# 1AC R2 Valley

### 1AC: Framework

#### Moral realism must start by being mind-independent – realism wouldn’t make sense if there were a plethora of moral truths contingent on the agent’s cognitively predisposed capacity because then moral truths wouldn’t exist outside of the ways we cohere them. Thus, the meta-ethic is substantive moral naturalism.

#### 1. The argument from supervenience is true and coherently explains the metaphysical grounding of morality.

**Lutz**, Matthew **and Lenman**, James, "Moral Naturalism", *The Stanford Encyclopedia of Philosophy*(Fall **2018** Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/fall2018/entries/naturalism-moral/>. //Massa

The first argument against normative non-naturalism concerns normative supervenience. **The normative supervenes on the natural; in all** metaphysically **possible worlds in which the natural facts are the same as** they are in **the actual world, the moral facts are the same** as well. **This** claim **has been called the “least controversial thesis in metaethics”** (Rosen forthcoming); **it is very widely accepted.** But it is also a striking fact that stands in need of some explanation. **For naturalists**, such an explanation is easy to provide: **the moral facts just are natural facts, so when we consider worlds that are naturally the same** as the actual world, **we will ipso facto be considering worlds that are morally the same** as the actual world. But for the non-naturalist, no such explanation seems available. In fact, **it seems** to be in principle **impossible for a non-naturalist to explain how the moral supervenes on the natural.** And if the non-naturalist can offer no explanation of this phenomenon that demands explanation, this is a heavy mark against non-naturalism (McPherson 2012).

It is highly controversial whether this argument succeeds (for discussion, see McPherson (2012), Enoch (2011, Ch. 6), Wielenberg (2014, Ch. 1), Leary 2017, Väyrynen 2017, Rosen forthcoming,). But if it does succeed, then it provides a good reason to think that moral properties, if they exist, must be natural properties.

#### Thus, moral naturalism prima facie justifies hedonism as the only ethical theory that can guide action. Naturalism demands empirical facts that are explained and physically verified from science which only a theory of pain and pleasure can provide since there is a psychological grounding for why they are good and bad. Thus, the standard is consistency with hedonic act utilitarianism.

### 1AC: Innovation

#### Advantage 1 is Innovation:

#### We are in an innovation crisis – new drugs are not being developed in favor of re-purposing old drugs to infinitely extend patent expiration.

Feldman 1 Robin Feldman 2-11-2019 "‘One-and-done’ for new drugs could cut patent thickets and boost generic competition" <https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/> (Arthur J. Goldberg Distinguished Professor of Law, Albert Abramson ’54 Distinguished Professor of Law Chair, and Director of the Center for Innovation)//SidK + Elmer

Drug companies **have brought great innovations** to market. Society rewards innovation with patents, or with non-patent exclusivities that can be obtained for activities such as testing drugs in children, undertaking new clinical studies, or developing orphan drugs. The rights provided by patents or non-patent exclusivities provide a defined time period of protection so companies can recoup their investments by charging monopoly prices. When patents end, lower-priced competitors should be able to jump into the market and drive down the price. **But that’s not happening**. Instead, drug companies build massive patent walls around their products, extending the protection **over and over again**. Some modern drugs have an avalanche of U.S. patents, with expiration dates **staggered across time**. For example, the rheumatoid arthritis drug Humira is **protected by more than 100 patents**. Walls like that **are insurmountable**. Rather than rewarding innovation, our patent system is now largely repurposing drugs. Between 2005 and 2015, **more than three-quarters** of the drugs associated with new patents **were not new ones** coming on the market but existing ones. In other words, we are mostly churning and recycling. Particularly troubling, new patents can be **obtained on minor tweaks** such as adjustments to dosage or delivery systems — a once-a-day pill instead of a twice-a-day one; a capsule rather than a tablet. Tinkering like this may have some value to some patients, but it nowhere near justifies the rewards we lavish on companies for doing it. From society’s standpoint, incentives should drive scientists back to the lab to look for new things, not to recycle existing drugs for minimal benefit.

#### We control Uniqueness – 78% of New Drugs aren’t innovative.

PFAD 21 Patients for Affordable Drugs 2-3-2021 “BIG PHARMA’S BIG LIE: THE TRUTH ABOUT INNOVATION & DRUG PRICES” <https://patientsforaffordabledrugs.org/2021/02/03/innovation-report/> (a patient advocacy and lobbying organisation based in Washington, D.C. founded by David Mitchell who suffers from multiple myeloma. Ben Wakana is the executive director. It focuses on policies to lower drug prices.)//Elmer

The drug industry talks a lot about how reforms to lower prices threaten cutting-edge breakthroughs, but in reality, **only a fraction of new medications are truly innovative**. **Since 1975**, **only 10** to 15 **percent** of drugs entering the market **represented** **therapeutic advances**; **instead**, **drug companies prioritized the development of existing drugs with minor variations that lack clinical significance**.21 Drug patents offer a stark illustration of this point. Between 2005 and 2015, **78 percent of drug patents were related to drugs already on the market.**22 **Instead of investing in R&D that could lead to new** breakthrough **therapies**, **drug companies spend resources obtaining patents on old drugs** — not to improve user experience — but **to extend patent protection**, prolong monopoly pricing periods, and keep generic competitors off the market. So if we understand that new drugs are not the same as new cures, a small reduction in new drugs doesn’t pose a threat to innovation. Harvard economist Richard Frank summed it up this way: “If drug companies claim lowering drug prices means somewhat fewer new drug launches, remember that there are **numerous new products sold every year whose elimination would have little to no impact on the health of Americans**.”23 If our current system of drug development does not result primarily in truly innovative drugs, we can’t let the pharmaceutical industry use the threat of R&D cuts as a scapegoat to thwart reforms. We can create a system that incentivizes valuable innovation that delivers meaningful clinical benefit to patients — instead of repurposing old drugs.

#### The only major study confirms our Internal Link – Evergreening decimates competition by resulting in functional monopolies

Arnold Ventures 20 9-24-2020 "'Evergreening' Stunts Competition, Costs Consumers and Taxpayers" <https://www.arnoldventures.org/stories/evergreening-stunts-competition-costs-consumers-and-taxpayers/> (Arnold Ventures is focused on evidence-based giving in a wide range of categories including: criminal justice, education, health care, and public finance)//Elmer

