The case was an 83-year-old woman whom Catherine had successfully treated for incontinence in the past. The woman returned because her incontinence reappeared.

Well, we did a dipstick, and there was blood in her urine. I spoke to the doctor, and he said, “blood in the urine—she may have bladder cancer.” I said, well, she has lots of vaginal dryness and I think this may be part of the problem. The doc said, “well, I’d send her right to urology. But I’ll go with you Cat, to see what happens.” So, I gave her estrogen cream, and on follow-up, the UA [urine analysis] was clear. No more blood in the urine and her incontinence had gone away. (Reconstructed from field notes)

Catherine’s story dramatized both nursing deference to medical expertise and physician consideration of nursing’s expertise. Catherine was “not a doctor.” She was a nurse. But in her telling, that designation carried its own weight. As Catherine continued her lecture, she narrated a fuller sense of what it meant to treat a patient “as a nurse.” She referred to “nursing interventions” she used in her practice. Much like the estrogen cream in the narrated case, these interventions were marked by simplicity and effectiveness. The simplicity was not about the problem itself but about a professional approach. Catherine simultaneously recognized physician knowledge of the esoteric while asserting the difference and utility of nursing knowledge.

Students also brought back stories of the possibilities for physician recognition. Matt recounted a conversation with one of his physician preceptors where he asked directly about the physician’s feelings about NPs. The physician answered by talking about the NP in the office, noting that she had been practicing longer than he had. “And he said, ‘there are some things she knows that I don’t know. And if she has questions, she can come to me.’” Acknowledgment of NP expertise was not only about whether an NP might have knowledge that a physician does not have but that he or she might have a different approach. Brooke described her first day at one of her clinical sites. She was “chit-chatting” with Dr. Morris, the owner of a suburban primary care practice.

He was telling me about seeing four generations of patients. And I said, “oh, they must love you.” And he said, “No, not really. But they love Simone [the NP]. They ask for Simone; they want to talk to Simone.” Because you know, Dr. Morris is very—it’s like the medical model. “Okay, what’s wrong with you? Okay, fix it. Done. Okay, next.” And the nurse practitioner comes from the nursing model, which is very holistic [and] relationship-based.

The value of nursing’s difference was about both patient preferences and clinical outcomes. During a set of lectures on childhood immunizations, Darlene Palmer, MSN, CRNP, began to tell a story of a mother who resisted immunizing her son. The mother’s first child had a seizure following a set of vaccinations. Consequently, she was adamantly opposed to vaccinations for her second child. Darlene explained that some physicians try to reason with the parent. But she advised, ‘I don’t go head-to-head, cognitively. I don’t ask them to show me evidence.’ Darlene stressed that they needed to directly address the real problem, which was fear. Their job as NPs was to acknowledge that fear and to use it to build common ground. Darlene advised, ‘come at this just like a nurse would; not like a scientist.’ As NPs, they would prove their value to both patients and collaborating physicians by demonstrating the utility of nursing-centered practice.

#### b) treatment approach – NPs professional norms are tailored to non-medical 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 nurse practitioners 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 nurse practitioners 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.”

## K

### 2ac – framework

#### [B] *advocacy* – their framework retracts from questioning policy, which is *net-worse* for building radical subjects – only an affirmative questioning of the state can avoid the expansion of the right

Reed 01 – Adolph, professor of political science at the New School for Social Research, a member of the Interim National Council of the Labor Party, and serves on the board of Public Citizen, Inc. (“A GI Bill For Everybody .” Dissent, vol. 48, no. 4, 2001., C.C. Preston <3)//NRG \*edits for ableist language denoted by [brackets]

One of the most regrettable and self-defeating developments within progressive policy circles during the last two decades has been an atrophy of practical, programmatic vision [goals]. This is especially true with respect to those policy areas that lie in the domain of social wage provision-for example, health care, education, affordable housing, income support, old-age security, civil rights, and labor rights. This has been one of Reaganism's subtler, but more far-reaching victories. By seizing the political initiative and setting the terms of public debate, the right has so demoralized us and put us so completely on the defensive politically that we often seem capable of struggling only to minimize losses or, at best, to press for minimally incremental, often concessionary reforms. The result is that we have been unable effectively to counter the right wing's fundamental proposition that government has little or no responsibility for securing the general welfare and providing access to opportunities for the enhancement of the lives of the general population. We seem to have lost the ability or the will to articulate policies for making the society as just and democratic as it should be; instead, we have become increasingly focused on trying to secure what we think might actually be attainable within a policy universe dominated by the right's denial of the efficacy of public action. This failure of progressive policy vision is understandable. Activist and advocacy groups that have faced the brunt of the endlessly escalating right-wing assault are necessarily forced into a defensive mode as their often already precariously situated constituencies have been its prime targets. However, the only way to turn the tide of the right's war against the social gains won in the middle half of the twentieth century is to present clearly-and generate public discussion around-an affirmative policy agenda that addresses people's most basic concerns and is a practical expression of a different view of public responsibility and governmental capacity. We need to shift the terms of public debate, to break the stranglehold of Margaret Thatcher's right-wing mantra that the late Daniel Singer summed up pithily as TINA-There Is No Alternative-to the unrestrained action of market forces. This task does not contradict or override the more immediate struggles to preserve past gains that have been under concerted attack, such as commitments to racial and gender justice, social security for the elderly, and governmental provision of quality public services. Indeed, it is a necessary complement to them. The only way to preserve those gains is to challenge the arguments used in attacking them. We need a clear voice that seeks to shift the terms of public debate by reasserting the principles of social solidarity and public responsibility that have become increasingly marginalized during the past two decades. This means focusing on objectives that speak to people's immediate, everyday concerns-even if these lie beyond today's political horizon and cannot reasonably be expected to bear fruit within less than several election cycles. Objectives such as universal health care and universal access to higher education are practically realizable if political will can be generated to implement them. How can we generate that will? We have to open a broad policy discussion that begins with the question, What would American public policy look like and how would our institutions operate if their first priority were to meet the most important concerns of the vast majority of the population? This majority is not currently included among those that define the parameters of policy debate; they have not participated in calculating the supposed limits of feasibility and practicality that narrow the political horizon. Yet, as Michael Zweig has argued persuasively in The Working Class Majority: America's Best Kept Secret, they are the American demos, the democratic base. The left's most vital task, therefore, is to encourage a truly popular discussion about national priorities and the means to fulfill them. Not only do poll data indicate that education is already a broadly shared concern; in our own lives and in our interactions with others, we all recognize the strain that paying for higher education imposes throughout the population. So it makes sense to argue that significant potential exists for building grassroots support for realistic strategies that would make access to higher education available to all Americans, so far as interest and ability can take them. In the comparably critical area of health care, the Maine legislature's passage of a single-payer bill, signed into law by the governor, is the most dramatic recent indication of openness within the public to policy strategies that break sharply with neoliberal orthodoxy. In last year's elections, single-payer ballot initiatives won by at least 60 percent majorities in non-binding referenda in six legislative districts across Massachusetts and in Alachua County, Florida (where the initiative received more votes than any presidential candidate). These are admittedly modest victories, but they at least reinforce a suspicion that popular sentiment can be cultivated in support of policies that address broadly shared needs in just and egalitarian ways, without subordinating them to market theology. The key ingredient missing from left politics at this juncture in the United States is a concerted strategy for building popular constituencies to pursue objectives that resonate with people's concerns and harnessing those objectives to a social ~~vision~~ [agenda] that lies outside the limits defined by current elite consensus. That is in large measure how the right was able to change the terms of political debate in the first place, though the vision around which it articulates those concerns is largely a scam. After Barry Goldwater was swamped by Lyndon Johnson in 1964, militants of the right embarked on a strategic, long-term campaign that was largely grassroots-based. They realized that their push had been premature; the Johnson landslide showed them that it was necessary to take a step back and try to create a popular constituency for their political agenda. They pursued this objective by doing several things that we have consistently failed to do since the high period of civil rights and antiwar activism in the 1960s. They mobilized activists at the local level around issue-based campaigns that challenged the prevailing axes of incrementalist policy debate-for instance, for school prayer and tax cuts, against abortion, affirmative action, the Equal Rights Amendment, and school busing. They identified and cultivated bases of support around each of these issues and worked to knit them together into a coherent movement. This is the stuff of social-movement building. For too long now progressives have operated as if we already have the mobilized constituencies that we need. The governing consensus in national politics indicates that we don't. This is one of the strategic limitations of the domestic mobilization to challenge the World Trade Organization and other neoliberal globalization initiatives. While a focus on mounting highly visible international protests is understandable and perhaps necessary, by themselves those actions do little to deepen popular awareness of the dynamics and dangers that activists wish to combat. To that extent, these mobilizations may be self-limiting in scope and effectiveness. Their continued success requires planting roots within the broader population. Most Americans, however, have at most inchoate and incoherent views of the stakes of economic globalization; the interpretation of this process for popular discourse remains-at least outside the ranks of already committed progressives and attentive union members-the province of corporate media and its sound-bite analyses. It is past time for us to learn the same lesson that the right learned after Goldwater's defeat. A common objection to this comparison is that the right succeeded because it plays to people's fears, which are supposedly easier to mobilize around than more abstract, less emotionally charged political programs. But the concrete fears that most people experience most acutely connect much more immediately with the programs of the left: for example, fear of job loss and declining living standards, lack of access to adequate health care, affordable housing, and quality education. Another objection, largely a smear by smug neoliberals, is that the left proposes no new ideas and offers only opposition without clear, practical alternatives. But the right galvanizes its ranks largely around opposition to abortion, taxation, civil rights, immigration, and social spending. And what ideas are more shopworn in American politics than racism, nativism, and unrestrained property rights? Indeed, the right persists in presenting itself as an opposition movement even as it consolidates its dominance of the political landscape under the mantra of bipartisanship. It is only by taking up the challenge of building a coherent movement, creating and cultivating popular support for a long-term struggle focused on everyday needs-what are sometimes described as "practical utopias"-that it will be possible to redefine the terms of national policy debate. Removal of financial constraint on access to higher education could be such an initiative. It could appeal immediately to students, parents, university faculty and staff, and the organizations that represent them. It also has a natural and historic base in the labor movement, and not only among unions that represent workers in the education sector. Free public education was one of the two main demands of the earliest American unions, along with the shorter work week. Despite the right's attempts to characterize public support for higher education as an upper-middle-class giveaway, this is an issue that has resonance throughout the population. The "Joe Sixpack" imagery that drives so much disingenuous right-wing populism is simply bogus. Interest in educating oneself and one's children-for both instrumental reasons related to employment and noninstrumental reasons related to intellectual curiosity and self-fulfillment-is not by any means the exclusive property of the upper middle class. It is a condescending caricature that other working people do not have similar aspirations. Indeed, an element of this issue's appeal is its broad resonance within the population; it has the potential to cut across the familiar lines of division by race, gender, age, inner city, and suburb that the right has successfully exploited and intensified over the past two decades. The Debs-Jones-Douglass Institute, a nonprofit educational organization associated with the Labor Party, will put out a call this fall for a grassroots campaign to make higher education universally accessible to all academically qualifying potential students. (Accessibility also should require adequate remedial and developmental support for borderline admits and easy movement from community college through university on the basis of interest and demonstrated ability.) This could be the beginning of a significant popular movement-on the order of earlier agitation for black Americans' civil rights, for the eight-hour day, or for old-age assistance-that helps to redefine the terms of national political debate. As those earlier movements did, it could also achieve its own objectives and, in the process, expand the foundation of American democracy.

