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### Advantage One

#### Advantage One is Federalism

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

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

The FTC’s State Action Report

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

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

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

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

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

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

III. DOCTRINAL CRITICISM

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

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

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

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

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

IV. PROPOSED SOLUTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

McGinnis 11

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

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

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

Wilson ‘13

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

#### Our arg is goldilocks – it’s not that SynBio is good or bad. It’s that regs needs to be well-crafted.

Miller ‘12

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

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

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

Specter ‘12

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

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

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

Philp ‘14

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

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

#### Only SynBio itself can counter accidental releases

Philp ‘14

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

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

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

#### Independently, the aff is an anti-racist approach to antitrust – Parker immunity blocks enforcement of anticompetitive practices sanctioned by state licensing boards. These boards entrench incumbent interests and exclude communities that lack socio-economic privilege

Weissmann ‘21

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

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

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

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

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

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

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

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

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

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

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

### Plan

#### Plan: The United States Federal Government should limit the state action immunity doctrine.

### Advantage Two

#### Adv Two is Practitioner Shortages:

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

McMichael ‘20

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

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

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

INTRODUCTION

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

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

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

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

States often justify SOP laws as necessary to ensure patient safety by preventing unqualified individuals from providing care. 11 Though these laws can further this goal, excessively restrictive SOP laws undermine the ability of NPs to care for patients. Prior work has shown that eliminating restrictive SOP laws and allowing NPs to practice 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

#### Scope of Practice (SOP) restrictions *block access* and *hamper options for patient health*.

LDI ‘20

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

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

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

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

#### Solvency is *empirical* and the *impact is significant*. Studies and empirics confirm this has saved many lives *per day* *per State*.

Chung ‘20

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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.

#### Only pairing the ACA with nurse practitioners tempers ongoing provider crunches

Auerbach ‘13

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

Numerous forecasts have predicted shortages of physicians in the United States, particularly in light of the expected increase in demand from the Affordable Care Act (ACA). Such predictions, however, might be far from the mark. Several recent innovations are attempting to change the way primary care is delivered — by expanding who provides care (e.g., physicians, nurse practitioners, physician assistants) and how care is coordinated (e.g., through teams).

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

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

Estimating the Supply and Demand for Primary Care Providers

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

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

The Effect of New Care Models on Provider Shortages

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

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

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

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

Schotten ’15

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

III. Moralism and Totalitarianism

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Gee ‘20

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

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

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

The consequences of ACA repeal would be dire:

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

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

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

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

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

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

1. 20 million fewer Americans are uninsured

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

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

2. The ACA protects people with preexisting conditions from discrimination

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

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

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

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

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

Medicaid expansion has led to better access to care and health outcomes for low-income individuals and their families across the country. A large body of 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.

#### We do not defend the law in all instances – but in the contingent realm of health provision, government policy is much better than the de facto Alt of an untouched market.

Parento ‘12

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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 individuals *truly* 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 dispariti*es 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.

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

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

Hudson ‘15

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

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

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

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

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

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

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

The Patient Role

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

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

Gaffney ‘16

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

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

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

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

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

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

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

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

2. Black doctors: Discrimination within the profession

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

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

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

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

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

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

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

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

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

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

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

3. Jim Crow medicine: Past and present

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

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

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

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

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

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

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

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

4. Health equity and health system universalism

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

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

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

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

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

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

#### Restrictive scope of practice laws restrict NPs working to address health disparities in underserved populations – holistic approach and trust make NPs uniquely situated

Heath 20 [Sara Heath, health care journalist for 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. Nurse practitioners 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, nurse practitioners 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.

# 2AC

## K

### Agency disad – 2AC

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

Hudson ‘15

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

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

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

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

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

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

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

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

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

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

Hudson ‘15

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

Conclusion

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

#### OR texas’s cross-x ramble proves no link and perm solvency

### Healthcare links

#### 1AC McMichael proves local elites and the AMA steer towards “physician-only” models. NPs can augment conventional medical models with greater nuance and cultural appreciation.

Heath 20 [Sara Heath, health care journalist for 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. Nurse practitioners 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, nurse practitioners 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.

#### Best studies are aff

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

Perhaps the most contentious point in the debate over NP SOP laws concerns the ability of NPs to deliver high-quality care without physician oversight. Opponents of NP independence generally argue that, without physician supervision, NPs cannot safely care for patients. For example, the California Medical Association has stated that it "opposes any attempts to remove physician oversight over [NPs] and believes that doing so would put the health and safety of patients at risk." 54 Some groups frame their arguments about quality of care in [\*900] terms of the different levels of education completed by NPs and physicians. 55 These arguments require the additional inferential step that more education is required to provide the type of care delivered by NPs, but they are effectively equivalent to statements that unsupervised NPs cannot safely care for patients. 56

Advocates of greater NP autonomy respond to these arguments by pointing to the available evidence that demonstrates NPs generally deliver care of comparable quality to that delivered by physicians. 57 Multiple studies have investigated the ability of NPs to deliver high-quality care, often comparing NP-supplied care to physician-supplied care. 58 A recent comprehensive analysis compared the quality of care delivered to Medicare beneficiaries by NPs and physicians and found that physicians perform better on certain quality measures and NPs perform better on other measures. 59 Related work has found no meaningful differences between NPs and physicians in caring for HIV [\*901] patients, 60 managing diabetes, 61 providing primary care, 62 prescribing medications, 63 or providing critical care. 64 Reviewing the evidence, the National Academy of Medicine concluded "that access to quality care can be greatly expanded by increasing the use of ... [NPs] in primary, chronic, and transitional care." 65

Opponents of broader NP SOP laws have criticized this evidence as irrelevant because these studies are often "performed in a setting of physician oversight and collaboration." 66 They argue that "using data from studies of nurse practitioners working under physician supervision to demand independent practice is a flawed practice, as there is no proof that nurse practitioner care without physician oversight is either safe or effective." 67 However, studies that have explicitly examined the role of relaxing NP SOP laws - as opposed to the role of NPs generally - in promoting the delivery of high-quality care have concluded that NP independence either improves or has little effect on the quality of care delivered.

A 2017 study found that NP "independence had no statistically significant effect on any of the three [clinically verified indicators of [\*902] healthcare quality] studied." 68 In contrast to claims that NP SOP laws are necessary for the protection of patients, 69 this study "did not substantiate the use of [SOP] restrictions for the sole purpose of consumer protection." 70 A separate study "cast[] further doubt on the theory that state regulations limiting NPs practice are associated with quality of care." 71 Examining patient-reported quality across many years of a nationally representative dataset, a recent study found that NP independence increases the probability that patients report being in excellent health. 72 Another study found that NP independence had no effect on infant mortality rates, an important indicator of healthcare quality. 73

Overall, existing evidence does not support the contention that unsupervised NPs provide unsafe or low-quality care. To be sure, physician groups are correct in their assertion that NPs are not trained to provide the same range of services as physicians - NPs do not perform surgery, for example. Within the scope of their training, however, the evidence demonstrates that NPs perform similarly to physicians.