In 2011, Elsa Dixler was diagnosed with multiple myeloma. That August, she was prescribed Revlimid, a drug that had come on the market six years earlier. By January 2012, she went into full remission, where she has remained since. So long as Revlimid retains its effectiveness, she will take it for the rest of her life. “I was able to go back to work, see my daughter receive her Ph.D, and have a pretty normal life,” said Dixler, a Brooklyn resident who is now 74. “So, on the one hand, I feel enormously grateful.” But Dixler’s normal life has come at a steep financial cost to her family and to taxpayers. Revlimid typically costs nearly $800 per capsule, and Dixler takes one capsule per day for 21 days, then seven days off, and then resumes her daily dose, requiring 273 capsules a year. Since retiring from The New York Times at the end of 2017, she has been on Medicare. Dixler entered the Part D coverage gap (known as the donut hole) “within minutes,” she said. She estimates that adding her deductible, her copayment of $12,000, and what her Part D insurance provider pays totals approximately $197,500 a year. Revlimid should have **been subject to competition** from generic drug makers starting in 2009, bringing down its cost by many orders of magnitude. But by obtaining **27 additional patents**, eight orphan drug exclusivities and 91 total additional protections from the U.S. Food and Drug Administration (FDA) since Revlimid’s introduction in 2005, its manufacturer, Celgene, has extended the drug’s **monopoly** **period** **by 18 years** — through March 8, 2028. “I cannot fathom the immorality of a business that relies on **squeezing people with cancer**,” Dixler said, noting her astonishment that Revlimid has obtained orphan drug protections when it treats a disease that is not rare and does not serve a very limited population. She also observed that Revlimid’s underlying drug is thalidomide, which has been around for decades. “They didn’t invent a new drug, rather, they found a new use for it,” she said. “The cost of Revlimid has imposed constraints on our retirement,” Dixler said, “but when I hear other people’s stories, I feel very lucky. A lot of people have been devastated financially.” Revlimid is a case study in a process known as “evergreening” — artificially sustaining a monopoly for years and even decades by manipulating intellectual property laws and regulations. Evergreening is most commonly used with blockbuster drugs generating the highest prices and profits. **Of the roughly 100 best-selling drugs, more than 70 percent have extended their protection** from competition at least once. More than half have extended the protection cliff multiple times. The true scope and cost of evergreening has been brought into sharper focus by a groundbreaking, publicly available, comprehensive database released Thursday by the Center for Innovation at the University of California Hastings College of Law and supported by Arnold Ventures. **The Evergreen Drug Patent Search is the first database to exhaustively track the patent protections filed by pharmaceutical companies**. Using data from 2005 to 2018 on brand-name drugs listed in the FDA’s Orange Book — a listing of relevant patents for brand name, small molecule drugs — it demonstrates the full extent of how evergreening has been used by Big Pharma to prolong patents and delay the entry of generic, lower-cost competition. “Competition is the backbone of the U.S. economy,” said Professor Robin Feldman, Director of the UC Hastings Center for Innovation, who spearheaded the database’s creation. “But it’s not what we’re seeing in the drug industry. “With evergreening, pharmaceutical companies repeatedly make slight, often trivial, modifications to drugs, dosage levels, delivery systems or other aspects to obtain new protections,” she said. “They pile these protections on over and over again — so often that 78 percent of the drugs associated with new patents were not new drugs coming on the market, but existing drugs.” Competition is the backbone of the U.S. economy. But it’s not what we’re **seeing in the drug industry**. Professor Robin Feldman Director of the UC Hastings Center for Innovation In recent decades, evergreening has systematically undermined the Drug Price Competition and Patent Term Restoration Act of 1984, which created the generic drug industry. Commonly known as the Hatch-Waxman Act, it established a new patent and market exclusivity regime in which new drugs are protected from competition for a specified period of time sufficient to allow manufacturers to recoup their investments and earn a reasonable profit. When that protection expires, generic drug makers are incentivized to enter the market through a streamlined regulatory and judicial process. Drug prices typically drop by as much as 20 percent when the first generic enters the market**, and with more than one generic manufacturer, prices can plummet by 80 to 85 percent**. “Hatch-Waxman created an innovation/reward/competition cycle, but it’s been distorted into an innovation/reward/more reward cycle,” Feldman said. “To paraphrase something a former FDA commissioner once said, the greatest creativity in Big Pharma should come from the research and development departments, not from the legal and marketing departments.” Feldman led the development of the Evergreen Drug Patent Search in response to repeated requests from Congressional committees, members of Congress, state regulators and journalists for information about specific drugs and companies. “We want to make it so anyone can have the question about drug protections at their fingertips whenever they want,” Feldman said. “It’s designed to be easy and user-friendly, and to enhance public understanding about how competition may be limited rather than enhanced through the drug patent system.” The **database** was **created through** a painstaking process of **combing** through **160,000 data points** **to examine every instance where a pharmaceutical company added a new drug patent or exclusivity**. “Most of it was done by hand,” Feldman said, “with multiple people reviewing it at every stage. And along the way we repeatedly made conservative choices. **We erred on the side of underrepresenting the evergreen gain** to be sure we were as fair and reasonable as possible.” Among the 2,065 drugs covered in Evergreen Drug Patent Search, there are many examples of the evergreening strategy used by pharma to delay the entry of competition, especially generics, often for widely prescribed drugs, including those used to treat heartburn, chronic pain, and opioid addiction. Nexium Before Nexium, there was Prilosec, a popular drug to treat gastroesophageal reflux disease (GERD). But its patent exclusivity was due to expire in April 2001. In the late 1990s, with a precipitous drop in revenue looming, Prilosec’s manufacturer, AstraZeneca, decided to develop a replacement drug. Using “one-half of the Prilosec molecule — an isomer of it,” the result was Nexium, which received approval in February 2001. Essentially an evergreened version of Prilosec, Nexium’s exclusivity was then extended by more than 15 years, as AstraZeneca received 97 protections stemming from 16 patents. These included revised dosages, compounds, and formulations. Feldman said that tinkering changes such as Nexium’s do not involve the substantial research and development required for a new drug, nor do they constitute true innovations, yet for a decade and a half, patients and taxpayers were forced to pay far more than was warranted for GERD relief. In fact, in 2016 — one year after patent exclusivity expired — Nexium still topped all drugs in Medicare Part D spending, totaling $1.06 billion. Suboxone Use of this combination of buprenorphine and naloxone for treating opioid addiction has exploded in the wake of the opioid epidemic. Since its approval, Suboxone’s manufacturer, Reckitt Benckiser (now operating as Indivior), extended its protection cliff eight times, gaining nearly two extra decades of exclusivity through early 2030. The drug maker gained six patents for creating a film version of the drug — notably around the time protection was expiring for its tablet version. (The therapeutic benefits of the film and tablet are identical.) An earlier version of Suboxone also obtained an orphan drug designation, despite an opioid epidemic that has expanded Suboxone’s customer base to millions of potential customers. Suboxone generates more than $1 billion in annual revenue and ranks among the 40 top-selling drugs in the U.S. Truvada When Truvada, commonly referred to as PrEP, was approved in 2004, this HIV-prevention drug was a breakthrough. But 16 years later — and 14 years after its original exclusivity was to expire — it retains its monopoly status. Truvada’s manufacturer, Gilead, has received 15 patents and 120 protections since it came on the market, extending its exclusivity for more than 17 years, until July 3, 2024. In countries where generic Truvada is available, PrEP costs $100 or less per month, compared to $1,600 to $2,000 in the U.S. As a result, Truvada is unaffordable to many people **who need protection from HIV**. Barred from access, they are left vulnerable to infection. “We’re establishing a precedent that a pharmaceutical company can charge whatever it wants even as it allows an epidemic to continue, and the government refuses to intervene,” said James Krellenstein, co-founder of the group PrEP4All. “That should scare every American. If it’s HIV today, it will be another disease tomorrow.” EpiPen First approved in 1987, the EpiPen has saved the lives of countless numbers of people with deadly allergies. But it is protected from competition until 2025 — 38 years after its introduction — because its owner, Mylan, has filed five patents, four since 2010, all involving tweaks to the automatic injector. The actual medication used, epinephrine, has existed for more than a century — the innovation here is in the delivery device. Because these small changes to the injector have maintained its monopoly for so long, the cost of an EpiPen package (containing two injectors) has risen from $94 when Mylan purchased the device to between $650 and $700 today. For many people, especially parents of children with severe reactions to common allergens like peanuts, EpiPen’s increasing price tag imposes an onerous financial burden. What Can Be Done As the Evergreen Drug Patent Search makes clear, the positive impact of Hatch-Waxman has been steadily and severely eroded by a regulatory system vulnerable to increasingly sophisticated forms of manipulation. “You might say that the patent and regulatory system has been weaponized,” Feldman said. “When billions of dollars are at stake, there’s a lot of money available to look for ways to exploit the legal system. And companies have become adept at this, as our work has found.” There are several key steps that Congress could take to restore the balance between innovation and competition that is the key to a successful prescription drug regulatory process. These may include: Imposing restrictions on the number of patents that prescription drug manufacturers can defend in court to discourage the use of anticompetitive patent thickets. Limiting the patentability of so-called secondary patents — which don’t improve the safety or efficacy of a drug — through patent and exclusivity reform. Reforming the 180-day generic exclusivity, which can currently be abused to block other competitive therapies. “**The Evergreen Drug Patent Search provides the publicly available, evidence-based foundation that defines the extent of the problem**, and it can be used to develop policies that solve the problem of anti-competitive patent abuses,” said Kristi Martin, VP of Drug Pricing at Arnold Ventures. “Our incentives have gotten out of whack,” Martin said. “The luxury of monopoly protection should only be provided to innovations that provide meaningful benefits in saving lives, curing illnesses, or improving the quality of people’s lives. It should not be provided to those gaming the system. If we can change that, we can save consumers, employers, and taxpayers many billions of dollars while increasing the incentives for pharmaceutical companies to achieve breakthroughs."

#### Reject Negative Turns – they’re pharmaceutical lies – the Plan isn’t anti-Patent, just pro-innovation – breaking down secondary patents is key.

* AT Advantage CPs to solve Drug Prices

Radhakrishnan 16 Priti Radhakrishnan 6-14-2016 "Pharma’s secret weapon to keep drug prices high" <https://www.statnews.com/2016/06/14/secondary-patent-gilead-sovaldi-harvoni/> (Priti Radhakrishnan is cofounder and director of the Initiative for Medicines, Access & Knowledge (I-MAK), a US-based nonprofit group of scientists and lawyers working globally to get people lifesaving medicines. Before founding I-MAK, she worked as a health attorney in the US, Switzerland, and India.)//Elmer

Skyrocketing drug prices are forcing states to take **unprecedented measures** to rein in health care spending. Vermont just became the nation’s first state to require prescription drug pricing transparency. The New York and Massachusetts attorneys general have launched investigations into major pharmaceutical companies’ and insurers’ drug pricing policies and strategies. These **are important steps**. **But** they **ignore a key driver of the problem: secondary patents**. Familiar to only a few people inside the insular world of intellectual property law, secondary patents work like this: Companies file for additional, defensive patents to thicken the protection around their original base patents. These additional patents **rarely represent anything new in terms of science**. Instead, their **purpose is to** **prolong** **a** company’s **monopoly** and, along with that, its ability to charge high prices for its drugs. Some drugs have dozens of secondary patents. Abbott Labs, for example, has over 108 patents on its HIV drug Kaletra. Take the case of Sovaldi, a treatment for hepatitis C developed by Gilead Sciences. In the United States, Gilead prices Sovaldi at up to $1,000 a pill, or about $84,000 for a complete course of treatment. This pricing strategy helped Gilead clear $18 billion in profits last year, while taxpayer-funded Medicaid programs, state health programs, and patients have trouble affording this astronomically priced drug. Sovaldi is comprised of a base compound — sofosbuvir — for which the pharma giant has filed three patents. On top of that, Gilead has pursued an additional 24 patents, with more likely to come. My organization, the Initiative for Medicines, Access & Knowledge (I-MAK), aims to ensure that people with hepatitis C and HIV around the world get the medicines they need to survive and lead healthy lives. We have evaluated Gilead’s patent portfolio and found that, based on US and international patent law, Gilead does not deserve any of its 27 patents for Sovaldi. Both the base and secondary patents for the drug are based on old science and commonly known techniques. Yet because of its defensive patenting strategy, Gilead will maintain an iron lock on its market share and charge exorbitantly high prices to Americans with hepatitis C until well into the 2030s. Harvoni, another medication that treats hepatitis C, combines sofosbuvir and a drug called ledipasvir. Currently, Harvoni has 27 secondary patents. If these were removed, people in the US could access far cheaper versions of the same drug as soon as 10 years earlier. Based on I-MAK’s conservative estimates, this could open access to treatment for millions of people in the US, saving patients and payers like Medicare and Medicaid $5 billion over an eight-year period. In the US, Harvoni is priced at $94,000 for a course of treatment. In middle-income, high-population countries like Argentina, Brazil, and China, people are forced to pay thousands of dollars for sofosbuvir. Stripping away unmerited patents would reduce drug costs and increase access for millions of people in the US and around the world. **Pharmaceutical companies love to claim that winnowing** their armada of **patents would be a disincentive to innovation** and would limit research into new drugs. **Don’t believe it**. **The industry devotes shockingly little funding to research and development**. Companies **spend** roughly **one-third** of their revenues **on marketing** **and only half as much on research** and development, while spending big on armies of lawyers to devise and defend secondary patents and other so-called “life cycle management” strategies. Drug **research funding** has been **declining for more than a decade**, **while** strategies of **secondary patenting have steadily increased.** We support patents — just not those that are unmerited and that unjustly prolong companies’ market power and prevent legitimate competition.