### 2ac – at: framework offense

#### Prefer our framework as a method of deconstructing marketized logics – economic techniques are not rigidly violent and must be analyzed in context

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

### A-to Calculation K – Top-Shelf

#### No link and impact turn – Not all calculation is tied to the bad ones AND their K justifies the worst violence.

Stanescu ’14

(James Stanescu - Professional Lecturer in Philosophy at American University, in Washington, D.C. “ Abstraction, Calculative Thinking, Global Warming, and Environmental Ethics; or the Polar Vortex of Thinking!” Critical Animal, 1/7/2014 – modified for language that may offend - http://criticalanimal.blogspot.com/2014/01/abstraction-calculative-thinking-global.html])

This polar vortex seems to be a good cause for our annual winter jokes from Republicans that global warming is somehow a lie. This time from Ted Cruz, but he is hardly the first. At the link, Weigel argues that the issue is a fundamental confusion between weather and climate. Weather being the immediate phenomenological event, climate being an abstraction. In order to understand something like rapid climate change or global warming, and the ability to understand its causes, and the ways we may stop or divert its destruction, requires serious calculative thinking. It requires care for our abstractions. Abstraction here should be hear in the register of Whitehead. It is a idea (like Nishida Kitaro's transcendence, Althusser's problématique, Foucault's historical a priori, and Deleuze and Guattari's concept) to talk about the way that knowledge's knowing comes to be known (that is an ugly 90s-style phrase, but I think you get the idea). To quote Massumi quoting Deleuze, "the opposite of the concrete is not the abstract, it is the discrete." As Massumi adds, “[t]he discrete: the slothful just-being-there of an inactive chunk of matter.” (Semblance and Event, 27). Abstraction does not take us out of the situation, rather abstraction gives us prehensions of the situation. Let us take the abstraction of global warming. Global warming is a lure for thinking about issues of consumption and production, of energy and waste, of diet, transportation, and development. We can understand how, as ethicists, we need this abstraction of global warming in order to ask and answer certain questions. And, we can also see here how the discrete is the opposite of the concrete, rather than the abstract. For example, Ted Cruz's 'joke' that Al Gore told me this wouldn't happen. Such a move refuses the very actual, very concrete reality of global warming by discreting the moment of snow and cold in D.C. from the broader reality and the broader context of global warming. We can give many other examples. How colorblind policies discrete the reality of racism, or how 'tone' criticisms are used to discrete the lived experiences under the abstract and concrete realities of white supremacy and heterosexist patriarchy. To bring us to animals, when we are able to cherish the family pet and treat her as if she was a family member, and then to go and eat the parts of bodies of other animals, is certainly a manifestation of the discrete. That is to say, the ability to de-contextualize our pets from animals in general is a moment of discretion, and not abstraction. My point here is that our response to global warming cannot simply be through appeals to phenomenological immediacy. Moreover, we will not be saved by virtue, infinite responsibility for the infinite other, or voluntarism. What we need is better abstractions, more calculative thinking, more en-framing, and stronger institutional responses. As David Wood has shown, when it comes to the wars in Iraq and Afghanistan, Katrina, global warming, and a variety of other events, it has been the conservative response to ~~embrace~~ (endorse) the impossibility of calculative thought. Perhaps our project going further is to, as Isabelle Stengers has argued, to calculate again. This is not the calculative thought of the capitalist cost-benefit system, but a different calculation. It is, to steal a phrase from Jane Bennett, about mutually enabling instrumentalizations. Long quotation from Stengers ahead, so bear with me: The cosmopolitical Parliament is not primarily a place where instantaneous decisions are made, but a delocalized place. It exists every time a "we" is constructed that does not identify with the identity of a solution but hesitates before a problem. I associate this "we" with the only slogan Leibniz ever proposed: Calculemus. Let us calculate. It's an odd expression, constructed to conceptualize the possibility of peace during a time of war. But Leibniz was a mathematician, not an accountant or statistician. For him, calculation was not a mere balance sheet contrasting homogeneous quantities, calculations of interest or benefits that were presented as being commensurable. For a mathematician, the accuracy of a calculation and the validity of its result are relatively simple questions, "trivial" in the language of mathematics. What is important, and which is not in the least trivial, is the position of the problem that will, possibly, allow it to be calculated, the precise creation of relationships and constraints, the distinction between the various ingredients, the exploration of the roles they are liable to play, the determinations or indeterminations they engender or bring about. There is no commensurability without the invention of a measurement, and the challenge of Leibniz's calculemus is, precisely, the creation of a "we" that excludes all external measures, all prior agreements separating those who are entitled to "enter" into the calculation and those subject to its result. [...] Calculemus, therefore, does not mean "let us measure," "let us add," "let us compare," but, first and foremost, let us create the "we" associated with the nature and terms of the operation to be risked. It is not a question of acting in the name of truth and justice, but of creating commensurability. It is a question of knowing that the "truth" of the created common measure will always be relative to what such creation will have been capable of, knowing also that a radical heterogeneity preexists such creation, the absence of any preexisting shared measure among the ingredients to be articulated. (Cosmopolitics II, pp. 399-401).

### 2ac – at: calculation link – Painter-Morland 17

#### Second, calculative logics can be re-deployed within institutions – transgression is co-opted by neoliberalism

Landa 15—The Open University (Ishay, “Bataille: The Master, the Slave, and Consumption”, Critical Sociology 2015, Vol. 41(7-8) 1087–1102, dml)

This means that the ‘bourgeois’ dominion was ultimately rejected qua the reign of the banal, the everyday, the useful. This is, put more conventionally, the profane realm of the masses. Capitalism – in such a romantic reading – is not so much cataclysmic, unjust and unhappy, as it is stable, stale and boring.13 Let the moment and the event come and disrupt its routines, not because they are ‘bad’, but because they are just that: routines. Consumation and everyday life are thus seen as incompatible; to consume sovereignly is to break free of the normal.14 In a move characteristic of romantic anti-capitalism, Bataille was obsessed with fighting prohibitions, marshalling against them ‘perversions’ of all sorts: the evil lies not in bad rules and corrupt institutions, but rather in rules and institutions as such – in that respect anticipating Foucault, who will be the most salient Bataillean in the second half of the 20th century.15