#### Patient agency *succeeds* and *does* improve health outcome.

**Hudson ‘15**

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These findings, when viewed comprehensively, provide a more fully fleshed understanding of the ways in which marginalized patients participate during the clinical interaction. The culture centered approach provides the ideal framework for interpreting the study results. Study participants were often mired in structural issues such as joblessness, underinsured status and mental health challenges. These challenges subsequently compelled patients to enact their agency strategically during the clinical interaction. Displays of patient agency and patient resistance **often functioned to optimize clinical outcomes**, especially in light of structural constraints such as less qualified physicians. Within this framework, marginalized patients' participation in clinical interactions can be understood as the product of inextricably intertwined factors.

#### Patients will activate their agency.

**Hudson ‘15**

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In addition, the patients in this study demonstrated patient **agency** **and** patient **resistance** without the aid or prompting of a question prompt list. **Contrary to** Epstein's (2006) **assertion that marginalized individuals "might not like to be activated,"**patients in this study demonstrated agentive behavior. In fact, these demonstrations represented patients' **attempts to obtain the best possible care amidst substandard health care *resources***. Clearly, **there is a lack of understanding concerning marginalized patient's** motivations and the strategic nature of their enacted **agency**and resistance. Participants in this study demonstrated - unprompted- the three behaviors that form **the cornerstone of patient activation**: asking questions, expressing concerns and assertively stating their needs. These displays of "activated" behavior occurred consistently among participants. In some cases, patients moved behind "activated" and agentive behaviors and challenged the physician.

### Calculation

#### No link and turn – even if they win that calculation is bad in the abstract, its good in the context of the aff – healthcare is massively complex its not as simple as making sure everyone feels okay, wading through hospital policy, nurse practitioner regs, etc. is all necessary calculations and same with adv 1 – synthetic diseases already exist which makes the calculations link nonunique and justifies our aff

#### Calculation K’s justify the worst violence. We can jettison the worst calcualtions without throwing all of them away.

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 [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 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).

#### Deeming Calculative thought as equivalent to domination ensures violent inaction.

Bronner ‘4

Stephen Eric Bronner, Professor of Political Science at Rutgers University, 2004, Reclaiming the Enlightenment: Toward a Politics of Radical Engagement, p. 3-5

“Instrumental reason” was seen as merging with what Marx termed the “commodity form” underpinning capitalist social relations. Everything thereby became subject to the calculation of costs and benefits. Even art and aesthetic tastes would become defined by a “culture industry”—intent only upon maximizing profits by seeking the lowest common denominator for its products. Instrumental rationality was thus seen as stripping the supposed­ly “autonomous” individual, envisioned by the philosophes, of both the means and the will to resist manipulation by totalitarian movements. En­lightenment now received two connotations: its historical epoch was grounded in an anthropological understanding of civilization that, from the first, projected the opposite of progress. This gave the book its power: Horkheimer and Adorno offered not simply the critique of some prior his­torical moment in time, but of all human development. This made it possi­ble to identify enlightenment not with progress, as the philistine bourgeois might like to believe, but rather—unwittingly—with barbarism, Auschwitz, and what is still often called “the totally administered society.” Such is the picture painted by Dialectic of Enlightenment.. But it should not be forgotten that its authors were concerned with criticizing enlightenment generally, and the historical epoch known as the Enlightenment in particular, from the standpoint of enlightenment itself: thus the title of the work. Their masterpiece was actually “intended to prepare the way for a positive notion of enlightenment, which will release it from entanglement in blind domina­tion.”4 Later, in fact, Horkheimer and Adorno even talked about writing a se­quel that would have carried a title like “Rescuing the Enlightenment” (Ret­tung der Aufklarung).5 This reclamation project was never completed, and much time has been spent speculating about why it wasn’t. The reason, I be­lieve, is that the logic of their argument ultimately left them with little positive to say. Viewing instrumental rationality as equivalent with the rationality of domination, and this rationality with an increasingly seamless bureaucratic order, no room existed any longer for a concrete or effective political form of opposition: Horkheimer would thus ultimately embrace a quasi-religious “yearning for the totally other” while Adorno became interested in a form of aesthetic resistance grounded in “negative dialectics.” Their great work initiated a radical change in critical theory, but its metaphysical subjectivism sur­rendered any systematic concern with social movements and political insti­tutions. Neither of them ever genuinely appreciated the democratic inheritance of the Enlightenment and thus, not only did they render critique independent of its philosophical foundations,6 but also of any practical inter­est it might serve. Horkheimer and Adorno never really grasped that, in contrast to the sys­tem builder, the blinkered empiricist, or the fanatic, the philosophe always evidenced a “greater interest in the things of this world, a greater confidence in man and his works and his reason, the growing appetite of curiosity and the growing restlessness of the unsatisfied mind—all these things form less a doctrine than a spirit.”7 Just as Montesquieu believed it was the spirit of the laws, rather than any system of laws, that manifested the commitment to jus­tice, the spirit of Enlightenment projected the radical quality of that commit­ment and a critique of the historical limitations with which even its best thinkers are always tainted. Empiricists may deny the existence of a “spirit of the times.” Nevertheless, historical epochs can generate an ethos, an existen­tial stance toward reality, or what might even be termed a “project” uniting the diverse participants in a broader intellectual trend or movement. The Enlightenment evidenced such an ethos and a peculiar stance toward reality with respect toward its transformation. Making sense of this, howev­er, is impossible without recognizing what became a general stylistic com­mitment to clarity, communicability, and what rhetoricians term “plain speech.” For their parts, however, Horkheimer and Adorno believed that re­sistance against the incursions of the culture industry justified the extreme­ly difficult, if not often opaque, writing style for which they would become famous—or, better, infamous. Their esoteric and academic style is a far cry from that of Enlightenment intellectuals who debated first principles in pub­lic, who introduced freelance writing, who employed satire and wit to demol­ish puffery and dogma, and who were preoccupied with reaching a general audience of educated readers: Lessing put the matter in the most radical form in what became a popular saying—”Write just as you speak and it will be beautiful”—while, in a letter written to D’Alembert in April of 1766, Voltaire noted that “Twenty folio volumes will never make a revolution: it’s the small, portable books at thirty sous that are dangerous. If the Gospel had cost 1,200 sesterces, the Christian religion would never have been established.”9 Appropriating the Enlightenment for modernity calls for reconnecting with the vernacular. This does not imply some endorsement of anti-intellectualism. Debates in highly specialized fields, especially those of the natural sciences, obviously demand expertise and insisting that intellectuals must “reach the masses” has always been a questionable strategy. The sub­ject under discussion should define the language in which it is discussed and the terms employed are valid insofar as they illuminate what cannot be said in a simpler way. Horkheimer and Adorno, however, saw the matter differ­ently. They feared being integrated by the culture industry, avoided political engagement, and turned freedom into the metaphysical-aesthetic preserve of the connoisseur. They became increasingly incapable of appreciating the egalitarian impulses generated by the Enlightenment and the ability of its advocates—Ben Franklin, Thomas Jefferson, James Madison, Thomas Paine, and Rousseau—to argue clearly and with a political purpose.1’ Thus, whether or not their “critical” enterprise was “dialectically” in keeping with the impulses of the past, its assumptions prevented them from articulating anything positive for the present or the future.