#### Only innovation now solves AMR super-bugs -- timeframe’s key.

Sobti 19 [Dr. Navjot Kaur Sobti is an internal medicine resident physician at Dartmouth-Hitchcock-Medical Center/Dartmouth School of Medicine and a member of the ABC News Medical Unit. May 1, 2019. “Amid superbug crisis, scientists urge innovation”. <https://abcnews.go.com/Health/amidst-superbug-crisis-scientists-urge-innovation/story?id=62763415>] Dhruv

[The United Nations](https://abcnews.go.com/Politics/amal-clooney-angelina-jolie-speak-us-weighed-vetoing/story?id=62574726) has called antimicrobial resistance a “global crisis.” With the [rise in superbugs](https://abcnews.go.com/Health/superbug-fungus-global-health-threat-600-us-infected/story?id=62297532) across the globe, common infections are becoming harder to treat, and lifesaving procedures riskier to perform. Drug-resistant infections result in about 700,000 deaths per year, with at least 230,000 of those deaths due to multidrug resistant tuberculosis, [according to a groundbreaking report from the World Health Organization (WHO).](https://www.who.int/antimicrobial-resistance/interagency-coordination-group/IACG_final_report_EN.pdf?ua=1) Given that antibiotic resistance is present in every country, antimicrobial resistance (AMR) now represents a global health crisis, according to the UN, which has urged immediate, coordinated and global action to prevent a potentially devastating health and financial crisis. With the rising rates of AMR -- including antivirals, antibiotics, and antifungals -- estimates from the WHO show that AMR may cause 10 million deaths every year by 2050, send 24 million people into extreme poverty by 2030, and lead to a financial crisis as severe as the on the U.S. experienced in 2008. Antimicrobial resistance develops when germs like bacteria and fungi are able to “defeat the drugs designed to kill them,” according to the Centers for Disease Control and Prevention. Through a biologic “survival of the fittest,” germs that are not killed by antimicrobials and continue to grow. WHO explains that “poor infection control, inadequate sanitary conditions and inappropriate food handling encourage the spread” of AMR, which can lead to “superbugs.” Those superbugs require powerful and oftentimes more expensive antimicrobials to treat. Examples of superbugs are far and wide, and can range from drug-resistant bacteria like Pseudomonas aeruginosa and Staphylococcus aureus to fungi like Candida. These bugs can cause illnesses that range from pneumonia to urinary tract and sexually transmitted infections. According to the WHO, AMR has caused complications for nearly 500,000 people with tuberculosis, and a number of people with HIV and malaria. The people at the [highest risk for AMR](https://www.who.int/news-room/detail/27-02-2017-who-publishes-list-of-bacteria-for-which-new-antibiotics-are-urgently-needed) are those with chronic diseases, people living in nursing homes, hospitalized in the ICU or undergoing life-saving treatments such as organ transplantation and cancer therapy. These people often develop infections, which can become antimicrobial-resistant, rendering them difficult, if not impossible, to treat. [(MORE: Melissa Rivers talks about her father's suicide with Dr. Jennifer Ashton)](https://abcnews.go.com/Health/melissa-rivers-talks-fathers-suicide-dr-jennifer-ashton/story?id=62733179&cid=clicksource_26_null_headlines_hed) The CDC notes that “antibiotic resistance has the potential to affect people at any stage of life,” including the “healthcare, veterinary, and agriculture industries, making it one of the world’s most urgent public health problems." AMR can cause prolonged hospital stays, billions of dollars in healthcare costs, disability, and potentially, death. “The most important thing is to understand and embrace the interconnectedness of all of this,” said Dr. Robert Redfield, director of the CDC, in a recent interview with ABC News’ Dr. Jennifer Ashton. It’s not just our countries that are connected.” Research has shown that superbugs like Candida auris “came from multiple places, at the same time. It wasn’t just one organism that [evolved]” in a single location, Redfield added. Given longstanding concerns about antimicrobial misuse leading to AMR, physicians have embraced a medical approach called antibiotic stewardship. This encourages physicians to carefully evaluate which antibiotic is most appropriate for their patient, and discontinue it once it is no longer medically needed. WHO has also highlighted that the inappropriate use of antimicrobials in agriculture -- such as on farms and in animals -- may be an underappreciated cause of AMR. Noting these trends, the WHO has urged for “coordinated action...to minimize the emergence and spread of antimicrobial resistance.” It urges all countries to make national action plans, with a focus on the development of new antimicrobial medications, vaccines, and careful antimicrobial use. Redfield emphasized the importance of vaccination during the global superbug crisis, stating that “the only way we have to eliminate an infection is vaccination.” He added that investing in innovation is key to solving the crisis. While WHO continues to advocate for superbug awareness, they warn that AMR has reversed “a century of progress in health.” The WHO added that “the challenges of antimicrobial resistance” are “not insurmountable,” and that coordinated action will “help to save millions of lives, preserve antimicrobials for generations to come and secure the future from drug-resistant diseases.”

#### Extinction - generic defense doesn’t apply.

Srivatsa 17 Kadiyali Srivatsa 1-12-2017 “Superbug Pandemics and How to Prevent Them” <https://www.the-american-interest.com/2017/01/12/superbug-pandemics-and-how-to-prevent-them/> (doctor, inventor, and publisher. He worked in acute and intensive pediatric care in British hospitals)//Elmer