The Pitfalls of Permanent Transgression

Such an ideology of transgression can be subjected to two kinds of political criticism: the first one concerns the absence of a truly radical thrust. Behind the dizzying façade, absolute negation tends to move in a circular fashion, and often ends up negating itself. Paradoxically, this ultra-anarchism leads to an affirmation of present institutions,16 of present norms and codes: what would be the sense in destroying them if other institutions would be just as bad, belonging in the same category of ‘institutions’? Even more to the point, such institutions, norms and taboos become indispensable for without them all the exuberance of the act of rebellion fizzles out. An obsolete taboo is like a damp squib, forfeiting its prospects of producing fireworks. Thus, as Michel Surya indicated, for all his embrace of perversion, Bataille dismissed the notion that one should do away with ‘religion and morality’. He insisted, on the contrary, that ‘it is pointless and impossible to seek to abolish them; that whoever wants to be sovereignly – but alone – free to transgress them must seek the dark, frightful and infernal pleasure of this curse and this fear’ (in Surya, 2002: 451). As Bataille himself put it, he wanted to ‘make plain the futility of the common contention that sexual taboos are nothing but prejudice, and it is high time we were rid of them.’ The surprising role of social injunctions as providing the very foundation for transgression, also carries seriously damaging implications which affect the core claims of ‘sovereignty’. Sovereignty as theorized by Bataille recommends itself as an act of total freedom, completely self-referential and autonomous. It is supposed to provide a trance which obliterates society and its asphyxiating mores. Such aloofness however appears illusory, once its obligation to épater le bourgeois [shock the system] is computed. Sovereignty appears to owe its existence to that very mass society which it aims to negate. This recalls Hegel’s shrewd exposure of the deceptive autonomy of the Cynics. ‘Diogenes,’ he observed, ‘in his whole character as a Cynic, is in fact merely a product of the social life of Athens, and what determined him was the opinion against which his entire way of life reacted. His way of life was therefore not independent, but merely a consequence of these social conditions, and itself an unprepossessing product of luxury.’ (Hegel, 2010: 231) Under close inspection, therefore, the sovereign is seen to react rather than act, not a major offence, perhaps, but one which becomes very grave indeed within a Nietzschean framework where few travesties are as bad as slavish ressentiment. Then again, one could hardly criticize Bataille where Nietzsche himself had faulted and where success, at least according to Fredric Jameson, is structurally unattainable. Jameson (1981: 202) cannily pointed out ‘the autoreferential structure’ of the ressentiment ideologeme, claiming that ‘the theory of ressentiment, wherever it appears, will always itself be the expression and the production of ressentiment.’

Secondly, to the extent that Bataillean transgression can help to combat institutions, it is by no means clear that its impact would be progressive, rather than conservative or reactionary. The purely formalistic nature of ‘negation’ means that it is a weapon that can cut both ways, in the cause of social repression and dispossession no less than that of popular empowerment. From a Hegelian and Marxist point of view, a society without institutions and prohibitions is neither conceivable nor desirable. The point is rather to abolish bad institutions, change and reform ambivalent ones, and create new practices and institutions, more adapted for the needs, wishes and desires of multifaceted, able and communicative ‘social individuals’ who are the products of historical development. But to fight institutions as such? Was not the demand to be admitted into existing institutions, say schools and hospitals, a fundamental progressive social demand, which was obtained only after prolonged and bitter historical struggles? But with Bataille and his major follower Foucault, institutions themselves become suspect.

Such theories can prove surprisingly serviceable to capitalism: if the fight is not primarily against private ownership of the means of production, and for, say, a system of universal education and healthcare, but rather against ‘institutions’, isn’t there something to be said for neo-liberalism, which so arduously ‘deconstructed’ – not just in theory but in practice too – so many institutions? Was not neo-liberalism delivering the people, especially those most likely to be manipulated and brainwashed, from the supervising and policing practices of hospitals? Did it not do its best to restrict access to universities to only the social elites, thereby delivering the mass from the insidious teachings at such intellectual centers of power? Seen under such a light, the neo-liberal state, with its cuts on public education, healthcare and welfare expenditure, emerges as surprisingly close to the ideal of a postmodernist state, engaged in active self-deconstructing. In a famous 1971 public debate with an unsuspecting Noam Chomsky, who defended traditional goals of social amelioration along humanist lines, Foucault disagreed: ‘It seems to me that the real political task,’ he asserted, ‘is to criticize the workings of institutions, which appear to be both neutral and independent; to criticize and attack them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight against them.’ For Foucault, these were ‘Institutions of knowledge, of foresight and care, such as medicine.’ Chomsky agreed, but instructively had enough presence of mind to emphasize the need to fight other institutions as well which feign social neutrality, ‘the central institutions of any industrial society, namely the economic, commercial and financial institutions and in particular, in the coming period, the great multi-national corporations.’ (Chomsky, 1971) This exchange took place when the European welfare state was at its historical peak. It may not be a complete coincidence that, more than four decades later, and following an all-out Foucauldian postmodernist onslaught on ‘power’ – an attack which was Bataillean at a second remove – the welfare state is in a sorry condition, whereas the multi-national corporations are stronger than ever.

### A2: NP Exploitation link

#### Their “reps” links are AMA agitprop

Galperin 20 (Roman V., McGill University - Desautels Faculty of Management, “Organizational Powers: Contested Innovation and Loss of Professional Jurisdiction in the Case of Retail Medicine,” Organization Science 31(2):508-534. https://doi.org/10.1287/orsc.2019.1314)//NRG

The model of deprofessionalization proposed here has implications for the literature on innovation in markets. Entry into professionalized markets by innovative firms—for example, retailers in primary healthcare, algorithmic advisors in financial services (Logg et al. 2019), document assembly software providers in legal services (Mountain 2007), or drone manufacturers in aviation (Helmore 2009)—is a kind of technological innovation where establishing acceptance of a new technological frame is especially important and challenging. Because incumbent professions have the incentives and the levers to resist adoption of the new frame, innovative firms may be more successful if they anticipate the resistance to the adoption of their innovation and account for it in developing their market entry strategies.

The case presented here specifically points to interprofessional tensions as an important factor in devising such strategies. For example, the feasibility of entry may depend not necessarily on the strength of the dominant profession in the field but rather on the relative strength of the second strongest profession, most often a subordinate one. The stronger the subordinate profession, the more dangerous its legal and cultural assets are for the dominant profession should these assets be repurposed by the corporate intruders to support their own entry.

The case of retail medicine also highlights the importance of a coordinated rhetorical strategy to support new entry into a professionalized market as culturally legitimate. Although research on technological frame adoption argues that innovation is not always adopted even if it has superior properties over the existing technology, the discourse around retail medicine suggests an even more extreme possibility— that technical superiority of an innovation may be construed as a liability. Although a new technology may be more efficient than the performance of the same work by expert practitioners, the efficiency need not be accepted as a universal virtue by market participants, and therefore, it does not necessarily make the innovation legitimate. When their jurisdiction is threatened, professions tend to cast economic efficiency as an undesirable feature of professional work by framing it as a property of commercialism, which puts profit ahead of service.

For the efficiency of new technology to be a virtue, those who bring the innovation to market ought to frame it as such. Retail clinics used NPs’ frame of efficiency as an answer to the problem of access to care. By pointing out the lack of access, especially among the most vulnerable populations, retail clinics (as NPs before them) pointed out physicians’ failure to follow through on their moral responsibility as a dominant profession. A history of moral arguments made by subordinate professions may therefore be a valuable asset for new entrants seeking to legitimize their innovation.

Generalizability and Future Research

Because the focus of this paper is on the emergence of one organizational form, the analysis presented here is necessarily limited. Some observers of the retail clinics industry claim that growth of retail medicine has increased access to primary care and may have lowered costs while maintaining quality (Mehrotra et al. 2009, Schleiter 2010). Given that the healthcare industry accounts for a large part of the economy in the United States and many other countries, the policy implications of understanding the drivers of increased efficiency of services in this case alone are consequential.

### 2ac – at: healthcare link – Healy 06

#### Healthcare fantasy is reductionist – the aff doesn’t fit under their binary understanding of care

Healy 06 (Stephen, PhD in Philosophy from University of Massachusetts Amherst, "CARE IN THE COMMUNITY ECONOMY: TOWARDS AN ALTERNATIVE DEVELOPMENT OF HEALTH CARE", September 2006, [www.communityeconomies.org/site/assets/media/stephenhealy/distotal08\_07\_06.pdf](http://www.communityeconomies.org/site/assets/media/stephenhealy/distotal08_07_06.pdf)

The social fantasy embodied in the figure of the needy patient and greedy provider changes and evolves over time, but the central function of these ideas is to legitimate the constraint and regulation of enjoyment. The ambiguity of physician and patient motivation and desires is disavowed in favor of an economy 61 of discipline that tells us we must constrain their enjoyment. The fact that this discourse never fully articulates the desires of patients and physicians—that ambiguity remains, no matter how much it is disavowed—has consequences for health care reform discourse.18

#### Rejection of community 0health centers due to physician pushback caused policy failures – they’re on the side of physicians

Healy 06 (Stephen, PhD in Philosophy from University of Massachusetts Amherst, "CARE IN THE COMMUNITY ECONOMY: TOWARDS AN ALTERNATIVE DEVELOPMENT OF HEALTH CARE", September 2006, [www.communityeconomies.org/site/assets/media/stephenhealy/distotal08\_07\_06.pdf](http://www.communityeconomies.org/site/assets/media/stephenhealy/distotal08_07_06.pdf)

Engel (2002) focuses on the role of ideological conflict in creating the deadlock between those who advocate a rational universal health care and those who insist that health care be left to the free market. By exploring the earliest efforts at reform, he argues, like Dukakis, that the ideological positions taken in this debate have been remarkably consistent throughout the twentieth century. The Committee on the Cost of Medical Care (CCMC), commissioned in 1906, found that there were significant disparities in access to care that broke down along the lines of socio-economic status, with the lowest quintile using medical services far less than the wealthier segments. Their proposal to correct this inequity was to forge a health system out of the disparate and independent components of medical care in the United States. Such a system was predicated on the creation of ‘community health centers,’ which would house inpatient and outpatient facilities, a pharmacy, clinics, and nursing and dental care. (Engel 2002, 38) The idea was that these community health centers would operate on an economy of scale—specifically a reduction of administrative overhead—without compromising the intimacy of doctor-patient relations. They were to be paid for by a universal income tax. In short, the belief was that universal access to care was of such importance that it should exist as a public commitment. What is astonishing is that both the problems the CCMC was trying to address and their proposed solution are strikingly similar to how progressive reformers frame the issue today (e.g. Sagar 2003; Goyer et al. 2004).