#### Rejecting calculative thought reproduces it

Buckley 2 (R. Philip, Professor of Philosophy – University of McGill, [Phenomenological Approaches to Moral Philosophy: A Handbook](http://www.google.com/url?sa=t&ct=res&cd=1&url=http%3A%2F%2Fbooks.google.com%2Fbooks%3Fid%3DQpxYqdhvIdIC%26pg%3DPA221%26lpg%3DPA221%26dq%3D%2522contemplative%2Bthought%2Bis%2Bextremely%2Bdifficult%2522%26source%3Dweb%26ots%3DFnTvlJGT28%26sig%3DPPuCoTVH8vJ6e87WEY3D2Qo4Rl8%26hl%3Den&ei=MUkJSLvAHZzSggSnuK2sAQ&usg=AFQjCNGKWhPcZZW1R3qqyD_QfsVkp9djUw&sig2=NN6Yn1vdnX7ovCDabTdK3A), p. 220-221)

To what does this “opposition” between calculative and contemplative thinking amount to? First, it is crucial to note that the thinking which Heidegger describes as taking place in science is not a “lesser” form that could be “upgraded” to a contemplative form of thought. The calculative thought of science is constitutionally incapable of being contemplative thought, and hence Heidegger’s oft-quoted assentation that “science does not think.”34 Certainly scientists can reflect on their own field, on its methods, procedures and so forth. But this sort of self-interrogation aimed at improvement is *part* of calculative thinking in the first place. Calculative thought turn in on itself remains calculative thought. This implies a “distance” between the calculative and contemplative forms of thought, or an unbridgeable “gap” (Klugt) (WHD, 4—5; WCT, 8). The difference between these two types of thinking is one of kind and not degree. This “gap” does not mean that calculative thought is somehow “bad,” or that contemplative thinking is “better.” To judge contemplative thought as superior to calculative thought is to think calculatively, and hence cannot be the task of authentic philosophy. Neither is Heidegger claiming that the nature of modern science as calculative is to be viewed as negative. It is the good “fortune” of science that it cannot “think” in the contemplative, deliberative, or recollective sense.7 The problem, it seems, occurs when calculative thought pushes aside other forms of thinking. Heidegger wants to undermine the exclusivity of calculative thinking without denigrating it. He desires to open a space for other forms of thinking. A first step away from the domination of calculative thinking consists in uncovering the presuppositions which underlie it, in seeing that calculation is not the only possibility of human “thought.” It may well be that the realm of contemplative thought can only be approached by means of this method which ultimately might be characterized as *avia negative*. Nonetheless, the description of calculative thought and its representational character does tell us something about the nature of contemplative thought. Contemplative thought is extremely difficult to attain because, by its very nature, it cannot be “attained.” To want to have a contemplative style of thought is to remain in the clutch of the basically possessive calculative style of thinking. 35 Contemplative thought is hence marked by a fundamental “passivity,” 36 it consists of a certain “letting-go” of all “attitudes,” of any “picturing” of the world. Put in terms which are even more expressive of passivity, contemplative thought is a “releasement” from the dominating style of calculative thought. Both “letting-go” and “releasement” are plausible translations of Heidegger’s basic characterization of thought as *Gelassenheit*.

### Alt

#### Perm: do the plan and all non-mutually exclusive parts of the alt

#### Bataille agrees transgression is paradoxical and theoretical at best—its political actualization shouldn’t extend to embracing extinction

Roberts-Hughes, 17—PhD in English Literature and Cultural Theory at King’s College London (Rebecca, “Transgression and conservation: rereading Georges Bataille,” Journal for Cultural Research Volume 21, 2017 - Issue 2, dml)

When I say that there is a conservativism in Bataille’s human subject, I distinguish this entirely from any political impulse in his writing or thinking. The ethical potential of transgression appears paradoxically in Bataille’s texts. He is clear that transgression is always radically other to any human system of ethics, yet sometimes – such as in The Accursed Share (1949) – he will discuss some types of transgression, like war, as more damaging to human civilisation than others (Bataille, 1949, pp. 31, 40). Perhaps the ethical dimension of Bataille’s argument in The Accursed Share is due to the political nature of his argument in this work and other events in his life at this time. Michel Surya argues that Bataille was involved in politics during the end of Second World War and the start of the cold war until 1953, just shortly after The Accursed Share was published (Surya, 2002, p. 363). Bataille was not a political conservative, but it is possible that the impact of the Second World War led him to think ethically about the importance of supporting, and conserving, life. The crucial point is that Bataille did not advocate conservativism, but then neither did he advocate transgression, even though he is seen to stand for it. Rather, he presented the two as facts of human existence.

The conservation I find in Bataille’s human, then, is about the endurance of its very humanity. When faced with the terror of the sublime, Immanuel Kant’s human is human by his ability to call upon the faculty of reason to reassert himself and overcome that terror (Kant, 1790, p. 119). Peter Sloterdijk uses the theory of immune systems to describe how modern humanity ensures its survival, describing its ‘attempts to balance out its shellessness in space, following the shattering of celestial domes, through an artificial civilizatory world’ (Sloterdijk, 1998, p. 24). Like other philosophers before and since him, Bataille describes a human being that forms, or defends, or conserves itself through its very modes of being human.

#### ALT’s framing of poetics and study as “malpractice” and a rupture in order is an unnecessary and counter-productive spectacularization of the everyday practices of people choosing whether and how they want to engage health care that the plan facilitates

Paul Mann, 1999, “The Exquisite Corpse of Georges Bataille,” *Masocriticism*, p.67-9