It is by now no secret that the human species is locked in a race of its own making with “**superbugs**.” Indeed, if popular science fiction is a measure of awareness, the theme has pervaded English-language literature from Michael Crichton’s 1969 Andromeda Strain all the way to Emily St. John Mandel’s 2014 Station Eleven and beyond. By a combination of massive inadvertence and what can only be called stupidity, we must now invent new and effective antibiotics faster than deadly bacteria evolve—and regrettably, they are rapidly doing so with our help. I do not exclude the possibility that bad actors might deliberately engineer deadly superbugs.1 But even if that does not happen, humanity faces an existential threat largely of its own making in the absence of malign intentions. As threats go, this one is entirely predictable. The concept of a “black swan,” Nassim Nicholas Taleb’s term for low-probability but high-impact events, has become widely known in recent years. Taleb did not invent the concept; he only gave it a catchy name to help mainly business executives who know little of statistics or probability. Many have embraced the “black swan” label the way children embrace holiday gifts, which are often bobbles of little value, except to them. But the threat of inadvertent pandemics is not a “black swan” because its probability is not low. If one likes catchy labels, it better fits the term “gray rhino,” which, explains Michele Wucker, is a high-probability, high-impact event that people manage to ignore anyway for a raft of social-psychological reasons.2 A pandemic is a quintessential gray rhino, for it is no longer a matter of if but of when it will challenge us—and of how prepared we are to deal with it when it happens. We have certainly been warned. The curse we have created was understood as a possibility from the very outset, when seventy years ago Sir Alexander Fleming, the discoverer of penicillin, predicted antibiotic resistance. When interviewed for a 2015 article, “The Most Predictable Disaster in the History of the Human Race, ” Bill Gates pointed out that one of the costliest disasters of the 20th century, worse even than World War I, was the Spanish Flu pandemic of 1918-19. As the author of the article, Ezra Klein, put it: “No one can say we weren’t warned. And warned. And warned. A pandemic disease is the most predictable catastrophe in the history of the human race, if only because it has happened to the human race so many, many times before.”3 Even with effective new medicines, if we can devise them, we must contain outbreaks of bacterial disease fast, lest they get out of control. In other words, we have a social-organizational challenge before us as well as a strictly medical one. That means getting sufficient amounts of medicine into the right hands and in the right places, but it also means educating people and enabling them to communicate with each other to prevent any outbreak from spreading widely. Responsible governments and cooperative organizations have options in that regard, but even individuals can contribute something. To that end, as a medical doctor I have created a computer app that promises to be useful in that regard—of which more in a moment. But first let us review the situation, for while it has become well known to many people, there is a general resistance to acknowledging the severity and imminence of the danger. What Are the Problems? Bacteria are among the oldest living things on the planet. They are masters of survival and can be found everywhere. Billions of them live on and in every one of us, many of them helping our bodies to run smoothly and stay healthy. Most bacteria that are not helpful to us are at least harmless, but some are not. They invade our cells, spread quickly, and cause havoc that we refer to generically as disease. Millions of people used to die every year as a result of bacterial infections, until we developed antibiotics. These wonder drugs revolutionized medicine, but one can have too much of a good thing. Doctors have used antibiotics recklessly, prescribing them for just about everything, and in the process helped to create strains of bacteria that are resistant to the medicines we have. We even give antibiotics to cattle that are not sick and use them to fatten chickens. Companies large and small still mindlessly market antimicrobial products for hands and home, claiming that they kill bacteria and viruses. They do more harm than good because the low concentrations of antimicrobials that these products contain tend to kill friendly bacteria (not viruses at all), and so clear the way for the mass multiplication of surviving unfriendly bacteria. Perhaps even worse, hospitals have deployed antimicrobial products on an industrial scale for a long time now, the result being a sharp rise in iatrogenic bacterial illnesses. Overuse of antibiotics and commercial products containing them has helped superbugs to evolve. We now increasingly face microorganisms that cannot be killed by antibiotics, antifungals, antivirals, or any other chemical weapon we throw at them. Pandemics are the major risk we run as a result, but it is not the only one. Overuse of antibiotics by doctors, homemakers, and hospital managers could mean that, in the not-too-distant future, something as simple as a minor cut could again become life-threatening if it becomes infected. Few non-medical professionals are aware that antibiotics are the foundation on which nearly all of modern medicine rests. Cancer therapy, organ transplants, surgeries minor and major, and even childbirth all rely on antibiotics to prevent infections. If infections become untreatable we stand to lose most of the medical advances we have made over the past fifty years. And the problem is already here. In the summer of 2011, a 43-year-old woman with complications from a lung transplant was transferred from a New York City hospital to the Clinical Center at the National Institutes of Health (NIH), in Bethesda, Maryland. She had a highly resistant superbug known as Klebsiella pneumoniae carbapenemase (KPC). The patient was treated and eventually discharged after doctors concluded that they had contained the infection. A few weeks later, a 34-year-old man with a tumor and no known link to the woman contracted KPC while at the hospital. During the course of the next few months, several more NIH patients presented with KPC. Doctors attacked the outbreak with combinations of antibiotics, including a supposedly powerful experimental drug. A separate intensive care unit for KPC patients was set up and robots disinfected empty rooms, but the infection still spread beyond the intensive care area. Several patients died and then suddenly all was silent on the KPC front, with doctors convinced they had seen the last of the dangerous bacterium. They couldn’t have been more mistaken. A year later, a young man with complications from a bone marrow transplant arrived at NIH. He became infected with KPC and died. This superbug is now present in hospitals in most, if not all U.S. states. This is not good. This past year an outbreak of CRE (carbapenem-resistant enterobacteriaceae) linked to contaminated medical equipment infected 11 patients and killed two in Los Angeles area hospitals. This family of bacteria has evolved resistance to all antibiotics, including the powerful carbapenem antibiotics that are often used as a last resort against serious infections. They are now so resilient that it is virtually impossible to remove them from medical tools such as catheters and breathing tubes placed into the body, even after cleaning. Then we have gonorrhea, chlamydia, and other sexually transmitted diseases that we cannot treat and that are spreading all over the world. Anyone who has sex can catch these infections, and because most people may not exhibit any symptoms they spread infections without anyone knowing about it. Sexually transmitted diseases used to be treatable with antibiotics, but in recent years we have witnessed the rise of multi-drug resistant STDs. Untreated gonorrhea can lead to infertility in men and women and blindness and other congenital defect in babies. As is well known, too, we have witnessed many cases of drug-resistant pneumonia. These problems have arisen in part because of simple mistakes healthcare professionals repeatedly make. Let me explain. Neither superbugs nor common bacterial infections produce any special symptoms indicative of their cause. Rashes, fevers, sneezing, runny noses, ear pain, diarrhea, vomiting, coughing, fatigue, and weakness are signs of common and minor illnesses as well as uncommonly deadly ones. Therefore, the major problem for clinicians is to identify a common symptom that may potentially be an early sign of a major infection that could result in an epidemic. We know that dangerous infections in any given geographical area do not start at the same time. They start with one victim and gradually spread. But that victim is only one among hundreds of patients a doctor will typically see, so many doctors will miss patients presenting with infections that are serious. They will probably identify diseases that kill fast, but slow-spreading infections such as skin infections that can lead to septicemia are rarely diagnosed early. In addition, I have seen doctors treating eczema with antibiotic cream, even though they know that bacteria are resistant to the majority of these drugs. This sort of action encourages simple infections to spread locally, because patients are therefore not instructed to take other, more useful precautions. On top of that, some people are frivolous about infections and assume doctors are exaggerating the threat. And some people are selfish. Once I was called to see a passenger during a flight who had symptoms consistent with infection. He boarded the plane with these symptoms, but began to feel much worse during the flight. I was scared, knowing how infections such as Ebola can spread. This made me think about a way to screen passengers before they board a flight. Airlines could refund a traveler’s ticket, or issue a replacement, in case of sickness—which is not the policy now. We currently have no method to block infectious travelers from boarding flights, and there are no changes in the incentive system to enable conscientious passengers to avoid losing their money if they responsibly miss a flight because of illness. Speaking of selfishness, I once saw a mother drop her daughter off at school with a serious bout of impetigo on her face. When I asked her why she had brought her daughter to school with a contagious infection, she said she could not spare the time to keep her at home or take her to the doctor. By allowing this child to contact other children, a simple infection can become a major threat. Fortunately, I could see the rash on the girl’s face, but other kids in schools may have rashes we cannot see. Incorrect diagnosis of skin problems and mistaken use of antibiotics to treat them is common all over the world, and so we are continually creating superbugs in our communities. Similarly, chest infections, sore throats, and illnesses diagnosed as colds that unnecessarily treated with antibiotics are also a major threat. By prescribing antibiotics for viral infections, we are not only helping bacteria develop resistance, but we are also polluting the environment when these drugs are passed in urine and feces. All of this helps resistant bacteria to spread in the community and become an epidemic. Ebola is very difficult to transmit because people who are contagious have visible and unusual symptoms. However, the emerging infections and pandemics of the future may not have visible symptoms, and they could break out in highly populous countries such as India and China that send thousands of travelers all over the world every day. When a person is infected with a contagious disease, he or she can expect to pass the illness on to an average of two people. This is called the “reproduction number.” Two is not that high a number as these things go; some diseases have far greater rates of infection. The SARS virus had a reproduction number of four. Measles has a reproduction number of 18. One person traveling as an airplane passenger and carrying an infection similar to Ebola can infect three to five people sitting nearby, ten if he or she walks to the toilet. The study that highlighted this was published in a medical journal a few years ago, but the airline industry has not implemented any changes or introduced screening to prevent the spread of infections by air travel passengers, a major vehicle for the rapid spread of disease. It is scary to think that nobody knows what will happen when the world faces a lethal disease we’re not used to, perhaps with a reproduction number of five or eight or even ten. What if it starts in a megacity? What if, unlike Ebola, it’s contagious before patients show obvious symptoms? Past experience isn’t comforting. In 2009, H1N1 flu spread around the world before we even knew it existed. The Questions Remains Why do seemingly intelligent people repeatedly do such collectively stupid things? How did we allow this to happen? The answer is disarmingly simple. It is because people are incentivized to prioritize short-term benefits over long-term considerations. It is what social scientists have called a “logic of collective action” problem. Everyone has his or her specialized niche interest: doctors their patients’ approval, business and airline executives their shareholders’ earnings, hospitals their reputations for best-practice hygienics, homemakers their obligation to keep their own families from illness. But no one owns the longer-term consequences for hundreds of millions of people who are irrelevant to satisfying these short-term concerns. Here is an example. At a recent Superbug Super Drug conference in London that I attended, scientists, health agencies, and pharmaceutical companies were vastly more concerned with investing millions of dollars in efforts to invent another antibiotic, claiming that this has to be the way forward. Money was the most pressing issue because, as everyone at the conference knew, for many years pharmaceutical companies have been pulling back from antibiotics research because they can’t see a profit in it. Development costs run into billions of dollars, yet there is no guarantee that any new drug will successfully fight infections. At the same conference Dr. Lloyd Czaplewski spoke about alternatives to antibiotics, in case we cannot come up with new ones fast enough to outrun superbug evolution. But he omitted mention of preventive strategies that use the internet or communication software to help reduce the spread of infections among families, communities, and countries. It is madness that we don’t have a concrete second-best alternative to new antibiotics, because we need them and we need them quickly. Of course, this is why we have governments, which have been known occasionally in the past as commonwealths. Governments are supposed to look out for the wider, common interests of society that niche-interested professionals take no responsibility for, and that includes public health. It is why nearly every nation’s government has an official who is analogous to the U.S. Surgeon General, and nearly every one has a public health service of some kind. Alas, national governments do not always function as they should. Several years ago physician and former Republican Senator Bill Frist submitted a proposal to the Senate for a U.S. Medical Expeditionary Corps. This would have been a specialized organization that could coordinate and execute rapid responses to global health emergencies such as Ebola. Nothing came of it, because Dr. Frist’s fellow politicians were either too shortsighted or too dimwitted to understand why it was a good idea. Or perhaps they simply realized that they could not benefit politically from supporting it. Plenty of mistakes continue to be made. In 2015, a particularly infectious form of bird flu ripped through 14 U.S. states, leading farmers to preventively slaughter nearly 40 million birds. The result of such callous and unnecessary acts is that, instead of exhausting themselves in the host population of birds, the viruses quickly find alternative hosts in which to survive, and could therefore easily mutate into a form that can infect humans. Earlier, during the 1980s, AIDS garnered more public attention because a handful of rich and famous people were infected, and because the campaign to eradicate it dovetailed with and boosted the political campaign on behalf of homosexual rights. Methicillin resistant Staphylococcus aureus (MRSA) in hospitals, by far the bigger threat at the time, was virtually ignored. Some doctors knew that MRSA would bring us to our knees and kill millions of people worldwide, but pharmaceutical companies and device and equipment manufacturers ignored these doctors and the thousands of patients dying in hospitals as a result of MRSA. They prioritized the wrong thing, and government did not correct the error. And that is partly how antibiotic-resistant infection went from an obscure hospital problem to an incipient global pandemic. Politics well outside the United States plays several other roles in the budding problem that we are confronting. Countries often will not admit they have a problem and request help because of the possible financial implications in terms of investment and travel. Guinea did not declare the Ebola epidemic early on and Chinese leaders, worried about trade and tourism, lied for months in 2002 about the presence of the SARS virus. In 2004, when avian influenza first surfaced in Thailand, officials there displayed a similar reluctance to release information. Hospitals in some countries, including India, are managed and often owned by doctors. They refuse to share information about existing infections and often categorically deny they have a problem. Reporting infections to public health authorities is not mandatory, and so hospitals that fail to say anything are not penalized. Even now, the WHO and the CDC do not have accurate and up-to-date information about the spread of E. coli or other infections, and part of the reason is that for-profit hospitals are reluctant to do anything to diminish their bottom line. Syria and Yemen are among those countries that are so weak and fragmented that they cannot effectively coordinate public healthcare. But their governments are also hostile to external organizations that offer relief. Part of the reason is xenophobia, but part is that this makes the government look bad. Relatedly, most poor-nation governments do not trust the efficacy of international institutions, and think that cooperating with them amounts to a re-importation of imperialism. They would rather their own people suffer and die than ask for needed help. That brings us to the level of international public health governance. Alas, sometimes poor-country governments estimate the efficacy of international institutions accurately. The WHO’s Ebola response in 2014-15 was a disaster. The organization was slow to declare a public health emergency even after public warnings from Médecins Sans Frontières, some of whose doctors had already died on the front line. The outbreak killed more than 28,000 people, far more than would have been the case had it been quickly identified. This isn’t just an issue of bureaucratic incompetence. The **WHO is under-resourced for the problems it is meant to solve. Funding comes from voluntary donations, and there is no mechanism by which it can quickly scale up its efforts during an emergency. The result is that its response to the next major disease outbreak is likely to be as inadequate as were its responses to Ebola, H1N1, and SARS**. Stakeholders admit that we need another mechanism, and most experts agree that the world needs some kind of emergency response team for dangerous diseases. But no one knows how to set one up amid the dysfunctional global governance structures that presently exist. Maybe they should turn to Bill Frist, whose basic concept was sound; if the U.S. government will not act, perhaps some other governments will, and use the UN system to do so. But as things stand, we lack a health equivalent of the military reserve. Neither government leaders nor doctors can mobilize a team of experts to contain infections. People who want to volunteer, whether for government or NGO efforts, are not paid and the rules, if any, are sketchy about what we do with them when they return from a mission. Are employers going to take them back? What are the quarantine rules? It is all completely ad hoc, meaning that humanity lacks the tools it needs to protect itself. And note, by the way, the contrast between how governments prepare for facing pandemics and how they prepare for making war. War is not more deadly to the human race than pandemics, but national defense against armed aggression is much better planned for than defense against threats to public health. There is a wealth of rules regarding it, too. Human beings study and plan for war, which kills people both deliberately and accidentally, but they do not invest comparable effort planning for pandemics, which are liable to kill orders of magnitude more people. To the mind of a medical doctor, this is strange. Creating Conditions for Infections to Spread Superbug infections spread for several interlocking reasons. Some are medical-epidemiological. Most of the infections of the past thirty years have started in one place and in one family. As already noted, they spread because many infectious diseases are highly contagious before the onset of symptoms, and because it is difficult to prevent patients who know they are sick from going to hospitals, work, and school, or from traveling further afield. But again, one reason for the problem is political, not medical. Many governments have no strategies in place to prevent pandemics because they are unwilling to tell their people how infections spread. They don’t want to worry people with such talk; it will make them, they fear, unpopular. So governments may have mountains of bureaucracy with great heaps of rules and regulations concerning public health, but they are generally unwilling to trust their own citizens to use common sense on their own behalf. This, too, seems very strange. Until now, no one has come forward to help us develop strategies to educate people how to identify and prevent the spread of infection to their families and communities. The majority of stakeholders have also been oblivious to the use of new technologies to help reduce the spread of these infections. There are some exceptions. In a fun blog post called Preparedness 101: Zombie Apocalypse, the CDC uses the threat of a zombie outbreak as a metaphor to encourage people to prepare for emergencies, including pandemics. It is well meaning and insightful, yet when my colleagues and I try to discuss ways of scaling up the CDC’s example with doctors and nurses, they shut down. Nobody plans for an actual crisis partly because it is too scary and hence paralyzing to think about. But it is also because it is not most health professionals’ job; it is not what they are trained and paid to do. It is always someone else’s job, except that it has turned out to be nobody’s job. Worse, the situation is not static. While we sit paralyzed, superbugs are evolving. Epidemiological models now predict how an algorithmic process of disease spread will move through the modern world. All urban centers around the entire globe can become infected within sixty days because we move around and cross borders much more than our ancestors did, thanks to air travel. A new pandemic could start crossing borders before we even know it exists. A flu-like disease could kill more than 33 million people in 250 days.3