The solution proffered by the CCMC sounds familiar and the scorn with which it was met bears an uncanny resemblance to the standard objections raised against government run universal health care to this day. At the time, the principal voice of opposition was the head of the American Medical Association (AMA), Morris Fishbein, who insisted that any sort of collectivization of risk led down the path to socialism and the ruination of the American moral fiber. In his forty-year tenure as the head of the AMA, Fishbein was unrelenting in his opposition. He even maintained his resistance to private insurance and sickness funds as forms of “collectivism” long after the majority of AMA members accepted them as a necessary evil (Engel 2002, 110).

#### Fourth, Healy votes for the perm as a “politics of possibility”

Healy 06 (Stephen, PhD in Philosophy from University of Massachusetts Amherst, "CARE IN THE COMMUNITY ECONOMY: TOWARDS AN ALTERNATIVE DEVELOPMENT OF HEALTH CARE", September 2006, [www.communityeconomies.org/site/assets/media/stephenhealy/distotal08\_07\_06.pdf](http://www.communityeconomies.org/site/assets/media/stephenhealy/distotal08_07_06.pdf)

The point, however, is not simply to render the health care economy visible in all of its diversity. Rather this is a first step towards an alternative politics of health care reform. Foremost, situating health care in the diverse economy changes the object that we are reforming. It is no longer a question of how to pay for care provided by physicians and hospitals but rather how we might rearrange all the paid and unpaid elements of the care economy in order to meet the needs of patients and the public as a whole. Rather than a politics of scarcity and restraint, the diverse economy allows us to imagine health care reform in relation to connection, possibility and articulation. In place of an economics of scarcity, there is a politics of possibility.

#### Fifth, the aff alone solves their impact – it categorically addresses failing form of care – I found this cool card right inside of theirs! [CONTINUED LATER] in their healy ev is where these portions are located

Healy 06 (Stephen, PhD in Philosophy from University of Massachusetts Amherst, "CARE IN THE COMMUNITY ECONOMY: TOWARDS AN ALTERNATIVE DEVELOPMENT OF HEALTH CARE", September 2006, [www.communityeconomies.org/site/assets/media/stephenhealy/distotal08\_07\_06.pdf](http://www.communityeconomies.org/site/assets/media/stephenhealy/distotal08_07_06.pdf)

[TEXAS EV ENDS FOR SOME REASON…]

The Importance of Being Affected

Dr. Francis Peabody, writing in 1927, observed that medical training focused increasingly upon the technical aspects of caregiving and the treatment of disease while paying little attention to cultivating the emotional intelligence that is required to “bond” with the patient. He argued that while the treatment of a disease may be entirely impersonal; the care of the patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both the diagnosis and treatment of illness are directly dependent upon it. (Peabody 1927, 877) Peabody also noted that separating physical disease and pain from psychosomatic malady is a skill that is predicated upon the physician’s ability to observe and interact with the patient. He spoke of the clinical need for physicians to be able to listen to and empathize with patients, in short, to be affected by their presence in the course of treating an illness. At a time when modern medical practice was still in its infancy, Peabody was already voicing concerns that mastering the “technical” aspects of treatment was threatening to displace the time required for the physician to acquire empathetic capacity. Peabody suggested that medical schools devote at least some time to this aspect of professional practice but he also recognized that this is necessarily a skill physicians acquire on the job. The capacity for empathy and discernment is something conferred by performing the labor itself and being affected by it.51

As we saw in chapter II, Dranove (2000) argues that affective labor/care was (and is) what physicians offer when they cannot cure. He asks us to consider a hypothetical instance in which we are ill and presented a choice between an average physician with exceptional bedside manner and an impersonal physician whose knowledge and expertise is in the precise ailment that we have. According to Dranove, the choice is obvious. He goes on to argue that patients unduly value the “caring-ness” of their care providers and that they should, instead, evaluate physicians, courses of treatment and hospitals in relation to another measure, for instance, quality of outcomes or medical error rates.

One implication of Dranove’s argument is that “affective” labor, while nice, is also largely irrelevant to medical outcomes and that emphasizing it is a waste of money. While Dranove is quite right to insist that there are differences in levels of expertise of physicians and in the quality of medical facilities, does it follow that it is unreasonable for patients to be concerned with the quality of the emotional labor they receive from their providers? The obvious rejoinder to Dranove’s argument is to ask why one cannot have physician who is both technically proficient in the delivery of care and affectively competent. Why shouldn’t affective labor be considered among the criteria of excellence in health care and as part of what people deserve as patients?52

Jerome Groopman’s fascinating Anatomy of Hope (2004) can be read as a rebuttal to Dranove’s argument that the “bedside manner” of the physician is of little or no consequence. Groopman describes the critical role that affect plays in the treatment of deadly disease. The affective encounter between patient and physician and its emotional consequences for both parties can create the conditions for healing (hope) or undermine it utterly (despair). Groopman argues that the technical treatment of disease may be more tied to its affective dimensions than we had previously realized. He has been a practicing oncologist since the 1970s and has participated in technological advances in the treatment of cancer. Over the course of his career, he has witnessed particular types of cancer go from being incurable to treatable and even curable. Alongside these technological advances he has noted over the years how the attitude of the individual patient plays a tremendous role in their survival—specifically their ability to be hopeful about the course of treatment. In turn he also realized that his attitude as a physician played a role in whether or not the patient was hopeful or despairing.

Groopman came to this understanding through the course of his clinical practice. No one taught him how to deal with the reactions of patients to receiving a cancer diagnosis and the role that attitude played in the course of treating disease. He learned early on, for instance, that it was folly to be dishonest with the patients—either to spare them grief or in the hopes of keeping them encouraged. A Pollyanna attitude is inevitably disappointed in the course of treating cancer. “Unexpected” relapses can crush the patient’s resolve to continue with treatment. Later Groopman learned that it was folly to be “completely honest” with the patient about their prognosis in that it severed the patient from any sense of hope and also any chance of the patient relating to him as a human being.

For Groopman hope is not unwarranted optimism. Nor, for Groopman, is hope what we have when empirical investigation suggests a favorable outcome. Hope is the recognition of the singular and contingent circumstances of an individual patient’s life in relation to the variable progression of any disease. At the same time, hope is something that is a birth right that humans should enjoy regardless of circumstance. As one of his fellow oncologists explained as he suffered from a cancer that he himself would have considered incurable, “I have a right to hope.”53

According to Groopman, this understanding of hope as a subtle sense of contingency and possibility has different meanings to different patients. Consequently, cultivating hope in a patient is always going to mean something different in each particular case. Groopman describes his experiences with one patient, Dan Conrad, who had a particularly aggressive form of non-Hodgkin’s lymphoma. The tumor was operable and yet the patient refused treatment, simply repeating that he knew there was no hope for him. Groopman, recognizing that Dan was a Vietnam veteran, used the metaphor of war hoping that it would inspire courage. He asked him to think of his cancer treatment as the site of a winnable battle in which he was the general and the physicians were soldiers awaiting orders. When this failed to elicit consent, Groopman asked Dan to think of his wife and family. In response to these entreaties Dan simply responded that he knew with an absolute certainty that he was going to die.

After talking with Dan for few days Groopman, finally—and quite accidentally—learned the origins of his depressive sense of certainty. Dan’s wife had spoken with a friend of her husband’s from the army and she relayed this information to a colleague of Groopman’s, who in turn relayed it to him. ‘Then the army buddy said to Mrs. Conrad that Dan’s situation was just like the case of another veteran from the unit,” Virginia related. Not long after the war, Betsy learned, one of Dan’s closest friends had developed cancer. The caller did not say what kind of cancer, but Dan had kept a vigil at the bedside from the time his friend went into the hospital, through the multiple complications of his ICU stay, until the man died. (Groopman 2004, 103) It was then that Groopman realized that his military analogy had completely “backfired.” He saw that he had failed to understand Dan as a person, to probe deeply into the details of his life. It seemed easy to integrate his status as a veteran into the typical battle scenarios that I and other doctors painted for patients. 148 But instead of picturing himself as a victorious warrior, he must have seen himself as so much cannon fodder, like his friend. (Groopman 2004, 103) With this knowledge Groopman was able, finally, to appeal to Dan’s sense of reason. He argued that cancer treatment had advanced considerably in the intervening years and that his friend’s fate was not necessarily his. It was enough of an opening to allow Dan to see the reason behind consenting to treatment. According to Groopman, once the mass of the tumor had been reduced enough to relieve the pressure on Dan’s lungs, his body was no longer able to convince Dan that he was on the threshold of death.