I would like at one and the same time to affirm this model and to dismiss it as the most desperate alibi of all. For “sacrificial consumption” can never become an explicit critical motive.13 At the moment it presents itself as a proper element of some critical method, it degenerates into another useful trope, another bit of intellectual currency, another paper-thin abyss, another proxy transgression; and the force of transgression moves elsewhere, beneath a blinder spot in the critical eye.14 Questions of motive or understanding, the fact that one might be self-critical or at least aware of recuperation, are immaterial: what is at stake here is not self-consciousness but economics, material relations of appropriation and exclusion, assimilation and positive loss. Whatever transgression occurs in writing on Bataille does so only through the stupid recuperation and hence evacuation of the whole rhetoric and dream of transgression, only insofar as the false profundity of philosophy or theory evacuates the false profundities it apes. To justify this as the sublime loss of loss is merely to indulge a paradoxical figure. Excess is not a project but a by-product of any discourse; the interest of Bataillean discourse lies chiefly in the compulsive and symptomatic way it plays with its feces. The spectacle of critics making fools of themselves does not reveal the sovereign truth of death: it is only masocritical humiliation, a pathological attempt to disavow the specter of death. As for the present essay, it makes no claims to any redeeming sacrifice. Far from presenting you with a truer Bataille, far from speaking in his voice more clearly than his other readers, this essay pleads guilty to the indictment against every appropriation. Until philosophy and theory squeal like a pig before Bataille’s work, as he claims to have done before Dali’s canvases, there will be no knowledge of Bataille. In the end, one might have to take and even stricter view: there is no discourse of transgression, either on or by Bataille. None at all. It would be necessary to write a “Postscript to Transgression” were it not for the fact that Foucault already wrote it in his “Preface,” were it not for the fact that Bataille himself wrote it the moment before he first picked up his pen. It makes no difference whether one betrays Bataille, because one lip syncs Bataille’s rhetoric or drones on in the most tedious exposition. All of these satellite texts are not heliotropic in relation to the solar anus of Bataille’s writing, of the executioners he hoped (really?) would meet him in the Bois de Boulogne, or depensives in spite of themselves. It would be sentimental to assign them such privileges. They merely fail to fail. They are symptoms of a discourse in which everyone is happily transgressing everyone else and nothing ever happens, traces of a certain narcissistic pathos that never achieves the magnificent loss Bataille’s text conveniently claims to desire, and under whose cover it can continue to account for itself, hoarding its precious debits in a masocriticism that is anything but sovereign and gloriously indifferent. What is given to us, what is ruinously and profitably exchanged, is a lie. Heterology gives the lie to meaning and discourse gives the lie to transgression, in a potlatch that reveals both in their most essential and constitutive relation. Nothing is gained by this communication except profit-taking from lies. We must indict Bataille as the alibi that allows all of this writing to go on and on, pretending it is nothing it is not, and then turn away from Bataille as from a sun long since gone nova, in order to witness the slow freezing to death of every satellite text. The sacrificial consumption of Bataille has played itself out; the rotten carcass has been consumed: no more alibis. What is at stake is no longer ecstatic sexuality or violent upheavals or bloody sacrifices under the unblinking eye of the sun; nor was it ever, from the very beginning of Bataille’s career. These are merely figures in the melodramatic theater of what is after all a “soft expenditure” (Hollier 1989, xv), a much more modest death, a death much closer to home. It has never been more than a question of the death of the theory and of theory itself as death. Of theory-death. A double fatality.

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#### **Turn - Reaction to crises is more consumption**

Bradshaw et al 21 (Corey J. A. Bradshaw, Global Ecology, College of Science and Engineering, Flinders University, Australia, Australian Research Council Centre of Excellence for Australian Biodiversity and Heritage; Paul R. Ehrlich, Department of Biology, Stanford University; Andrew Beattie, Department of Biological Sciences, Macquarie University, Australia; Gerardo Ceballos, Instituto de Ecología, Universidad Nacional Autónoma de México; Eileen Crist, Department of Science, Technology, and Society, Virginia Tech; Joan Diamond, Millennium Alliance for Humanity and the Biosphere, Department of Biology, Stanford University; Rodolfo Dirzo, Department of Biology, Stanford University; Anne H. Ehrlich, Department of Biology, Stanford University; John Harte, Energy and Resources Group, University of California, Berkeley, The Rocky Mountain Biological Laboratory; Mary Ellen Harte, The Rocky Mountain Biological Laboratory; Graham Pyke, Department of Biological Sciences, Macquarie University, Australia; Peter H. Raven, Missouri Botanical Garden; William J. Ripple, Department of Forest Ecosystems and Society, Oregon State University; Frédérik Saltré, Global Ecology, College of Science and Engineering, Flinders University, Australia, Australian Research Council Centre of Excellence for Australian Biodiversity and Heritage; Christine Turnbull, Department of Biological Sciences, Macquarie University, Australia; Mathis Wackernagel, Global Footprint Network; and Daniel T. Blumstein, La Kretz Hall, Institute of the Environment and Sustainability, and Department of Ecology and Evolutionary Biology, University of California, Los Angeles; “Underestimating the Challenges of Avoiding a Ghastly Future,” Frontiers in Conservation Science, 1-13-2021, DOI: 10.3389/fcosc.2020.615419)