### 1AC: 2 Drug Prices

#### Evergreening keeps Drug Prices high.

Amin 18 Tahir Amin 6-27-2018 "The problem with high drug prices isn't 'foreign freeloading,' it's the patent system" [High drug prices caused by US patent system, not 'foreign freeloaders' (cnbc.com)](https://www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html) <https://www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html> (co-founder of nonprofit I-MAK.org)//Elmer

**'Evergreening'** Instead of going to new medicines, the study finds that 74 percent of new patents during the decade went to drugs that already existed. It found that 80 percent of the nearly 100 best-selling drugs extended their exclusivity protections at least once, and 50 percent extended their patents more than once—with the effect of **prolonging** the **time before generics** could reach the market **as drug prices continued to rise**. The strategy is called “evergreening”: drug makers add on new patents to prolong a drug’s exclusivity, even when the additions aren’t fundamentally new, non-obvious, and useful as the law requires. One of the most expensive cancer drugs on the market, **Revlimid**®, is a case in point: **priced at** over $**125,000** per year of treatment, Celgene has sought **105 patents** on Revlimid®, many of which have been granted, extending its monopoly until the end of 2036. That gives the Revlimid® patent portfolio a lifespan of 40 years, which is being used to block or deter generic competitors from entering the market. But a recent I-MAK analysis finds that several of Celgene’s patents are mere add-ons—not fundamentally new to deserve a patent. And because of the thicket of patents around Revlimid®, **payers** are **projected to spend $45 billion** **in excess costs** on that drug alone as compared to what they could be paying if generic competitors were to enter when the first patent expires in 2019. Meanwhile, Celgene is also among the pharmaceuticals that have been recently scolded by the FDA for refusing to share samples with generic makers so they can test their own products against the brands in order to attain FDA approval. **In the absence of** genuine **competition** in the U.S. prescription drug market, **monopolies are yielding reckless pricing schemes and prohibitively expensive drugs** for Americans (and people around the world) who need them. In 2015, for example, U.S. Senators Wyden and Grassley found after an 18-month bipartisan investigation that the notorious $84,000 price tag for the hepatitis C drug made by Gilead was based on “a pricing and marketing strategy designed to maximize revenue with little concern for access or affordability.” Gilead’s subsequent hepatitis C drug Harvoni® was introduced to the market at a still higher cost of $94,500. Who benefits when drugs are priced so high? Not the 85 percent of Americans with hepatitis C who are still not able to afford treatment.

#### High Drug Prices forces patients to go underground for drugs.

* AT Medicare CP – won’t cover Drugs – CP can’t fiat coverage

Bryant 11 Clifton Bryant 2011 “The Routledge Handbook of Deviant Behaviour” (former professor of sociology at VA Tech)//Elmer

Now, the field of medicine is able to achieve seemingly miraculous results, through organ transplantation, reviving patients who have been "clinically" dead, and curing supposedly "incurable diseases." Medical miracles are not cheap, however, and **the costs of** medical care and **drugs** have risen (and **continue to rise**) at a near-astronomical rate. Consequently, **neither** **private** medical insurance plans **nor Medicare** **will** now **cover certain** procedures, treatments, and **medicines**. In the future, with continuing reform of the US healthcare system, even fewer procedures, treatments, and medications might will be covered. Certainly, some medical treatment will be "rationed," and particular categories of people (such as the elderly) may be systematically denied the coverage they need. As a result of all this, **medical**- and health-related **crime** and deviance **will inevitably rise**. Medical insurance, Medicare, and Medicaid fraud, which is already prevalent today, will increase exponentially. Smugglers will "bootleg" ever more pharmaceuticals into the US, and a large, thriving, nationwide black market will develop **for those who cannot afford to buy uncovered medications**. More medicines and diagnostic equipment will be stolen, and back- street medical procedures using such stolen equipment may well be offered for cash with no questions asked. Armed robberies of valuable pharmaceuticals from drug stores and super- markets will increase, too. Bribery to obtain insurance-uncovered or rationed medical care (or, indeed, any kind of medical care where demand exceeds supply) will likely mushroom. This is actually common in some countries around the world. **Counterfeiting** expensive pharmaceuticals **will be prevalent**, and medical frauds of all kinds will be very widespread. Many of these frauds will be directed at the elderly population as it continues to increase in size. The elderly will be particularly vulnerable because they are most likely to be denied coverage for certain medical procedures or treatments. For instance, private health insurance and Medicare will both refuse to cover a woman in her mid-80s for potentially life-saving heart-bypass surgery. As a result, she will be a prime candidate for victimization by medical fraud that offers her affordable, but bogus, treatment. There is already a thriving international black market in human organs (Schepper-Hughes 2009). Kidneys are obtained from poor individuals in impoverished countries for relatively modest sums of money. This cash allows the donors to purchase luxuries, such as a small automobile, educate their children, or simply sustain their families for a few months. The organs are sometimes transferred quickly to a hospital in the donor's own country for transplant surgery. But on other occasions they are transported to the US or another Western country. In the US, obtaining an organ for transplantation in this fashion is illegal. Nevertheless, the practice will undoubtedly increase greatly in the future. Where medical care and medicines become exorbitantly expensive, cheaper ways to obtain them, even when these are illicit, will be sought. Where there are shortages of medical care or medicines, perhaps because of rationing, other means of obtaining them, even if deviant, will surely be employed. As the cost and the difficulty of obtaining medical care and medicines increase, the implications for increased crime and deviance become almost limitless.

#### That kills Millions.

Greenberger 20 Phyllis E. Greenberger 12-3-2020 "Counterfeit Medicines Kill People" <https://www.healthywomen.org/health-care-policy/counterfeit-medicines-kill-people/who-suffers-because-of-counterfeit-drugs> (HealthWomen’s Senior Vice President of Science & Health Policy)//Elmer

**Over 1 million people die each year from fake drugs**. COVID-19 Have you ever had a hard time getting a prescription filled? Or maybe you've had to wrestle with your insurance provider to get them to pay for a medication vital for your health? Worse, maybe you're one of the 27.5 million uninsured Americans who find it difficult to get health care, let alone obtain the prescription drugs you may need. If you've had any of these experiences, then perhaps you've turned to the internet to buy medications that would require a prescription. While legal online pharmacies do exist, many online pharmacies are fraudulent, selling counterfeit medications, and millions of people have fallen victim to these scammers. Make no mistake: **Counterfeit medicine is not real**. The **active ingredients** that help you stay healthy may be **missing** **or diluted** to levels that are no longer potent. This **can be dangerous and even life-threatening**, as people rely on their medications to keep them well, and sometimes even alive. Many counterfeit medicines aren't even drugs at all, but rather **snake oil cures that make people sick** — they may even **contain** **dangerous ingredients such as heavy metals, highway paint or even rat poison.** The World Health Organization (WHO) estimates that over 1 million people die each year from these substandard drugs. It's estimated that more than 10% of all pharmaceuticals in the global supply chain are counterfeit in normal times, and during COVID-19, the increased use of telehealth and the appearance of fraudulent doctors has led to a surge in drug fraud. In October of this year, Peter Pitts, president of the Center for Medicine in the Public Interest, a nonpartisan research organization, said pharmaceutical fakery was a "spreading cancer." Counterfeiting is a major problem that requires the federal government to step up to slow — and eventually prevent — its spread. It's also vital that consumers know exactly what's at stake when taking these fake drugs. Who suffers because of counterfeit drugs? Expensive prescription medications and generic drugs in nearly every therapeutic class may be counterfeited. Out of $4.3 billion worth of counterfeit medications seized between 2014 and 2016, 35% were marked as antibiotics. Some of the other most common culprits in counterfeit medicine are used to "treat" HIV/AIDS, erectile dysfunction and weight loss. No matter what condition or disease the counterfeit medication is intending to treat, the outcome can be disastrous. **Counterfeit medications exacerbate other existing health crises**. The United States, for example, is in the midst of an opioid epidemic that is killing 130 people per day. As of 2018, counterfeit drugs containing illegally imported fentanyl (a powerful opioid) had contributed to this tragedy by causing deaths in 26 states. The U.S. Department of Justice found that, in at least one case, these counterfeit drugs had been sold through a fraudulent online pharmacy.