The point not to be missed here is that this expensive, technical, and ultimately life- saving operation would not have occurred if Groopman lacked the time, skill, or inclination to understand the source of this man’s resistance to treatment, the specific origins of his sense of hopelessness. Receptivity to affect is what allowed Groopman to be effective, to think of the treatment of illness not simply as a technical process but one where affective intensities, and the bodily sense of hope or despair they produce, must be mediated as well.55

If opening himself to the emotional meaning of disease is what allowed Groopman to save the veteran, in other instances this same capacity is what allows him to respect the wishes of another patient to stop treatment. Groopman relates the story of a Barbara, a woman who developed breast cancer for the second time after a short period of remission. This woman was absolutely clear with him that she wanted to continue treatment only so long as it enabled her to continue to enjoy life and that she would be the person who would make that determination. During her initial consultation Barbara handed Dr. Groopman a card authorizing her pastor to be her legal health proxy and with that gesture communicated that she had an understanding that this care was to be palliative in nature. Groopman was suspicious of her equanimity in the face of death but also was curious as to its origin, if indeed it was her genuine emotional response to terminal illness.

Groopman learned that Barbara was a deeply religious woman and she probed him about his own beliefs during the course of her visits. There was something in her curiosity and courage that deeply affected him. After sending Barbara’s cancer into a series of temporary remissions with first, second, and third line chemotherapy regimens, Groopman realized that no other treatments were left to keep Barbara’s cancer in check. When he told her that he could do nothing more for her Barbara’s composure faltered for only a moment and then she responded that he had one medicine left to administer—the friendship that they had developed over the course of the past year. After Barbara left, I sat in my office. My eyes moved to a book on the shelf that I had read not long before: Doctoring by Eric Cassell. Cassell, a primary care physician, wrote it at the end of a long career. He articulated a feeling that I had vaguely sensed but never fully realized. There are some patients whom a doctor grows to love. It is a unique type of love, distinct from any other type of love the doctor has experienced before. It moves outside of the bounds of the usual doctor-patient relationship; feelings and thoughts that are no longer strictly professional and are shared among true friends. Barbara had sparked that love in me. (Groopman 2004, 132) Clearly Groopman’s capacity to listen and be effective as a physician was what allowed him to put Barbara in control of her own palliative treatment. Groopman was affected by Barbara in a way that allowed him to deepen his appreciation for the meaning(s) of hope. While Groopman agrees with Kubler Ross that acceptance is the final stage of the dying process, even “acceptance” is not without hope. Barbara persisted to the end in her relations with Dr. Groopman, her church and even in mediating conflicts in her family. Her hope was that the connections she made with people would persist after she was gone. If Groopman’s experience with Dan illustrates the importance of understanding what prevents a patient from having hope, his experience with Barbara illustrates how hope can persist even in the face of certain death.

Through Groopman’s analysis of hope, we can see how care is productive of affect and that caring is a process of negotiating ones way through the affective intensity. According to Groopman, getting the patient to recognize the singular and contingent outcome of illness or injury is what is required to give them a sense of realistic hope. Imparting hope requires an attunement to the particular life history of the patient and also a receptivity to their desires and anxieties. It demands, ideally, a certain opening up on the part of the caregiver, even an identification with the patient. This is, to be sure, a demanding practice. In my view this is precisely why many care providers speak of the need to establish a 151 certain “distance” or of a need to maintain a certain emotional reserve outside of the context of caregiving. Perhaps we can understand this need for distance not as a calculated callousness, but rather an attempt to achieve the correct point of tension, a way of negotiating between identifying with patient while bearing in mind their autonomy as well as one’s own psychic and physical integrity. Cultivating hope, allowing it to come into existence in a particular way for each patient, is a skill that Groopman has acquired by being a physician. It is something that has deeply affected and transformed him.5

I would argue that this experience of becoming a caregiver is not confined to professional providers. To return to Arno et al. (1999) and Donelan (2002), both of these researchers painted a decidedly split representation of the emotional impact of informal caregiving. On the one hand caregiving was draining physically and financially, depressing and physically hazardous. On the other hand, their informants also spoke of it as one of the most important and rewarding aspects of their lives. The in-depth interviews I have conducted with informal care providers all attest to this split—care is exhausting and yet simultaneously the labor itself is a source or energy, drive and satisfaction. Are we not confronted here with an instance where the emotional and even physical impact of caring labor is autonomous from its affective intensity? This dichotomous experience of caring labor was repeated by professionals I spoke to in the field—from administrators, to surgeons, to alternative practitioners. Recognizing this split nature of caring labor as enabling/disabling, depressing/fulfilling seems to suggest that the goal of health care reform should be to maximize the enabling affect of care while minimizing its draining, depressing side.

It is perhaps impossible, in the final analysis, to fully eliminate the “draining” aspects of care or to create only those circumstances of caring that maximize joyful participation. I believe that taking the affective intensity of care seriously has implications for how we might imagine health care reform. Health care reform might begin with listening to or even reinvigorating an already existing discourse on how to negotiating the affective intensity and emotional consequences of caregiving. This will perhaps allow us to imagine a process of health care reform that goes beyond the steady application of a miserly attitude and towards one that is directed by a different ethic.

Ethics, Duty, Care, Symbolic Death and the Affective Event In the section that follows draws upon emergent theorizations of an ethic of care. Beyond being the simple expression of a “human desire” to care for others—for instance, Carol Gilligan’s (1982) imagination of a feminine ethics of care—I am going to argue for an ethic of care that involves itself with a process of clarifying duty in intensely affecting circumstances. Here the principal issue is not whether to care, or why one cares, but rather how. Answering this question of “how to care” frequently brings the care provider face to face with the contradictory and intensely affective experience of being a care provider. While this may involve a sense of felt obligation, caring sometimes demands the transgression of social norms that separate self from other. At first blush, it is 153 difficult to imagine that “duty” towards others and “transgression” of others are anything other than opposed to one another. The new Lacanians, however, make the case that the fulfillment of duty requires this deliberate transgression—that caring, like love, violates the law that separates self and other. From this perspective, this transgression either undermines or transforms the person who bears this duty-to-care. It is this understanding of duty that makes the recent work of psychoanalytic theorists relevant to a new conception of health care reform. These theorists point out that fidelity to an ethics of care is actually a commitment to being “unmade” or even potentially undone by the caregiving process— receiving its affective intensity, risking literal and symbolic death, in a way that transforms the caregiving subject.

[TEXAS EV BEGINS AGAIN]

#### Sixth, Psychoanalysis is wrong – over-explains and is a tautology

Robinson 05 (Andrew, Early Career Fellow in the School of Politics – University of Nottingham, “The Political Theory of Constitutive Lack: A Critique”, Theory & Event, 8(1))

 Lacanian analysis consists mainly of an exercise in projection.  As a result, Lacanian "explanations" often look more propagandistic or pedagogical than explanatory.  A particular case is dealt with only in order to, and to the extent that it can, confirm the **already-formulated** structural theory.  Judith Butler criticizes Zizek's method on the grounds that 'theory is applied to its examples', as if 'already true, prior to its exemplification'.  'The theory is articulated on its self-sufficiency, and then shifts register only for the pedagogical purpose of illustrating an already accomplished truth'.  It is therefore 'a theoretical fetish that disavows the conditions of its own emergence'[52](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn52).  She alleges that Lacanian psychoanalysis 'becomes a theological project' and also 'a way to avoid the rather messy psychic and social entanglement' involved in studying specific cases[53](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn53).  Similarly, Dominick LaCapra objects to the idea of constitutive lack because specific 'losses cannot be adequately addressed when they are enveloped in an overly generalised discourse of absence... Conversely, absence at a "foundational" level cannot simply be derived from particular historical losses'[54](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn54).  Attacking 'the long story of conflating absence with loss that becomes constitutive instead of historical'[55](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn55), he accuses several theorists of eliding the difference between absence and loss, with 'confusing and dubious results', including a 'tendency to avoid addressing historical problems, including losses, in sufficiently specific terms', and a tendency to 'enshroud, perhaps even to etherealise, them in a generalised discourse of absence'[56](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn56).  Daniel Bensa’d draws out the political consequences of the projection of absolutes into politics.  'The fetishism of the absolute event involves... a suppression of historical intelligibility, necessary to its depoliticization'.  The space from which politics is evacuated 'becomes... a suitable place for abstractions, delusions and hypostases'.  Instead of actual social forces, there are 'shadows and spectres'[57](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn57).       The operation of the logic of projection is predictable.  According to Lacanians, there is a basic structure (sometimes called a 'ground' or 'matrix') from which all social phenomena arise, and this structure, which remains unchanged in all eventualities, is the reference-point from which particular cases are viewed.  The "fit" between theory and evidence is constructed **monologically** by the **reduction** of the latter to the former, or by **selectivity** in inclusion and reading of examples.  At its simplest, the Lacanian myth functions by a short-circuit between a particular instance and statements containing words such as "all", "always", "never", "necessity" and so on.  A contingent example or a generic reference to "experience" is used, **misleadingly**, to found a claim with supposed universal validity.  For instance, Stavrakakis uses the fact that existing belief-systems are based on exclusions as a basis to claim that all belief-systems are necessarily based on exclusions[58](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn58), and claims that particular traumas express an 'ultimate impossibility'[59](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn59).  Similarly, Laclau and Mouffe use the fact that a particular antagonism can disrupt a particular fixed identity to claim that the social as such is penetrated and constituted by antagonism as such[60](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn60).  Phenomena are often analysed as outgrowths of something exterior to the situation in question.  For instance, Zizek 's concept of the "social symptom" depends on a reduction of the acts of one particular series of people (the "socially excluded", "fundamentalists", Serbian paramilitaries, etc.) to a psychological function in the psyche of a different group (westerners).  The "real" is a supposedly self-identical principle which is used to reduce any and all qualitative differences between situations to a relation of formal equivalence.  This shows how mythical characteristics can be projected from the outside, although it also raises different problems: the under-conceptualization of the relationship between individual psyches and collective phenomena in Lacanian theory, and a related tendency for psychological concepts to acquire an ersatz agency similar to that of a Marxian fetish.  "The Real" or "antagonism" occurs in phrases which have it doing or causing something.       As Barthes shows, myth offers the psychological benefits of empiricism without the epistemological costs.  Tautology, for instance, is 'a minor ethical salvation, the satisfaction of having militated in favour of a truth... without having to assume the risks which any somewhat positive search for truth inevitably involves'[61](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn61).  It dispenses with the need to have ideas, while treating this release as a stern morality.  Tautology is a rationality which simultaneously denies itself, in which 'the accidental failure of language is magically identified with what one decides is a natural resistance of the object'[62](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn62).       This passage could almost have been written with the "Lacanian Real" in mind.  The characteristic of the Real is precisely that one can invoke it without defining it (since it is "beyond symbolization"), and that the accidental failure of language, or indeed a contingent failure in social praxis, is identified with an ontological resistance to symbolization projected into Being itself.  For instance, Zizek 's classification of the Nation as a Thing rests on the claim that 'the only way we can determine it is by... empty tautology', and that it is a 'semantic void'[63](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn63).  Similarly, he claims that 'the tautological gesture of the Master-Signifier', an empty performative which retroactively turns presuppositions into conclusions, is necessary, and also that tautology is the only way historical change can occur[64](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn64).  He even declares constitutive lack (in this case, termed the "death drive") to be a tautology[65](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn65). Lacanian references to "the Real" or "antagonism" as the cause of a contingent failure are reminiscent of Robert Teflon's definition of God: 'an explanation which means "I have no explanation"'[66](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn66).  An "ethics of the Real" is a minor ethical salvation which says very little in positive terms, but which can pose in macho terms as a "hard" acceptance of terrifying realities.  It authorizes truth-claims - in Laclau's language, a 'reality' which is 'before our eyes[67](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn67)', or in Newman's, a 'harsh reality' hidden beneath a protective veil[68](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn68) - without the attendant risks.  Some Lacanian theorists also show indications of a commitment based on the particular kind of "euphoric" enjoyment Barthes associates with myths.  Laclau in particular emphasizes his belief in the 'exhilarating' significance of the present[69](http://muse.jhu.edu.proxy-remote.galib.uga.edu/journals/theory_and_event/v008/8.1robinson.html#_edn69), hinting that he is committed to euphoric investments generated through the repetition of the same.