Simultaneous with population growth, humanity's consumption as a fraction of Earth's regenerative capacity has grown from ~ 73% in 1960 to 170% in 2016 (Lin et al., 2018), with substantially greater per-person consumption in countries with highest income. With COVID-19, this overshoot dropped to 56% above Earth's regenerative capacity, which means that between January and August 2020, humanity consumed as much as Earth can renew in the entire year (overshootday.org). While inequality among people and countries remains staggering, the global middle class has grown rapidly and exceeded half the human population by 2018 (Kharas and Hamel, 2018). Over 70% of all people currently live in countries that run a biocapacity deficit while also having less than world-average income, excluding them from compensating their biocapacity deficit through purchases (Wackernagel et al., 2019) and eroding future resilience via reduced food security (Ehrlich and Harte, 2015b). The consumption rates of high-income countries continue to be substantially higher than low-income countries, with many of the latter even experiencing declines in per-capita footprint (Dasgupta and Ehrlich, 2013; Wackernagel et al., 2019). This massive ecological overshoot is largely enabled by the increasing use of fossil fuels. These convenient fuels have allowed us to decouple human demand from biological regeneration: 85% of commercial energy, 65% of fibers, and most plastics are now produced from fossil fuels. Also, food production depends on fossil-fuel input, with every unit of food energy produced requiring a multiple in fossil-fuel energy (e.g., 3 × for high-consuming countries like Canada, Australia, USA, and China; overshootday.org). This, coupled with increasing consumption of carbon-intensive meat (Ripple et al., 2014) congruent with the rising middle class, has exploded the global carbon footprint of agriculture. While climate change demands a full exit from fossil-fuel use well before 2050, pressures on the biosphere are likely to mount prior to decarbonization as humanity brings energy alternatives online. Consumption and biodiversity challenges will also be amplified by the enormous physical inertia of all large “stocks” that shape current trends: built infrastructure, energy systems, and human populations. It is therefore also inevitable that aggregate consumption will increase at least into the near future, especially as affluence and population continue to grow in tandem (Wiedmann et al., 2020). Even if major catastrophes occur during this interval, they would unlikely affect the population trajectory until well into the 22nd Century (Bradshaw and Brook, 2014). Although population-connected climate change (Wynes and Nicholas, 2017) will worsen human mortality (Mora et al., 2017; Parks et al., 2020), morbidity (Patz et al., 2005; Díaz et al., 2006; Peng et al., 2011), development (Barreca and Schaller, 2020), cognition (Jacobson et al., 2019), agricultural yields (Verdin et al., 2005; Schmidhuber and Tubiello, 2007; Brown and Funk, 2008; Gaupp et al., 2020), and conflicts (Boas, 2015), there is no way—ethically or otherwise (barring extreme and unprecedented increases in human mortality)—to avoid rising human numbers and the accompanying overconsumption. That said, instituting human-rights policies to lower fertility and reining in consumption patterns could diminish the impacts of these phenomena (Rees, 2020). Failed International Goals and Prospects for the Future Stopping biodiversity loss is nowhere close to the top of any country's priorities, trailing far behind other concerns such as employment, healthcare, economic growth, or currency stability. It is therefore no surprise that none of the Aichi Biodiversity Targets for 2020 set at the Convention on Biological Diversity's (CBD.int) 2010 conference was met (Secretariat of the Convention on Biological Diversity, 2020). Even had they been met, they would have still fallen short of realizing any substantive reductions in extinction rate. More broadly, most of the nature-related United Nations Sustainable Development Goals (SDGs) (e.g., SDGs 6, 13–15) are also on track for failure (Wackernagel et al., 2017; Díaz et al., 2019; Messerli et al., 2019), largely because most SDGs have not adequately incorporated their interdependencies with other socio-economic factors (Bradshaw and Di Minin, 2019; Bradshaw et al., 2019; Messerli et al., 2019). Therefore, the apparent paradox of high and rising average standard of living despite a mounting environmental toll has come at a great cost to the stability of humanity's medium- and long-term life-support system. In other words, humanity is running an ecological Ponzi scheme in which society robs nature and future generations to pay for boosting incomes in the short term (Ehrlich et al., 2012). Even the World Economic Forum, which is captive of dangerous greenwashing propaganda (Bakan, 2020), now recognizes biodiversity loss as one of the top threats to the global economy (World Economic Forum, 2020). The emergence of a long-predicted pandemic (Daily and Ehrlich, 1996a), likely related to biodiversity loss, poignantly exemplifies how that imbalance is degrading both human health and wealth (Austin, 2020; Dobson et al., 2020; Roe et al., 2020). With three-quarters of new infectious diseases resulting from human-animal interactions, environmental degradation via climate change, deforestation, intensive farming, bushmeat hunting, and an exploding wildlife trade mean that the opportunities for pathogen-transferring interactions are high (Austin, 2020; Daszak et al., 2020). That much of this degradation is occurring in Biodiversity Hotspots where pathogen diversity is also highest (Keesing et al., 2010), but where institutional capacity is weakest, further increases the risk of pathogen release and spread (Austin, 2020; Schmeller et al., 2020). Climate Disruption The dangerous effects of climate change are much more evident to people than those of biodiversity loss (Legagneux et al., 2018), but society is still finding it difficult to deal with them effectively. Civilization has already exceeded a global warming of ~ 1.0°C above pre-industrial conditions, and is on track to cause at least a 1.5°C warming between 2030 and 2052 (IPCC, 2018). In fact, today's greenhouse-gas concentration is >500 ppm CO2-e (Butler and Montzka, 2020), while according to the IPCC, 450 ppm CO2-e would give Earth a mere 66% chance of not exceeding a 2°C warming (IPCC, 2014). Greenhouse-gas concentration will continue to increase (via positive feedbacks such as melting permafrost and the release of stored methane) (Burke et al., 2018), resulting in further delay of temperature-reducing responses even if humanity stops using fossil fuels entirely well before 2030 (Steffen et al., 2018). Human alteration of the climate has become globally detectable in any single day's weather (Sippel et al., 2020). In fact, the world's climate has matched or exceeded previous predictions (Brysse et al., 2013), possibly because of the IPCC's reliance on averages from several models (Herger et al., 2018) and the language of political conservativeness inherent in policy recommendations seeking multinational consensus (Herrando-Pérez et al., 2019). However, the latest climate models (CMIP6) show greater future warming than previously predicted (Forster et al., 2020), even if society tracks the needed lower-emissions pathway over the coming decades. Nations have in general not met the goals of the 5 year-old Paris Agreement (United Nations, 2016), and while global awareness and concern have risen, and scientists have proposed major transformative change (in energy production, pollution reduction, custodianship of nature, food production, economics, population policies, etc.), an effective international response has yet to emerge (Ripple et al., 2020). Even assuming that all signatories do, in fact, manage to ratify their commitments (a doubtful prospect), expected warming would still reach 2.6–3.1°C by 2100 (Rogelj et al., 2016) unless large, additional commitments are made and fulfilled. Without such commitments, the projected rise of Earth's temperature will be catastrophic for biodiversity (Urban, 2015; Steffen et al., 2018; Strona and Bradshaw, 2018) and humanity (Smith et al., 2016). Regarding international climate-change accords, the Paris Agreement (United Nations, 2016) set the 1.5–2°C target unanimously. But since then, progress to propose, let alone follow, (voluntary) “intended national determined contributions” for post-2020 climate action have been utterly inadequate. Political Impotence If most of the world's population truly understood and appreciated the magnitude of the crises we summarize here, and the inevitability of worsening conditions, one could logically expect positive changes in politics and policies to match the gravity of the existential threats. But the opposite is unfolding. The rise of right-wing populist leaders is associated with anti-environment agendas as seen recently for example in Brazil (Nature, 2018), the USA (Hejny, 2018), and Australia (Burck et al., 2019). Large differences in income, wealth, and consumption among people and even among countries render it difficult to make any policy global in its execution or effect. A central concept in ecology is density feedback (Herrando-Pérez et al., 2012)—as a population approaches its environmental carrying capacity, average individual fitness declines (Brook and Bradshaw, 2006). This tends to push populations toward an instantaneous expression of carrying capacity that slows or reverses population growth. But for most of history, human ingenuity has inflated the natural environment's carrying capacity for us by developing new ways to increase food production (Hopfenberg, 2003), expand wildlife exploitation, and enhance the availability of other resources. This inflation has involved modifying temperature via shelter, clothing, and microclimate control, transporting goods from remote locations, and generally reducing the probability of death or injury through community infrastructure and services (Cohen, 1995). But with the availability of fossil fuels, our species has pushed its consumption of nature's goods and services much farther beyond long-term carrying capacity (or more precisely, the planet's biocapacity), making the readjustment from overshoot that is inevitable far more catastrophic if not managed carefully (Nyström et al., 2019). A growing human population will only exacerbate this, leading to greater competition for an ever-dwindling resource pool. The corollaries are many: continued reduction of environmental intactness (Bradshaw et al., 2010; Bradshaw and Di Minin, 2019), reduced child health (especially in low-income nations) (Bradshaw et al., 2019), increased food demand exacerbating environmental degradation via agro-intensification (Crist et al., 2017), vaster and possibly catastrophic effects of global toxification (Cribb, 2014; Swan and Colino, 2021), greater expression of social pathologies (Levy and Herzog, 1974) including violence exacerbated by climate change and environmental degradation itself (Agnew, 2013; White, 2017, 2019), more terrorism (Coccia, 2018), and an economic system even more prone to sequester the remaining wealth among fewer individuals (Kus, 2016; Piketty, 2020) much like how cropland expansion since the early 1990s has disproportionately concentrated wealth among the super-rich (Ceddia, 2020). The predominant paradigm is still one of pegging “environment” against “economy”; yet in reality, the choice is between exiting overshoot by design or disaster—because exiting overshoot is inevitable one way or another. Given these misconceptions and entrenched interests, the continued rise of extreme ideologies is likely, which in turn limits the capacity of making prudent, long-term decisions, thus potentially accelerating a vicious cycle of global ecological deterioration and its penalties. Even the USA's much-touted New Green Deal (U. S. House of Representatives, 2019) has in fact exacerbated the country's political polarization (Gustafson et al., 2019), mainly because of the weaponization of ‘environmentalism' as a political ideology rather than being viewed as a universal mode of self-preservation and planetary protection that ought to transcend political tribalism. Indeed, environmental protest groups are being labeled as “terrorists” in many countries (Hudson, 2020). Further, the severity of the commitments required for any country to achieve meaningful reductions in consumption and emissions will inevitably lead to public backlash and further ideological entrenchments, mainly because the threat of potential short-term sacrifices is seen as politically inopportune. Even though climate change alone will incur a vast economic burden (Burke et al., 2015; Carleton and Hsiang, 2016; Auffhammer, 2018) possibly leading to war (nuclear, or otherwise) at a global scale (Klare, 2020), most of the world's economies are predicated on the political idea that meaningful counteraction now is too costly to be politically palatable. Combined with financed disinformation campaigns in a bid to protect short-term profits (Oreskes and Conway, 2010; Mayer, 2016; Bakan, 2020), it is doubtful that any needed shift in economic investments of sufficient scale will be made in time.