#### Counterfeit Drugs cause Anti-Biotic Resistance.

Jahnke 19 Art Jahnke 1-14-2019 "How Bad Drugs Turn Treatable Diseases Deadly" <https://www.bu.edu/articles/2019/how-bad-drugs-turn-treatable-diseases-deadly/> (Senior editor Art Jahnke began his career at the Real Paper, a Boston area alternative weekly. He has worked as a writer and editor at Boston Magazine, web editorial director at CXO Media, and executive editor in Marketing & Communications at Boston University, where his work was honored with many awards. Art has served on the editorial board of the Boston Review and has taught at Harvard University summer school and Emerson College.)//Elmer

Four decades later as a Boston University professor of biomedical engineering and materials science and engineering, Zaman was reminded of the dangers of low-quality drugs in his native country when he learned that **more than 200 people in the city of Lahore died after being treated with an adulterated version of a hypertension drug.** That event, in 2012, altered the course of Zaman’s research. Now, he focuses on the global problem of “**substandard drugs**,” poorly made medicines containing ingredients that are either ineffective or toxic. His most recent discovery has startling implications for our understanding of drug resistance: a low-quality version of rifampin, a broad spectrum antibiotic typically used as the first line of defense to treat tuberculosis, **can** greatly **contribute to the development of drug-resistant infections**. The findings, published in Antimicrobial Agents and Chemotherapy, are particularly pressing because **drug-resistant TB** is **an increasing** **problem worldwide**. Of the **10 million new cases** of tuberculosis in 2016, about 600,000 were rifampin resistant, requiring second-line treatments which come with increased toxicity. “**There had not been a definitive study** showing that lack of [antibiotic] quality leads to resistance,” says Zaman, who is also a Howard Hughes Medical Institute Professor of Biomedical Engineering and International Health. “**Now we are sure that it does**, and it does with TB, **a** global **problem that has become stubbornly hard to resolve**.” “We had always thought of this a scientific issue, but now it is also an ethical issue.”Muhammad Zaman Zaman says substandard drugs, as well as drugs that are **deliberate counterfeits**, are all too common in developing nations. A recent survey by the World Health Organization found that in low- and middle-income countries, **one in ten medicines is substandard or falsified**. One contributing factor could be that government enforcement of safe manufacturing practices is feeble or nonexistent. In Pakistan, for example, a country of nearly 200 million people, only a handful of federal inspectors monitor the quality of drug manufacturing.

#### High Drug Prices pushes people into poverty – our internal is causal.

Hoban 10 Rose Hoban 9-13-2010 "High Cost of Medicine Pushes More People into Poverty" <https://www.voanews.com/science-health/high-cost-medicine-pushes-more-people-poverty> (spent more than six years as the health reporter for North Carolina Public Radio – WUNC, where she covered health care, state health policy, science and research with a focus on public health issues. She left to start North Carolina Health News after watching many of her professional peers leave or be laid off of their jobs, leaving NC with few people to cover this complicated and important topic. ALSO cites Laurens Niens who is a Health Researcher at Erasmus University Rotterdam)//Elmer

Health economist Laurens Niëns found that drugs needed to treat chronic diseases could be considered unaffordable **for many people in poor countries**. Medicines can be expensive and often make up a large portion of any family's health care budget. And the burden can be even greater for people in poor countries, where the **cost of vital medicines can push them into poverty**. The problem is growing as more people around the world are diagnosed with chronic diseases such as high blood pressure and diabetes. Being diagnosed with a chronic disease usually compells patients to seek treatment for a prolonged period of time. That increases the eventual price tag for health, says health economist Laurens Niëns at Erasmus University in the Netherlands. Niëns examined medication pricing data from the World Health Organization and also looked at data from the World Bank on household income in many countries. Using the data, he calculated how much people need to spend on necessities such as food, housing, education and medicines. "The medicines we looked at are medicines for patients who suffer from asthma, diabetes, hypertension and we looked at an adult respiratory infection," Niëns says. "Three conditions are for chronic diseases, which basically means that people need to procure those medicines each and every day." Niëns focused on the cost of medicine for those conditions. He found the essential drugs could be considered unaffordable for many people in poor countries - so much so that their cost often pushes people into abject poverty. "The proportion of the population that is living below the poverty line, plus the people that are being pushed below the poverty line, can **reach up to 80 percent** in some countries for some medicines," Niëns says. He points out that generic medicines - which are more affordable than brand-name medications - are often **not available in the marketplace**. And, according to Niëns, poor government policies can drive up the cost of medications. "For instance, a lot of governments actually tax medicines when they come into the country," he says. "[They] have no standard for the markups on medicines through the distribution chain. So often, governments think they pay a good price for the medicines when they procure them from the producer. However, before such a medicine reaches a patient, markups are sometimes up to 1,000 percent."

#### This is a form of pharmaceutical capitalism – exploiting marginalized groups in the third world.

Lift Mode 17 3-10-2017 "Pharmaceutical Colonialism” <https://medium.com/@liftmode/pharmaceutical-colonialism-3-ways-that-western-medicine-takes-from-indigenous-communities-3a9339b4f24f> (We at Liftmode.com are a team of professionals from a variety of backgrounds, dedicated to the mission of providing the highest quality and highest purity nutritional health supplements on the market. We look specifically for the latest and most promising research in the fields of cognition enhancement, neuroscience and alternative health supplements, and develop commercial strategies to bring these technologies to the marketplace.)//Elmer

3. **Cost of medicine as a form of debt** **One of the biggest methods of extracting money from rural and indigenous communities is through increased costs of medication**. Pharmaceutical colonialism often uses the premise of providing cheap medication for the world’s neediest to acquire local knowledge and natural resources. This premise is pushed into society through advertising campaigns and processes like lobbying. However, those who benefit most are often the shareholders, and not the people who need help. An example was the 2009 Reuters report which found that nearly **a million people** were **dying from malaria** dying every year **due to overly expensive medication**. According to the report, Artemisinin combination therapies (ACTs) can cost up to 65 times the daily minimum wage in countries that are most affected by malaria. These high prices **come after the government subsidies** which push them down as low as possible.[19] Another famous and recent example was the businessman Martin Shkreli, who pushed the cost of an AIDS drug up from $13.50 to over $700 per pill. This created an outrage on social media and it highlighted the underlying mindset behind most pharmaceutical companies — profit above all. An interesting and disturbing source of information about this is the film Fire in the Blood, which documents how **western pharmaceutical companies** **blocked the sale of cheap antiretroviral drugs to AIDS patients** **in Sub-Saharan Africa**.[20] “There is indeed a sense in which all modern **medicine** is **engaged in a colonizing process**… It can be seen in **the** increasing **professionalization of medicine and the exclusion of ‘folk’ practitioners**, in the close and often symbiotic relationship between medicine and the modern state, in the far-reaching claims made by medical science for its ability to prevent, control, and even eradicate human diseases.”[21] — D Arnold, Colonizing the Body, 1993 Pharmaceutical companies have been responsible for saving millions of lives due to their advances in medicine. However, the number of lives that have been lost due to the lack of affordability of medicine and the lack of equity and sharing of profits is estimated to be extremely high. **Western capitalism** has the **potential to act as a new form of colonialism**, and the modern medical method is one great way to extend the branches of capitalism into developing countries. The slums in Brazil highlight the blatant inequality between nations and people.

#### The Alternative to the Aff isn’t no medicine but exploitive medicine – the Plan’s orientation is a sequencing strategy to resistance.

Ahmed 20 A Kavum Ahmed 6-24-2020 "Decolonizing the vaccine" <https://africasacountry.com/2020/06/decolonizing-the-vaccine> (A. Kayum Ahmed is Division Director for Access and Accountability at the Open Society Public Health Program in New York and teaches at Columbia University Law School.)//Duong+Elmer

Reflecting on a potential COVID-19 vaccine trial during a television interview in April, a French doctor stated, “If I can be provocative, shouldn’t we be doing this study in Africa, where there are no masks, no treatments, no resuscitation?” These remarks reflect a colonial view of Africa, reinforcing the idea that Africans are non-humans whose black bodies can be experimented on. This colonial perspective is also clearly articulated in the alliance between France, The Netherlands, Germany and Italy to negotiate priority access to the COVID-19 vaccine for themselves and the rest of Europe. In the Dutch government’s announcement of the European vaccine coalition, they indicate that, “… the alliance is also working to make a portion of vaccines available to low-income countries, including in Africa.” In the collective imagination of these European nations, Africa is portrayed as a site of redemption—a place where you can absolve yourself from the sins of “vaccine sovereignty,” by offering a “portion of the vaccines” to the continent. Vaccine sovereignty reflects how European and American governments use public funding, supported by the pharmaceutical industry and research universities, to obtain priority access to potential COVID-19 vaccines. The concept symbolizes the COVID-19 **vaccine** (when it eventually becomes available) as **an instrument of power deployed to exercise control** **over who will live and who must die**. In order to counter vaccine sovereignty, we must decolonize the vaccine. Africans have a particular role to play in leading this decolonization process as subjects of colonialism and as objects of domination through coloniality. Colonialism, as an expansion of territorial dominance, and coloniality, as the continued expression of Western imperialism after colonization, play out in the vaccine development space, most notably on the African continent. So what does decolonizing the vaccine look like? And how do we decolonize something that does not yet exist? For Frantz Fanon, “**Decolonization**, which sets out to change the order of the world, **is**, obviously, a program of **complete disorder**.” Acknowledging that the COVID-19 **vaccine has been weaponized** **as an instrument of power** by wealthy nations, **decolonization** **requires** a Fanonian program of **radical re-ordering.** In the context of vaccine sovereignty, this re-ordering **necessitates** the **dismantling** of the **profit-driven biomedical system**. This program starts with **de-linking from** **Euro-American constructions of knowledge and power** that reinforce vaccine sovereignty through the profit-driven biomedical system. Advocacy campaigns such as the “People’s Vaccine”, which calls for guaranteed free access to COVID-19 vaccines, diagnostics and treatments to everyone, everywhere, are a good start. Other mechanisms, such as the World Health Organization’s COVID-19 Technology Access Pool, similarly supports universal access to COVID-19 health technologies as global public goods. Since less than 1% of vaccines consumed in Africa are manufactured on the continent, regional efforts to develop vaccine manufacturing capacity such as those led by the Africa Center for Disease Control and Prevention, as well as the Alliance of African Research Universities, must be supported. These efforts collectively advance delinking and move us closer toward the re-ordering of systems of power. The opportunity for disorder is paradoxically enabled by the COVID-19 pandemic, which has permitted moments of existential reflection in the midst of the crisis. A few months ago, a press release announcing the distribution of “a portion of the vaccines” to Africans, may have been lauded as European benevolence. But in the context of a pandemic that is more likely to kill black people, Africa’s reliance on Europe for vaccine handouts is untenable, necessitating a re-examination of the systems of power that hold this colonial relationship in place. The Black African body appears to be good enough to be experimented on, but not worthy of receiving simultaneous access to the COVID-19 vaccine as Europeans. Consequently, Africans continue to feel the effects of colonialism and white supremacy, and understand the pernicious nature of European altruism. By reinforcing the current system of vaccine research, development and manufacturing, it has become apparent that European governments want to retain their colonial power over life and death in Africa through the COVID-19 vaccine. Resistance to this colonial power requires the decolonization of the vaccine.