#### Seventh, citing Badiou’s “Event” as the alt makes resistance impossible

Hallward 3 (Peter, Lecturer in the French department at King's College, London, translator of Badiou's Ethics: An Essay on the Understanding of Evil, BADIOU: A SUBJECT TO TRUTH, p. 279)

Like his friend Syivain Lazarus, Badiou rejects the very category of "society," and with it every reference to a social "<totality,"world,> or'historical world.'"20 Why? Because the concept of society—in particular the variant known as "civil society"—articulates the subjective and the objective together, as components of a single dialectic Society implies some sort of interconnection of "politics and History” the subjective and the state." And "social analysis" is noth¬ing other than an attempt to relate the subjective and the objective through the mediation of something like class, disposition, behavior, consciousness, representation, or mentality.21 To dwell on the forms of such mediation is by Badiou's criteria simply to depoliticize the situation in advance. In his insistence upon an exclusively universal, exclusively subjective commitment, Badiou preserves the militant integrity of a vanguard interventionism in an age otherwise remarkable for its cynicism, defeatism, and managerial pessimism. He does so, however, by reinforcing a debatable line between "true" political action and the systematic or "administrative" engagement with irreducibly structural forms of injustice and exploitation, by which I mean precisely the sorts of issues generally grouped under the label of "social" work—poverty reduction and the provision of housing, welfare, education, public services, and so on. It is one thing to recognize that these two forms of engagement never amount to the same thing and cannot be analyzed in the same way; it is something else to insist upon the strict subtraction of the former from the latter. Progressive social institutions (schools, hospitals, trade unions, and so on) have a direct impact on the environment in which any political movement takes place and are themselves surely among the most valuable—and often most acutely contested—achievements of popular mobilization. In our contemporary situation, the very existence of public services has become an irreducibly political question. Deprived of any reference to social mediation, moreover, Badiou's emancipatory project simply confronts an inflated model of the state as its sole and exclusive adversary. Since there is nothing between subject and state, so on issues ranging from poverty and unemployment to chauvinist bigotry, "the state is responsible."22 End of discussion. Badiou lacks, in other words, a developed notion of hegemony, as proposed by Gramsci and as pursued, in different ways, by Raymond Williams and Ernesto Laclau. He also lacks, for the same reason, a nuanced appreciation of the technologies of power in Foucault's sense, understood as those productive, locally effective procedures (governing individuation, production, reproduction, punishment, educa¬tion, etc) that enable the consolidation of centralized power as their effect.

### 2ac – at: alt – black malpractice

#### Second, it fails, gets co-opted within the university – instrumental use of debate to experiment beyond the scope of university logics is better

Webb 18—Senior Lecturer in Education at the University of Sheffield (Darren, “Bolt-holes and breathing spaces in the system: On forms of academic resistance (or, can the university be a site of utopian possibility?),” Review of Education, Pedagogy, and Cultural Studies, 40:2, 96-118, dml)

It is easy to be seduced by the language of the undercommons. Embodying and enacting it, however, is difficult indeed. Being within and against the university, refusing the call to order through insolent obstructive unprofessionalism, is almost impossible to sustain. Halberstam (2009, 45) describes the undercommons as “a marooned community of outcast thinkers who refuse, resist, and renege on the demands of rigor, excellence, and productivity.” A romantic and appealing notion for sure but refusing and reneging on “the university of excellence” will cost you your job. When Moten describes subversion as a “series of immanent upheavals” expressed through “vast repertoires of high-frequency complaints, imperceptible frowns, withering turns, silent sidesteps, and ever-vigilant attempts not to see and hear” (2008, 1743), one is reminded instantly of Thomas Docherty, disciplined and suspended for his negative vibes.7

Being with and for the maroon community is difficult too. First of all, “Where and how can we find/see the Undercommons at work?” (Ĉiĉigoj, Apostolou-Hölscher, and Rusham 2015, 265). Where and how can one find those liminal spaces of sabotage and subversion, and how does one occupy them in a spirit of hapticality, study, and militant arrhythmia that brings the utopic underground to the surface of the fierce and urgent now? Beautiful language, but how does one live it? Networks do, of course, exist—the Undercommoning Collective, the Edu-Factory Collective, the International Network for Alternative Academia, to name but a few. These are promising spaces for bringing together and harboring the maroons and the fugitives. But networks are typically short-lived, and—as Harney and Moten warned—there is a danger of institutionalization, of taking institutional practices with you into alternative spaces “because we’ve been inside so much” (Harney and Moten 2013, 148). And so, predictably, meetings of the fugitives come with structure, order, an official agenda, and circulated minutes. The outcasts convene in conventional academic conferences, with parallel sessions, panels of papers, lunch breaks, wine and nibbles (e.g., Edu-Factory 2012). These spaces offer time out, welcome respite, a breathing space, a trip abroad, and then one returns to work.

If hapticality, the touch of the undercommons, is “a visceral register of experience … the feel that what is to come is here” (Bradley 2014, 129–130), then this seems elusive. It is hard to detect a sense of the utopic undercommons rising to the surface of the corporate-imperial university. Moten describes the call to disorder and to study as a way to “excavate new aesthetic, political, and economic dispositions” (Moten 2008, 1745). But this notion of excavating is highly problematic. It is common within the discourse of “everyday utopianism”—finding utopia in the everyday, recovering lost or repressed transcendence in “everydayness” (Gardiner 2006)—to describe the process of utopian recovery in terms of excavating: excavating repressed desires, submerged longings, suppressed histories, untapped possibilities. But the fundamental questions of where to dig and how to identify a utopian “find” are never adequately addressed (see Webb 2017). Gardiner defines utopia as “a series of forces, tendencies and possibilities that are immanent in the here and now, in the pragmatic activities of everyday life” (2006, 2). But how are these forces, tendencies and possibilities to be identified and recovered? For Harney and Moten, it is through study, hapticality and militant arrhythmia. These are slippy concepts, however, evading concrete material referents.

What is it to inhabit the undercommons? Those who have written of their experiences refer to “small acts of marronage” such as poaching resources and redeploying them in ways at odds with the university’s designs and demands (Reddy 2016, 7), or exploiting funding streams “to form cracks in the institution that enable the Others to invade the university” (Smith, Dyke, and Hermes 2013, 150). For Adusei-Poku (2015), the undercommons is a space of refuge which is all about survival (2015, 4–5). We who feel homeless in the university are forced into refuge. We gather together to survive. We may gain satisfaction from small acts of marronage, but this is less about bringing the utopic common underground to the surface as it is a form of “radical escapism” (Adusei-Poku 2015, 4). Benveniste (2015, v) tells us that: “The undercommons has no set location and no return address. There is no map for entering and no guide for staying. The only condition is a living appetite. Listen to its hunger for difference.” We need more than poetry, however. And we need more than a series of minor acts of resistance. As Srnicek and Williams rightly emphasize, resistance is a defensive, reactive gesture, resisting against. Resistance is not a utopian endeavour: “We do not resist a new world into being” (Srnicek and Williams 2016, 47). The undercommons, when one can find it, is a bolt hole, a place of refuge, a breathing space in the system. We need something more.