### A2: Scorched Earth

#### Financialization’s sustainable

Konings 18 (Martijn Konings, Associate Professor of Political Economy at the University of Sydney, author of *The Emotional Logic of Capitalism* and *Capital and Time: For a New Critique of Neoliberal Reason*, series editor for the Stanford University Press book series, Currencies, “A Critique of the Critique of Finance,” Stanford University Press Blog, 2-7-2018, https://stanfordpress.typepad.com/blog/2018/02/a-critique-of-the-critique-of-finance.html)

Critics of neoliberal capitalism rarely recognize the productive power of speculation. If there is one theme that unites the various critiques of contemporary finance, it is the emphasis on its speculative character. Financial growth is said to be driven not by the logic of efficient markets, but rather by irrational sentiment, “animal spirits” that do not respect fundamental values. Emphasizing the role of volatility in contemporary capitalism (evident at the time of writing, as the stock market is experiencing a downturn) is important as an antidote to notions of market efficiency and equilibrium. But it is a mistake to think that it provides a sufficient basis for effective critique. Predictions regarding the limits or collapse of neoliberal finance have simply not enjoyed a good track record. Over and over, the contemporary financial system has proven capable of sustaining higher levels of speculative activity than anticipated. This has certainly been true of the past decade. Capital and Time: For a New Critique of Neoliberal Reason is my attempt to make sense of this—that is, to understand what might be wrong or missing in the existing heterodox critique of speculation, and to advance a more accurate understanding of the role of uncertainty, risk, and speculation in contemporary capitalism. At the heart of the critique of speculation we find a distinction between real and fictitious forms of value. Although “essentialist” (or “foundationalist”) modes of explanation have been under fire across the social sciences for several decades now, when it comes to the critique of finance they have had considerable staying-power: without a notion of real value, it often seems, we lose any objective standard against which to assess the speculative gyrations of capitalist markets. Capital and Time asks what kind of critical theory we might develop if we bracket the anxious attachment to a notion of fundamental value. To that end, it turns to the work of economist Hyman Minsky. Although Minsky has been popularized precisely as a critic of speculation, he in fact insisted that almost all value judgments and investments were to some degree speculative—their success or failure would be determined in an unknown future. For him, the key economic question is how order emerges in a world that offers no guarantees, how more or less stable standards and norms arise amidst uncertainty. Of course, the “endogenous” origin of financial standards is a well-rehearsed theme in heterodox economics—indeed, it is a staple of the “post-Keynesian” literature that claims Minsky’s legacy. But such perspectives have never been able to break with the idea that financial stability is at its core dependent on external interventions that suppress speculative impulses. For Minsky, however, this is to miss the point about endogeneity. To his mind, there was no clear dividing line between financial practices and their governance: central banks and other public authorities are no more able to see into the future and to transcend uncertainty than private investors are. Minsky was therefore highly skeptical about official claims of discretionary precision management: financial governance is always embroiled in the very risk logic that it is charged with managing. That also means that financial policy can appear quite ordinary, even banal: at the heart of capitalist financial management is a logic of backstopping and bailout that responds to the possibility that the failure of an institution may take down wider financial structures. The stability of the post-New Deal financial system is often attributed to the Glass-Steagall separation of the stock market and commercial banking. But Minsky tended to view Glass-Steagall as one of several measures to direct bank credit away from the stock market towards other, no less speculative ends, notably consumer and mortgage financing. To his mind, the stability of the post-war period derived rather from the creation of an extensive financial safety net (which included, for instance, deposit insurance, which removed the rationale behind bank runs) that served to socialize risk. This institutional arrangement turned out to have a significant drawback: a pattern of chronic inflation emerged that, by the late 1970s, was widely perceived as a major problem. Minsky’s lack of faith in the possibility of cleanly staged external interventions led him to feel that that there was no real way out of this predicament. Monetarist doctrines, ascendant during the 1970s under the influence of Milton Friedman, relied on exactly the belief in an arbitrarily defined monetary standard that Minsky rejected as naïve. Muddling through, it seemed, was the price of avoiding another financial crash and depression. The Volcker shock of 1979 changed this dynamic in a way that Minsky had not foreseen but that is comprehensible when seen through the lens he provided us with. Paul Volcker looked to monetarism not as a means to enforce an external limit or standard on the financial system, but as a politically expedient way to break with accommodating policies and to proactively engage the endogenous dynamics of finance. The consequences of the Volcker shock were predictable (which is exactly why the Federal Reserve had been reluctant to pursue similar policies in previous years): inflation gave way to instability and crisis. Inflation was conquered as jobs were lost and wages stagnated. And, far from money being returned to its neutral exchange function, opportunities for speculation multiplied. The American state was never going to sit idly by as the financial system returned to dynamics of boom and bust: when instability took the form of systemic threats, authorities would bail out the institutions that had overextended themselves. Of course, Volcker would not have been able to predict the specific features of the too-big-to-fail regime as it emerged during the 1980s and evolved subsequently; but the very point of the neoliberal turn in financial management that he had overseen was to create a context where risk could be socialized in ways that were more selective and therefore did not entail generalized inflation. The inflation of asset values that has been such a marked feature of the past four decades has always been premised centrally on the willingness of authorities to view the “moral hazard” of the too-big-to-fail logic as a policy instrument—even if they may have decried it officially as a regrettable corruption of market principles. Spectacular bailouts, mundane policies to protect the key nodes of the payment systems, the “Greenspan put”, the different iterations of quantitative easing—these are all variations on that basic too-important-to-fail logic. Existing critical perspectives tend to view crisis and the need for bank bailouts as manifesting the essential incoherence of neoliberal finance, its lack of solid foundations and the irrationality of speculation. Capital and Time breaks with such moralistic assessments. The way deepening inequality and the speculative growth of asset values continue to feed off each other is troubling for any number of reasons, but there is nothing inherently “unsustainable” about it—the process does not have a natural or objective limit. At this point in time, the critique of speculation does little more than lend credibility to official discourses that present crises as preventable and bailouts as one-off, never-to-be-repeated interventions. In that way, it prevents us from critically relating to a neoliberal reality that has been shaped to its core by the speculative exploitation of risk and uncertainty, and in which regressive risk socialization serves as the everyday logic of financial governance.