### 1AC: Plan

#### Plan – The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines by implementing a one-and-done approach for patent and exclusivity protection.

#### The Plan solves Evergreening.

Feldman 3 Robin Feldman 2-11-2019 "‘One-and-done’ for new drugs could cut patent thickets and boost generic competition" <https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/> (Arthur J. Goldberg Distinguished Professor of Law, Albert Abramson ’54 Distinguished Professor of Law Chair, and Director of the Center for Innovation)//SidK + Elmer

I believe that one period of protection **should be enough**. We should make the legal changes necessary to prevent companies **from building patent walls** and piling up mountains of rights. This could be accomplished **by a “one-and-done” approach** for patent protection. Under it, a drug would receive just one period of exclusivity, and no more. The choice of which “one” could be left entirely in the hands of the pharmaceutical company, with the election made when the FDA approves the drug. Perhaps development of the drug went swiftly and smoothly, so the remaining life of one of the drug’s patents is of greatest value. Perhaps development languished, so designation as an orphan drug or some other benefit would bring greater reward. The choice would be up to the company itself, based on its own calculation of the maximum benefit. The result, however, is that a pharmaceutical company chooses whether its period of exclusivity would be a patent, an orphan drug designation, a period of data exclusivity (in which no generic is allowed to use the original drug’s safety and effectiveness data), or something else — but **not all of the above** and more. Consider Suboxone, a combination of buprenorphine and naloxone for treating opioid addiction. The drug’s maker has extended its protection cliff eight times, including obtaining an orphan drug designation, which is intended for drugs that serve only a small number of patients. The drug’s first period of exclusivity ended in 2005, but with the additions its protection now lasts until 2024. That makes almost two additional decades in which the public has borne the burden of monopoly pricing, and access to the medicine may have been constrained. Implementing a one-and-done approach in conjunction with FDA approval underscores the fact that these problems and solutions are designed for pharmaceuticals, not for all types of technologies. That way, one-and-done could be implemented through **legislative changes to the FDA’s drug approval system**, and would apply to patents granted going forward. One-and-done would apply to both patents and exclusivities. A more limited approach, a baby step if you will, would be to invigorate the existing patent obviousness doctrine as a way to cut back on patent tinkering. Obviousness, one of the five standards for patent eligibility, says that inventions that are obvious to an expert or the general public can’t be patented. Either by congressional clarification or judicial interpretation, many pile-on patents could be eliminated with a ruling that the core concept of the additional patent is nothing more than the original formulation. Anything else is merely an obvious adaptation of the core invention, modified with existing technology. As such, the patent would fail for being perfectly obvious. Even without congressional action, a more vigorous and robust application of the existing obviousness doctrine could significantly improve the problem of piled-up patents and patent walls. Pharmaceutical companies have become adept at maneuvering through the system of patent and non-patent rights to create mountains of rights that can be applied, one after another. This behavior lets drug companies keep competitors out of the market and beat them back when they get there. We shouldn’t be surprised at this. Pharmaceutical companies are profit-making entities, after all, that face pressure from their shareholders to produce ever-better results. If we want to change the system, we must change the incentives driving the system. And right now, the incentives for creating patent walls are just too great.

#### Reforming the Patent Process would lower Drug Prices and incentivize Pharma Innovation by revitalizing the Market.

Stanbrook 13, Matthew B. "Limiting “evergreening” for a better balance of drug innovation incentives." (2013): 939-939. (MD (University of Toronto) PhD (University of Toronto))//Elmer

At issue in the Indian case was “evergreening,” a now widespread practice by the pharmaceutical industry designed to extend the monopoly on an existing drug by modifying it and seeking new patents.2 Currently, half of all drugs patented in Canada have multiple subsequent patents, extending the lifetime of the original patent by about 8 years.3 Manufacturers, in defence of these practices, predictably tout the advantages of new versions of their products, which often represent more potent isomers or salts of the original drugs, longer-lasting formulations or improved delivery systems that make adherence easier or more convenient. But the new versions are by definition “**me too” drugs**, and demonstration that the resulting **incremental benefits** in efficacy and safety are clinically meaningful **is often lacking**. Moreover, the original drugs have often been “blockbusters” used for years to improve the health of millions of patients. It seems hard to argue convincingly why such beneficial drugs require an upgrade, often just before their patents expire. Rather than the marginal benefits accrued from tinkering with already effective agents, patients worldwide are in desperate need of new classes of pharmaceuticals for the great many health conditions for which treatments are presently inadequate or entirely lacking. But developing truly innovative drugs is undeniably a high-risk venture. It is important and necessary that pharmaceutical companies continue to take these risks, because they are usually the only entities with sufficient resources to do so. Therefore, companies must continue to perceive **sufficient incentives** to continue investing in innovation. Indeed, there is evidence that the prospect of future evergreening has become part of the incentive calculation for innovative drug development.4 But surely it is perverse to extend unpredictably a period of patent protection that the government intended to be clearly defined and predictable, and to maintain incentives that drive companies to divert their **drug-development resources away from innovation**. **Current patent legislation may not be optimal** for striking the right balance between encouraging innovation and facilitating profiteering. Given the broad societal importance of patent legislation, ongoing research to enable active governance of this issue should be a national priority. In the last decade, Canada’s laws have been among the friendliest toward evergreening in the world.5 We should now reflect on whether this is really in our national interest. Governments, including Canada’s, would do well to take inspiration from India’s example and tighten regulations that currently facilitate evergreening. This might involve **denying future patents for modifications** that currently would receive one. An overall reduction in the duration of all secondary patents on a therapy might also be considered. Globally, a more flexible and individualized approach to the length of drug patents might be a more effective strategy to align corporate incentives with population health needs. Limits on evergreening would likely reduce the **extensive patent litigation** that contributes to the **high prices of generic drugs** in Canada.3 Reducing economic pressure on generic drug companies may facilitate current provincial initiatives to lower generic drug prices. As opportunities to generate revenue from evergreening are eliminated, research-based pharmaceutical companies would be left with no choice but to invest more in innovative drug development to maintain their profits.

### 1AC: Method

#### Debate is imperfect, but only our interpretation can harness legal education to understand the law’s strategic reversibility paired with intellectual survival skills.

Archer 18, Deborah N. "Political Lawyering for the 21st Century." Denv. L. Rev. 96 (2018): 399. (Associate Professor of Clinical Law at NYU School of Law)//Elmer