The occupation Can the occupied building operate as a site of utopian possibility within the corporate-imperial university? Reflections on, and theorizations of, two recent waves of occupation—“Occupied California” 2009–2010 and the UK Occupations 2010–2011—have answered this question affirmatively. The “occupation” should not be understood here as solely or necessarily “student occupation.” It goes without saying—though sadly so often does need saying —that “faculty also have a responsibility to fight with and for students” (Smeltzer and Hearn 2015, 356). Though led by a new historical subject, “the graduate without a future” (Schwarz-WeinStein 2015, 11), the importance of faculty support for the occupations was emphasized on both sides of the Atlantic (Research and Destroy 2010, 11; Dawson 2011, 112; Holmes and R&D and Dead Labour 2011, 14; Ismail 2011, 128; Newfield and EduFactory 2011, 26). Long before Occupy took shape in Zuccotti Park, “occupation” was being heralded as the harbinger of a new society and a new way of being. If we return to the notion of creating utopian spaces, the key aim for some of the occupiers was to create communes within the university walls—to communize space (Inoperative Committee 2011, 6).8 Communization here is understood as a form of insurrectionary anarchism that refuses to talk of a transition to communism, insisting instead upon the immediate formation of zones of activity removed from exchange, money, compulsory labor, and the impersonal domination of the commodity form (Anon 2010a, 5). As one pamphlet declared: We will take whatever measures are necessary both to destroy this world as quickly as possible and to create, here and now, the world we want: a world without wages, without bosses, without borders, without states. (Anon 2010d, 34) This is a revolutionary anarchism that takes the university campus as the site for a practice—communization—that not only prefigures but also realizes the vision of a free society. Heavily influenced by The Coming Insurrection (Invisible Committee 2009), but tapping into a long tradition of anarchist theory and practice from Hakim Bey’s Temporary Autonomous Zones (Bey 1985) to David Graeber’s Direct Action (Graeber 2009), occupation becomes “the creation of a momentary opening in capitalist time and space, a rearrangement that sketches the contours of a new society” (Research and Destroy 2010, 11). It is “an attempt to imagine a new kind of everyday life” (Hatherley 2011, 123). Firth (2012) refers to these momentary openings as critical, experimental utopias: Such utopias are … simultaneously immanent and prefigurative. They are immanent insofar as they allow space for the immediate expression of desires, satisfaction of needs and also the articulation of difference or dissent. They are prefigurative to the extent that they allow one to practice and exemplify what one would like to see at a more proliferative range in the future (26) The ultimate aim is for the practice to spread beyond the campus through a dual process of provocative rupture—the idea that insurrectionary moments can unleash the collective imagination and stimulate an outpouring of creativity that blows apart common sense and offers glimpses of a future world (Gibson-Graham 2006, 51; Shukaitis and Graeber 2007, 37)—and “contaminationism,” that is, spreading by means of example (Graeber 2009, 211). It may well have been the case that communism was realized on the campuses of Berkeley and UCL, that a momentary opening in capitalist space/time appeared through which another world could be glimpsed. The occupation, however—whether California, London, or anywhere else—is likely always to remain a localized temporary disruptive practice. A practice with utopian potency, for sure, in terms of suspending normalized forms of discipline and opening new egalitarian discursive spaces (Rheingans and Hollands 2013; Nişancioğlu and Pal 2016). In terms of wider systemic change, however, “small interventions consisting of relatively non-scalable actions are highly unlikely to ever be able to reorganise our socioeconomic system” (Srnicek and Williams 2016, 29). What “the occupation” demonstrates more than anything is the reality of the corporate-imperial university, as the institutional hierarchy, backed by the carceral power of the police and criminal justice system, inevitably disperses the occupiers—often using militarized force—and repossesses the occupied space in a strong assertion of its ownership rights not only to university buildings but also to what constitutes legitimate thought and behavior within them (on this see Docherty 2015, 90). The significance, and utopian potential, one attaches to campus occupations depends in part upon the significance one attaches to the university as a site of struggle. For the Edu-Factory Collective: As was the factory, so now is the university. Where once the factory was a paradigmatic site of struggle between workers and capitalists, so now the university is a key space of conflict, where the ownership of knowledge, the reproduction of the labour force, and the creation of social and cultural stratifications are all at stake. This is to say the university is not just another institution subject to sovereign and governmental controls, but a crucial site in which wider social struggles are won and lost. (Caffentzis and Federici 2011, 26) Clearly, if this is true, then the form the struggle takes, and the example it sets, is of immense significance. Srnicek and Williams describe as “wishful thinking” the idea that the occupation might spread beyond the campus by means of rupture or contamination (2016, 35). However, if the university really is a key site of class struggle (Seybold 2008, 120; Haiven and Khasnabish 2014, 38), a site through which wider struggles are refracted and won or lost, then the transformative potential of the occupation needs to be attended to seriously. The analysis of the university offered by the Edu-Factory Collective is, however, outdated. Sounding like Daniel Bell writing in 1973 about how universities had become the “axial structures” of post-industrial society (Bell 1973, 12), the analysis does not hold water today. Moten overdoes it when he tells us that “the university is a kind of corpse. It is dead. It’s a dead institutional body” (Moten 2015, 78). What is clear, however, is that “focusing on the university as a site of radical transformation is a mistake” (Holmes and R&D and Dead Labour 2011, 13). As has been widely noted, there is very little distinguishing universities from other for-profit corporations (Readings 1996; Lustig 2005; Washburn 2005; Shear 2008, Tuchman 2009). What does separate them is their inefficiency, due in large part to the fact that universities operate also as medieval guilds, with faculties “ruled by masters who lord over journeymen and apprentices in an artisanal system of production” (Jemielniak and Greenwood 2015, 77). If the university is a sinister hybrid monstrosity—part medieval guild, part criminal corporation—which has no role other than reproducing its own privilege, then no special status can be attributed to campus protests. In this case, “A free university in the midst of a capitalist society is like a reading room in a prison” (Research and Destroy 2010, 10). A reading room in a prison. Another apposite metaphor. The occupation is a safe space, offering temporary respite, a place to hide, a refuge, a bolt-hole, a breathing space. As with the utopian classroom and the undercommons, what the occupation suggests is that “defending small bunkers of autonomy against the onslaught of capitalism is the best that can be hoped for” (Srnicek and Williams 2016, 48). Conclusion Zaslove was right to characterize utopian pedagogy within the corporateimperial university as the search for bolt-holes and breathing spaces in the system. He himself suggests that, “All university classes should become dialogic-experiential models that educate by expanding the zones of contact with wider communities” (2007, 102). Like so many others, Zaslove sees dialogic-experiential models of education beginning in the classroom then expanding outward. The literature is full of references to “exceeding the limits of the university classroom” (Coté, Day, and de Peuter 2007a, 325), “extend [ing] beyond the boundaries of the campus” (Ruben 2000, 211), and “breeching the walls of the university compounds and spilling into the streets” (Research and Destroy 2010, 10). This all brings to mind Giroux’s notion of academics as border crossers (Giroux 1992), but it also paints a picture of academics taking as their starting point the university and from there crossing the border into the community and the street.

The University can be the site for fleeting, transitory, small-scale experiences of utopian possibility—in the classroom, the undercommons, the occupation. It cannot be the site for transformative utopian politics. It cannot even be the starting point for this. Given the corporatization and militarization of the university, academics are increasingly becoming “functionaries of elite interests” inhabiting a culture which serves to reproduce these interests (Shear 2008, 56). Within the university, “radical” initiatives or movements will soon be co-opted, recuperated, commodified, and neutralized (Gibson-Graham 2006, xxvi; Seybold 2008, 123; Neary 2012b, 249; Rolfe 2013, 21). Institutional habitus weights so heavily that projects born in the university will be scarred from the outset by a certain colonizing “imaginary of education” (Burdick and Sandlin 2010, 117). And we have long known that the university is but one space of learning, and perhaps not a very important one at that. Identifying the academy as the starting point for a utopian pedagogy privileges this arcane space over sites of public pedagogy such as film, television, literature, sport, advertising, architecture, media in its various forms, political organizations, religious institutions, and the workplace (Todd 1997).

Perhaps the emphasis on creating radical experimental spaces within the academy needs to shift toward operating in existing spaces of resistance outside it. Haiven and Khasnabish argue that many social movements function already as “social laboratories for the generation of alternative relationships, subjectivities, institutions and practices” (2014, 62), providing “a space for experiments in knowledge production, radical imagination, subjectification, and concrete alternative-building” (Khasnabish 2012, 237). Why locate utopian pedagogy in the university when “critical utopian politics” can take place in “infrastructures of resistance” such as intentional communities, housing collectives, squats, art centers, community theatres, bars, book shops, health collectives, social centers, independent media and, increasingly of course, the digital sphere (Firth 2012; Shantz 2012; Amsler 2015; Dallyn, Marinetto, and Cederstrom 2015)? Moving beyond short-term, localized, temporary modes of resistance, utopian pedagogy would work across these sites to develop a long-term strategy and vision.