### extra

#### Bataille’s worldview necessarily dismisses the systems that check elite dominance

Wolin ‘6

(Richard, Distinguished Professor of History at the [City University of New York](http://en.wikipedia.org/wiki/City_University_of_New_York) Graduate Center, “Left Fascism: Georges Bataille and the German Ideology”Constellations vol. 2 issue 3, pp. 397-428)

Here, the analysis must begin with an examination of Bataille’s essay, “The Psychological Structure of Fascism,” often rightly hailed as a theoretical breakthrough in our understanding of the mass psychological appeal of modern authoritarian rule. Yet, the essay also contains a barely veiled admiration for the vitality and energy of the existing fascist states, especially when contrasted with the decadence and inertia of the contemporary European democracies. Bataille purveys a critique of parliamentarianism that is as zealous as anything one finds in the work of Carl Schmitt. Parliamentary decision-making, he claims, partakes wholly of the order of the homogenous. It aims solely at co-optation, the elimination of difference. As such, it is purely instrumental and serves primarily to suppress the breakthrough of heterogeneous elements that threaten to explode the normative bases of the given economic and political order. As Bataille observes, in a striking anticipation of Jean-Francois Lyotard’s association of “consensus” and “terror”: “The reduction of differences in parliamentary practice indicates all the possible complexity of the internal activity of adaptation required by *homogeneity.*60 Bataille can perceive no fundamental differences between the conduct of political and economic life in modern democratic societies, insofar as both are examples *par excellence* of homogeneity – this despite the fact that discussion aims at mutual understanding, whereas economic activity is goal-oriented and utilitarian. Given this curt dismissal of the institutional bases of democracy, it comes as little surprise that Bataille glorifies the role played by fascism in modern political life as a type of breakthrough of the heterogeneous. For Bataille, “the fascist leaders are incontestably part of heterogeneous existence. Opposed to democratic politicians, who represent in different countries the platitude inherent to *homogeneous* society, Mussolini and Hitler immediately stand out as something *other*.”62 What he admires about these men and the movement they represent is that they embody “a force that situates them above other men,” which accounts for their “sovereignty.” Yet, he also esteems greatly their thoroughgoing antagonism to law: “the fact that laws are broken is only the most obvious sign of the transcendent, *heterogeneous* nature of fascist action.”63 Here, the parallels with Schmitt’s critique of bourgeois legal positivism are of course profound. Both Schmitt and Bataille view the institution of law as the consummate embodiment of the spirit of bourgeois rationalism. It symbolizes everything they detest about the reigning social order: its prosaic longing for security, its unrevolutionary nature, its abhorrence of “transcendence,” its anathematization of the vitality and intensity one finds in the “exception” (Schmitt) or “transgression” (Bataille). Moreover, for Bataille the system of law merits especially harsh treatment insofar as it signifies a type consecration of the profane order of things, as such, it stands as an impediment to contact with the heterogeneous or the sacred. Bataille concludes his endorsement of fascist politics with the following encomium: “*Heterogeneous* fascist action belongs to the entire set of higher forms. It makes an appeal to sentiments traditionally defined as *exalted* and *noble* and tends to constitute authority as an unconditional principle situated above any utilitarian judgment.” As opposed to the bourgeois order of life, which, with its utilitarianism and its legalism, merely sanctifies “the prose of the world,” fascism offers a new political aesthetic, the return, as it were, of an *aesthetic politics*: a type of politics that reintroduces the long lost elements of charismatic leadership (in Bataille’s terms, “sovereignty”), violence, and martial glory. It is, moreover, a politics that facilitates a great emotional cathexis between leaders and masses, a point which Bataille emphasizes repeatedly. For one of fascism’s great attributes is that it “clearly demonstrates what can be expected from a timely recourse to reawakened affective forces” – forces capable of guaranteeing a measure of *collective solidarity*, which have been banished from a society in which the division of labor and rationalization reign supreme. In sum, fascism serves to reintroduce a type of *ecstatic politics* into the forlorn and disenchanted landscape of political modernity, a politics that aims at the creation of a quasi-Nietzschean *ecstatic community*.

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### Alt

#### Utility maximization is inevitable – can’t turn off *homo economicus*

Barnhizer 6 — David R. Barnhizer, Emeritus Professor at Cleveland State University’s Cleveland-Marshall College of Law, 2006 (“Waking from Sustainability's "Impossible Dream": The Decisionmaking Realities of Business and Government,” *Georgetown International Environmental Law Review* (18 Geo. Int'l Envtl. L. Rev. 595), Available Online to Subscribing Institutions via Lexis-Nexis)

The scale of social needs, including the need for expanded productive activity, has grown so large that it cannot be shut off at all, and certainly not abruptly. It cannot even be ratcheted down in any significant fashion without producing serious harms to human societies and hundreds of millions of people. Even if it were possible to shift back to systems of local self-sufficiency, the consequences of the transition process would be catastrophic for many people and even deadly to the point of continual conflict, resource wars, increased poverty, and strife. What are needed are concrete, workable, and pragmatic strategies that produce effective and intelligently designed economic activity in specific contexts and, while seeking efficiency and conservation, place economic and social justice high on a list of priorities. n60

The imperative of economic growth applies not only to the needs and expectations of people in economically developed societies but also to people living in nations that are currently economically underdeveloped. Opportunities must be created, jobs must be generated in huge numbers, and economic resources expanded to address the tragedies of poverty and inequality. Unfortunately, natural systems must be exploited to achieve this; we cannot return to Eden. The question is not how to achieve a static state but how to achieve what is needed to advance social justice while avoiding and mitigating the most destructive consequences of our behavior.