There is a role for the academic in utopian politics, but not in the university-as-such. The utopian pedagogue has a responsibility to exploit their own privilege and to work with students, communities and movements outside and divorced from the university. As Shear rightly notes, academics (and especially those working in the humanities and social sciences) “inhabit a privileged space in which critical inquiry concerning social hegemony and political-economic domination” is possible (Shear 2008, 56). Within the university, however, spaces for embodying and enacting this kind of inquiry have become constrained, compromised, monitored, surveilled, co-opted, and recuperated. As I have argued throughout this article, utopian pedagogy has become a search for bolt-holes and breathing spaces in the system. Beyond the academy, however, there is a role to play. As Chomsky (2010) tells us, with privilege comes responsibility. And as Giroux frames it, this is an ethical and political responsibility to provide “theoretical resources and modes of analysis” to help forge “a utopian imaginary” (Giroux 2014a; 153; 2014b, 200). This means putting one’s knowledge and resources to use in the service of a collaborative process of memory- and story-making, pulling together disparate inchoate dreams and yearnings in order to generate a utopian vision that can help inform, guide, and mobilize long-term collective action for systemic change.

### 2ac – at: end licensing alt

#### Licensing is critical to worker wellbeing – the alt wrecks nurse practitioners

Robinson 18 (Nick, Affiliated Fellow, Center on the Legal Profession, Harvard Law School, “The Multiple Justifications for Occupational Licensing,” Washington Law Review, vol. 93, no. 4, December 2018, p. 1903-1960. HeinOnline, <https://heinonline.org/HOL/P?h=hein.journals/washlr93&i=1937)//NRG>

D. Buffering Producers from the Market

By limiting entry into an occupation and prescribing standards of practice, occupational licensing protects practitioners from at least some of the competitive forces of the larger market. Because of this effect, economists and others have often criticized licensing for being anticompetitive.131 This anticompetitive effect may be justified because a licensing requirement protects consumers from harm or has some other social benefit, like fostering communities of knowledge or promoting social trusteeship.

Yet, this anticompetitive effect may itself serve the public interest in some contexts. For example, occupational licensing may protect producers from market instability in a market that the public relies on for needed goods or services. In Nebbia v. New York,232 the U.S. Supreme Court rejected a Fourteenth Amendment challenge to a law that fixed the price of milk because it "prevent[ed] ruthless competition from destroying the wholesale price structure on which the farmer depends for his livelihood, and the community for an assured supply of milk." '33 A similar argument can be made for using occupational licensing to protect certain occupations from price wars that may otherwise repel talented practitioners from the labor market or stop capable students from entering the occupation.

Such anticompetitive protectionism may also be used to explicitly stabilize the labor market for the benefit not of consumers, but of labor. Karl Polyani famously maintained that a key role of the state should be to slow the chum of modem capitalism and its dislocating effects on members of society.23 4 Occupational licensing can be seen as one way of achieving this end. Although occupational licensing may increase the price of some services for the poor and middle class, it also provides those in an occupation that requires a license (a significant portion of the workforce) with a higher income and other benefits, like less chance of being unemployed and a greater probability of receiving a pension plan. 35 Many in the poor and middle class aspire to be in an occupation that requires a license, as they once aspired to be in a union job, in the hopes of building their lives around the relative stability, prestige, and security licensing can bring.236 Like union jobs, these better-paid, more secure positions may provide broader positive externalities to society, such as creating a stable environment for families to prosper.

In this way, occupational licensing may be viewed as an imperfect check against some of the harshness of the modem economy, whether this is volatile labor markets, wage stagnation or decline, or reduction in worker autonomy.23 Unlike alternative strategies to deal with economic volatility, such as resource transfers from winners to losers, licensing provides a buffer that can allow those in these occupations to continue to build skills and work with dignity.

#### Ending licensing causes corporatized nursing which is way worse

Robinson 18 (Nick, Affiliated Fellow, Center on the Legal Profession, Harvard Law School, “The Multiple Justifications for Occupational Licensing,” Washington Law Review, vol. 93, no. 4, December 2018, p. 1903-1960. HeinOnline, <https://heinonline.org/HOL/P?h=hein.journals/washlr93&i=1937)//NRG>

C. Relationships of Trust

Eliot Freidson famously described professional self-regulation as the "third logic." 212 He claimed that professions were traditionally guided by neither the consumerist logic of the market nor the management driven logic of bureaucracy, but instead expertise coupled with an internal code of ethics.213 This understanding that practitioners aspire towards a higher occupational mission can encourage trust between practitioners and consumers, the public, government, and other professional colleagues. For example, the public has historically trusted doctors to give advice in a patient's best interest, not the doctor's financial interest (even if this trust has declined in the United States in recent decades). 214 Lawyers rely on other lawyers not to lie to them during discovery.2 " 5 And the government relies on architects to help enforce building codes216 or doctors to help decide who qualifies for government programs like social security disability." 7 Importantly, professional communities frequently work to pass on this sense of social trusteeship to new practitioners as they meet their educational licensing requirements, and later, if this trust is seriously betrayed, these practitioners may have their occupational license revoked.2

Since licensing provides a monopoly to practitioners to engage in an occupational activity, licensing can limit the ability of large corporations and other employers from exercising disproportionate control over either practitioners or their occupation. Michael Sandel has claimed that to further the ideals of republican self-governance, workers need to be empowered to have greater economic autonomy-freed from brute market forces that can distract citizens from their democratic duties and the concentration of power in large corporations that can undermine the public square.2 " 9 While Sandel does not invoke professions specifically in his argument, occupational licensing, and the professions' self-regulation, provides one avenue for producers to exercise power over their work and employment market.

Indeed, professional self-regulation, in particular, can reduce the potential for capture of regulation by large corporations. For example, in the United Kingdom, the Legal Services Board regulates the legal profession and is controlled by non-lawyers.21 Commentators have raised concerns that these public regulators may be unduly influenced not by the bar, but instead by corporate interests that desire to liberalize the legal market to allow corporations to directly profit from providing legal services.2

### 2ac – antitrust link

#### Antirust K all wrong. Reductionist *and* rejects tools that curtail violence.

* … post-dating oddly matters bc past examples don’t assume how the Aff/Khan might deploy anti-trust.
* … more than link D – Alt forgoes workable option to re-shape the very power they criticize.
* Author = uber-qual’d… peer-reviewed cultural theory journal recent lit..

Paul 22 Sanjukta Paul - Assistant Professor of Law, Romano Stancroff Research Scholar, Wayne State University - J.D., Yale Law School - From the article: “A Democratic Vision for Antitrust” - From the Journal – Dissent - Published by University of Pennsylvania Press - Volume 69, Number 1, Winter 2022, pp. 56-62 (Article) – modified for language that may offend - available via Project Muse

Last spring, prominent Big Tech critic Lina Khan became the new chair of the Federal Trade Commission (FTC)—an appointment widely ~~seen as~~ (considered) a coup for progressive reform. In her confirmation hearing, she characterized the agency’s overarching goal in terms of “fair competition.” This choice of emphasis is significant for understanding the antitrust reform project of which Khan is a leader. At its core, the project is a policy paradigm aimed at creating fair markets—markets characterized by socially beneficial competition, fair prices, and decent wages.

While both proponents and detractors of this reform project sometimes conflate competition policy with the goal of maximizing economic competition for its own sake, in reality, competition law has always assessed economic rivalry and coordination in relation to broader social ends. For a long time, that assessment has been obscured—not to mention insufficiently tethered to the original goals of federal antitrust law. The reform project aims to reorient the use of antitrust in expressly egalitarian and democratic directions.

For decades, competition law and policy have been dominated by the neoclassical law and economics paradigm, which claims that visible market design and coordination interfere with competitive dynamics that would otherwise lead to an efficient allocation of social resources, and thus to the maximization of social welfare. While recent shifts in mainstream economic thinking have led to more discussion of imperfect competition, particularly in labor markets, the “market failures” and power imbalances that justify interventions are on this view still essentially special cases. Moreover, this idealized picture of markets still obscures certain forms of background coordination—especially the often hierarchical and extractive coordination that happens within business firms—while treating other coordination mechanisms as exceptional, with the potential to distort ideal market outcomes.

Conventionally organized business firms are just one of the many means we have to coordinate economic activity; others include labor unions, producers’ cooperatives, and public price boards, to take just a few examples. Because competition law makes ground-up decisions about many forms of economic coordination, and influences the regulatory stance toward others, antitrust reforms hold the potential to affect a broad set of economic policies.

We should not act as if putatively neutral, technocratic appeals to idealized competition can replace moral and political choices about economic life. Nor, however, should we treat actual competition as inherently tainted by its association with neoclassical theory. Channeled appropriately, competition is healthy rivalry: it encourages technological and operational innovations that can have broad social benefits, and it represents an important check on arbitrary bureaucratic power by preserving outside options for workers, consumers, and businesses. Channeled inappropriately, competition can lead to the destructive undermining of rivals (in contrast to constructive outperformance), overwhelm socially valuable independent enterprises, and destroy existing market settlements characterized by fair prices and decent wages. There is no universal logic of competition for policymakers to apply, either dark or redemptive: it is legal, social, and political choices (almost) all the way down.

To move from principles to some specifics, we can ~~look at~~ (consider) the approach the reform project might take in three policy areas: policing corporate mergers and acquisitions, accommodating horizontal and bottom-up economic coordination, and re-regulating the law of vertical restraints. *These* reforms, which are mutually reinforcing, all have the power to help build a more equal and democratic legal organization of the economy.