### Sustainability

#### Excess is sustainable

King and Lichtenstein 21 (David King, Founder and Chair, Centre for Climate Repair at Cambridge, University of Cambridge; and Jane Lichtenstein, Associate, Centre for Climate Repair at Cambridge, University of Cambridge; “Surviving the next 50 years is an existential crisis – 3 things we must do now,” The Print, 8-14-2021, https://theprint.in/opinion/surviving-the-next-50-years-is-an-existential-crisis-3-things-we-must-do-now/715069/)

The challenge of surviving the next 50 years is now seen as a planet-wide existential crisis; we need to work together urgently, just to secure a short-term future for human civilisation. Global weather patterns are violently disrupted: Greece burns; the south of England floods; Texas has had its coldest weather ever, while California and Australia suffer apocalyptic wild fires. All of these violent, record-breaking events are a direct result of rapid heating in the Arctic – occurring faster than in the rest of the world. A warm Arctic triggers new ocean and air currents that change the weather for everyone. The only way to reverse some of these catastrophic patterns, and to regain a kind of stability in climate and weather systems, is “climate repair” – a strategy we call “reduce, remove, repair” – which demands that we make very rapid progress to net zero global emissions; that there is massive, active removal of greenhouse gases from the atmosphere; and, in the first instance, that we refreeze the Earth’s poles and glaciers to correct the wild weather patterns, slow down ice-melt, stabilise sea level, and break the feedback loops that relentlessly accelerate global warming. There are no either/or options. Reducing emissions About 70% of world economies have net zero emissions commitments over varying timescales, but this has come too late to restore climate stability. The IPCC has asked for accelerated progress on this trajectory, but whatever happens, current emission rates of atmospheric greenhouse gases imply global warming of 1.5℃ by 2030 and well over 2℃ above pre-industrial level by the end of the century – a devastating outcome. In particular, melting ice and thawing permafrost are considered inevitable even if rapid and deep CO2 emissions reductions are achieved, with sea-level rise to continue for centuries as a result. In every area of the world, climate events will become more severe and more frequent, whether flooding, heating, coastal erosion or fires. There are definitely important steps that can still reduce the scale of this devastation, including faster and deeper emissions reductions. However, this is not enough on its own to avert the worst. Together there is real evidence that the massive removal of greenhouse gases from the atmosphere and solutions such as repairing the Earth’s poles and glaciers could help humanity find a survivable way out of this crisis. Removing greenhouse gases Taking CO2 and equivalent greenhouse gases out of the atmosphere, with the aim of getting back to 350ppm (parts per million) by 2100, involves creating new CO2 “sinks” – long-term stores from which CO2 cannot escape. Sinks operate at many scales, with forest planting, mangrove restoration, wetland and peat preservation all crucially important. Very large projects, such as the restoration of the Loess Plateau in China demonstrate scalable CO2 removal, with multiple add-on benefits of food production, bio-diversity enhancement and weather stabilisation. Habitat restoration can also make economic sense. In the Philippines, mangrove is the focus of a cost-benefit analysis. Mangrove captures four times more carbon than the same area of rainforest, provides numerous ecosystem services and protects against flooding, conferring socio-economic benefits and significantly reducing the cost of dealing with extreme weather events. Big new carbon sinks must be created wherever safely possible, including in the oceans. Interventions that mimic natural processes, known to operate safely “in the wild”, are a workable starting point. Promotion of ocean pastures to restore ocean diversity and fish and whale stocks to the levels last seen 300 years ago is one such possibility – offering new sustainable food sources for humans, as well as contributing to climate ecosystem services and carbon sinks. In nature, sprinklings of iron-rich dust blow from deserts or volcanic eruptions, onto the surface of deep oceans, generating – in a matter of months – rich ocean pastures, teeming fish stocks and an array of marine wildlife. Studies of ocean kelp regeneration show the full range of real-life impacts, from increased protein sources for human consumption, to restoration of pre-industrial levels of ocean biodiversity and productivity, and extensive carbon sequestration. Extending the scale and number of ocean pastures could be achieved by systematically scattering iron-rich dust onto target areas in oceans around the world. The approach is intuitively scalable, and could sequester perhaps 30 billion tons per year of CO2 if 3% or so of the world’s deep oceans were to be treated annually. Large-scale carbon-sink creation of this kind is pivotal if the atmosphere is to return to pre-industrial CO2 levels. A billion tons per year of sequestration is the minimum threshold coordinated by the Centre for Climate Repair at Cambridge given the intensity of the climate crisis. While the scale of intervention is sometimes called “geoengineering”, the approach is closer to forest planting or mangrove restoration. The aim is to remove CO2 from the atmosphere using natural means, to return us to pre-industrial levels within a single generation. Repairing the planet The immediate challenge is to stabilise the planet, achieving a manageable equilibrium that gives a last chance to shift to renewable energy and towards a circular global economy, with new norms in urban, rural and ocean management. “Repairing” systematically seeks to draw the Earth back from climate tipping points (which, by definition, cannot happen without direct effort), providing a supporting framework in which “reduce” and “restore” can happen. Political and societal will is needed. The most urgent effort is to refreeze the Arctic, interrupting a bleak spiral of accelerating ice loss, sea-level rise – and the acceleration of climate change and violent global weather changes that they cause. Arctic temperatures have risen much faster (and increasingly so) than global average temperatures, when compared with pre-industrial levels. Figure 1 shows this clearly from 1850 to the present day. Melting Arctic ice embodies a powerful feedback force in climate change. White ice reflects the Sun’s energy away from the Earth before it can heat the surface. This is known as the albedo effect. As ice melts, dark-blue seawater absorbs increasing amounts of the Sun’s energy, warming increases, and ever-larger areas of ice disappear each summer, expanding the acceleration. Arctic temperatures govern winds, ocean currents and weather systems across the globe. A tipping point is passing: sea-ice loss is becoming permanent and accelerating; Greenland ice will follow and will eventually raise global sea-levels by over seven metres. Total loss may take centuries but, decade by decade, there will be relentless incremental impacts. By mid-century the melting will be irreversible, and sea-level rise alone will leave low-lying countries like Vietnam in desperate circumstances, with reductions to global rice production a certainty, many millions of climate refugees and no obvious pathway forward for such nations. Figure 1: comparison between average global temperature change, and change in the Arctic region from 1850 to present day. Provided by Nerilie Abram using IPCC data, ANU, Australia, 2021 The rapid Arctic temperature increase is matched by the rapid and accelerating loss in minimum (summer) sea-ice volume (Figure 2), which further accelerates the temperature rise in a spiral of reinforcing feedback loops. Figure 2: decline in annual minimum Arctic Sea ice volume 1980-2020. Provided by Nerilie Abram using IPCC data, ANU, Australia, 2021 It is vital to pivot the world back from this ice-melt tipping point, and to repair the Arctic as rapidly as possible. Marine cloud brightening in which floating solar-powered pumps spray salt upwards to brighten clouds and create a reflective barrier between the Sun and the ocean, is known to cool ocean surfaces and is a promising way to promote Arctic summer cooling. It mimics nature, and can be scaled up or down in a flexible way. Studies of marine cloud brightening, its climate impacts and interactions with human systems, are underway. As with promotion of ocean pastures, such solutions must be critically analysed, but there is no longer any doubt of their crucial importance. What we do in the next five years determines the viability of humanity’s future. Even if we narrow our aspirations to “survival”, fixing on a timescale of 50 years or so, the challenges are daunting. Humanity deserves better. We know what to do to be able to imagine thousands of years of human civilisation ahead, as well as behind us.