Political justice lawyers must be able to break apart a systemic problem **into manageable components**. The complexity of social problems, can cause law students, and even experienced political lawyers, to become overwhelmed. In describing his work challenging United States military and economic interventions abroad, civil rights advocate and law professor Jules Lobel wrote of this process: “Our foreign-policy litigation became a sort of Sisyphean quest as we maneuvered through a hazy maze cluttered with gates. Each gate we unlocked led to yet another that blocked our path, with the elusive goal of judicial relief always shrouded in the twilight mist of the never-ending maze.”144 Pulling apart a larger, systemic problem into its smaller components can help elucidate options for advocacy. An instructive example is the use of excessive force by police officers against people of color. Every week seems to bring a new video featuring graphic police violence against Black men and women. Law students are frequently outraged by these incidents. But the sheer frequency of these videos and lack of repercussions for perpetrators overwhelm those students just as often. What can be done about a problem so big and so pervasive? To move toward justice, advocates must be able to break apart the forces that came together to lead to that moment: intentional discrimination, implicit bias, ineffective training, racial segregation, lack of economic opportunity, the over-policing of minority communities, and the failure to invest in non-criminal justice interventions that adequately respond to homelessness, mental illness, and drug addiction. None of these component problems are easily addressed, but breaking them apart is more manageable—and more realistic—than acting as though there is a single lever that will solve the problem. After identifying the component problems, advocates can select one and repeat the process of breaking down that problem until they get to a point of entry for their advocacy. 2. Identifying Advocacy Alternatives As discussed earlier, political justice lawyering embraces litigation, community organizing, interdisciplinary collaboration, legislative reform, public education, direct action, and other forms of advocacy to achieve social change. After parsing the underlying issues, lawyers need to identify what a lawyer can and should do on behalf of impacted communities and individuals, and this includes determining the most effective advocacy approach. Advocates must also strategize about what can be achieved in the short term versus the long term. The fight for justice is a marathon, not a sprint. Many law students experience frustration with advocacy because they expect immediate justice now. They have read the opinion in Brown v. Board of Education, but forget that the decision was the result of a decades-long advocacy strategy.145 Indeed, the decision itself was no magic wand, as the country continues to work to give full effect to the decision 70 years hence. Advocates cannot only fight for change they will see in their lifetime, they must also fight for the future.146 Change did not happen over night in Brown and lasting change cannot happen over night today. Small victories can be building blocks for systemic reform, and advocates must learn to see the benefit of short-term responsiveness as a component of long-term advocacy. Many lawyers subscribe to the American culture of success, with its uncompromising focus on immediate accomplishments and victories.147 However, those interested in social justice must adjust their expectations. Many pivotal civil rights victories were made possible by the seemingly hopeless cases that were brought, and lost, before them.148 In the fight for justice, “success inheres in the creation of a tradition, of a commitment to struggle, of a narrative of resistance that can inspire others similarly to resist.”149 Again, Professor Lobel’s words are instructive: “the current commitment of civil rights groups, women’s groups, and gay and lesbian groups to a legal discourse to legal activism to protect their rights stems in part from the willingness of activists in political and social movements in the nineteenth century to fight for rights, even when they realized the courts would be unsympathetic.”150 Professor Lobel also wrote about Helmuth James Von Moltke, who served as legal advisor to the German Armed Services until he was executed in 1945 by Nazis: “In battle after losing legal battle to protect the rights of Poles, to save Jews, and to oppose German troops’ war crimes, he made it clear that he struggled not just to win in the moment but to build a future.”151 3. Creating a Hierarchy of Values Advocates challenging complex social justice problems can find it difficult to identify the correct solution when one of their social justice values is in conflict with another. A simple example: a social justice lawyer’s demands for swift justice for the victim of police brutality may conflict with the lawyer’s belief in the officer’s fundamental right to due process and a fair trial. While social justice lawyers regularly face these dilemmas, law students are not often forced to struggle through them to resolution in real world scenarios—to make difficult decisions and manage the fallout from the choices they make in resolving the conflict. Engaging in complex cases can force students to work through conflicts, helping them to articulate and sharpen their beliefs and goals, forcing them to clearly define what justice means broadly and in the specific context presented. Lawyers advocating in the tradition of political lawyering anticipate the inevitable conflict between rights, and must seek to resolve these conflicts through a “hierarchy of values.”152 Moreover, in creating the hierarchy, the perspectives of those directly impacted and marginalized should be elevated “because it is in listening to and standing with the victims of injustice that the need for critical thinking and action become clear.”153 One articulation of a hierarchy of values asserts “people must be valued more than property. Human rights must be valued more than property rights. Minimum standards of living must be valued more than the privileged liberty of accumulated political, social and economic power. Finally, the goal of increasing the political, social, and economic power of those who are left out of the current arrangements must be valued more than the preservation of the existing order that created and maintains unjust privilege.”154 C. Rethinking the Role of the Clinical Law Professor: Moving From Expert to Colleague Law students can learn a new dimension of lawyering by watching their clinical law professor work through innovative social justice challenges alongside them, as colleagues. This is an opportunity not often presented in work on small cases where the clinical professor is so deeply steeped in the doctrine and process, the case is largely routine to her and she can predict what is to come and adjust supervision strategies accordingly.155 However, when engaged in political lawyering on complex and novel legal issues, both the student and the teacher may be on new ground that transforms the nature of the student-teacher relationship. A colleague often speaks about acknowledging the persona professors take on when they teach and how that persona embodies who they want to be in the classroom—essentially, whenever law professors teach they establish a character. The persona that a clinical professor adopts can have a profound effect on the students, because the character is the means by which the teacher subtly models for the student—without necessarily ever saying so— the professional the teacher holds herself to be and the student may yet become. In working on complex matters where the advocacy strategy is unclear, the clinical professor makes himself vulnerable by inviting students to witness his struggles as they work together to develop the most effective strategy. By making clear that he does not have all of the answers, partnering with his students to discover the answers, and sharing his own missteps along the way, a clinical law professor can reclaim opportunities to model how an experienced attorney acquires new knowledge and takes on new challenges that may be lost in smaller case representation.156 Clinical law faculty who wholeheartedly subscribe to the belief that professors fail to optimize student learning if students do not have primary control of a matter from beginning to end may view a decision to work in true partnership with students on a matter as a failure of clinical legal education. Indeed, this partnership model will inevitably impact student autonomy and ownership of the case.157 But, there is a unique value to a professor working with her student as a colleague and partner to navigate subject matter new to both student and professor.158 In this relationship, the professor can model how to exercise judgment and how to learn from practice: to independently learn new areas of law; to consult with outside colleagues, experts in the field, and community members without divulging confidential information; and to advise a client in the midst of ones own learning process.159 III. A Pedagogical Course Correction “If it offends your sense of justice, there’s a cause of action.” - Florence Roisman, Professor, Indiana University School of Law160 In response to the shifts in my students’ perspectives on racism and systemic discrimination, their reluctance to tackle systemic problems, their conditioned belief that strategic litigation should be a tool of last resort, and my own discomfort with reliance on small cases in my clinical teaching, I took a step back in my own practice. How could I better teach my students to be champions for justice even when they are overwhelmed by society’s injustice; to challenge the complex and systemic discrimination strangling minority communities, and to approach their work in the tradition of political lawyering. I reflected not only on my teaching, but also on my experiences as a civil rights litigator, to focus on what has helped me to continue doing the work despite the frustrations and difficulties. I realized I was spending too much time teaching my students foundational lawyering skills, and too little time focused on the broader array of skills I knew to be critical in the fight for racial justice. We regularly discussed systemic racism during my clinic seminars in order to place the students’ work on behalf of their clients within a larger context. But by relying on carefully curated small cases I was inadvertently desensitizing my students to a lawyer’s responsibility to challenge these systemic problems, and sending the message that the law operates independently from this background and context. I have an obligation to move beyond teaching my students to be “good soldiers for the status quo” to ensuring that the next generation is truly prepared to fight for justice.161 And, if my teaching methods are encouraging the reproduction of the status quo it is my obligation to develop new interventions.162 Jane Aiken’s work on “justice readiness” is instructive on this point. To graduate lawyers who better understand their role in advancing justice, Jane Aiken believes clinics should move beyond providing opportunities for students to have a social justice experience to promoting a desire and ability to do justice.163 She suggests creating disorienting moments by selecting cases where students have no outside authority on which to rely, requiring that they draw from their own knowledge base and values to develop a legal theory.164 Disorienting moments give students: experiences that surprise them because they did not expect to experience what they experienced. This can be as simple as learning that the maximum monthly welfare benefit for a family of four is about $350. Or they can read a [ ] Supreme Court case that upheld Charles Carlisle’s conviction because a wyer missed a deadline by one day even though the district court found there was insufficient evidence to prove his guilt. These facts are often disorienting. They require the student to step back and examine why they thought that the benefit amount would be so much more, or that innocence would always result in release. That is an amazing teaching moment. It is at this moment that we can ask students to examine their own privilege, how it has made them assume that the world operated differently, allowing them to be oblivious to the indignities and injustices that occur every day.165 Giving students an opportunity to “face the fact that they cannot rely on ‘the way things are’ and meet the needs of their clients” is a powerful approach to teaching and engaging students.166 But, complex problems call for larger and more sustained disorienting moments. Working with students on impact advocacy in the model of political lawyering provides a range of opportunities to immerse students in disorienting moments. A. Immersing Students in “Disorienting Moments”: Race, Poverty, and Pregnancy Today, I try to immerse my students in disorienting moments to make them justice ready and move them in the direction of political lawyering. My clinic docket has always included a small number of impact litigation matters. However, in the past these cases were carefully screened to ensure that they involved discrete legal issues and client groups. In addition, our representation always began after our outside co-counsel had already conducted an initial factual investigation, identified the core legal issues, and developed an overall advocacy strategy, freeing my students from these responsibilities. Now, my clinic takes on impact matters at earlier stages where the strategies are less clear and the legal questions are multifaceted and ill- defined. This mirrors the experiences of practicing social justice lawyers, who faced with an injustice, must discover the facts, identify the legal claims, develop strategy, cultivate allies, and ultimately determine what can be done—with the knowledge that “nothing” is not an option. This approach provides students with the space to wrestle with larger, systemic issues in a structured and supportive educational environment, taking on cases that seem difficult to resolve and working to bring some justice to that situation. They are also gaining experience in many of the fundamentals of political lawyering advocacy. Recently, my students began work on a new case. Several public and private hospitals in low-income New York City neighborhoods are drug testing pregnant women or new mothers without their knowledge or informed consent. This practice reflects a disturbing convergence between racial and economic disparities, and can have a profound impact on the lives of the poor women of color being tested at precisely the time when they are most in need of support. We began our work when a community organization reached out to the clinic and spoke to us about complaints that hospitals around New York City were regularly testing pregnant women—almost exclusively women of color—for drug use during prenatal check ups, during the chaos and stress of labor and delivery, or during post-delivery. The hospitals report positive test results to the City’s Administration for Children’s Services (“ACS”), which is responsible for protecting children from abuse and neglect, for further action.167 Most of the positive tests are for marijuana use. After a report is made, ACS commences an investigation to determine whether child abuse or neglect has taken place, and these investigations trigger inquiries into every aspect of a family’s life. They can lead to the institution of child neglect proceedings, and potentially to the temporary or permanent removal of children from the household. Even where that extreme result is avoided, an ACS investigation can open the door to the City’s continued, and potentially unwelcome, involvement in the lives of these families. These policies reflect deeply inequitable practices. Investigating a family after a positive drug test is not necessarily a bad thing. After all, ACS offers a number of supportive services that can help stabilize and strengthen vulnerable families. And of course, where children’s safety is at risk, removal may sometimes be the appropriate result. However, hospitals do not conduct regular drug tests of mothers in all New York City communities. Private hospitals in wealthy areas rarely test pregnant women or new mothers for drug misuse. In contrast, at hospitals serving poor women, drug testing is routine. Race and class should not determine whether such testing, and the consequences that result, take place. Investigating the New York City drug-testing program immersed the students in disorienting moments at every stage of their work. During our conversations, the students regularly expressed surprise and discomfort with the hospitals’ practices. They were disturbed that public hospitals— institutions on which poor women and women of color rely for something as essential as health care—would use these women’s pregnancy as a point of entry to control their lives.168 They struggled to explain how the simple act of seeking medical care from a hospital serving predominantly poor communities could deprive patients of the respect, privacy, and legal protections enjoyed by pregnant women in other parts of the City. And, they were shocked by the way institutions conditioned poor women to unquestioningly submit to authority.169 Many of the women did not know that they were drug tested until the hospital told them about the positive result and referred them to ACS. Still, these women were not surprised: that kind of disregard, marginalization, and lack of consent were a regular aspect of their lives as poor women of color. These women were more concerned about not upsetting ACS than they were about the drug testing. That so many of these women could be resigned to such a gross violation of their rights was entirely foreign to most of my students. B. Advocacy in the Face of Systemic Injustice Although the students are still in the early stages of their work, they have already engaged in many aspects of political justice lawyering. They approached their advocacy focused on the essence of political lawyering— enabling poor, pregnant women of color who enjoy little power or respect to claim and enjoy their rights, and altering the allocation of power from government agencies and institutions back into the hands of these women. They questioned whose interests these policies and practices were designed to serve, and have grounded their work in a vision of an alternative societal construct in which their clients and the community are respected and supported. The clinic students were given an opportunity to learn about social, legal, and administrative systems as they simultaneously explored opportunities to change those systems. The students worked to identify the short and long term goals of the impacted women as well the goals of the larger community, and to think strategically about the means best suited to accomplish these goals. And, importantly, while collaborating with partners from the community and legal advocacy organizations, the students always tried to keep these women centered in their advocacy. In breaking down the problem of drug testing poor women of color, the students worked through an issue that lives at the intersection of reproductive freedom, family law, racial justice, economic inequality, access to health care, and the war on drugs. In their factual investigation, which included interviews of impacted women, advocates, and hospital personnel, and the review of records obtained through Freedom of Information Law requests, the students began to break down this complex problem. They explored the disparate treatment of poor women and women of color by health care providers and government entities, implicit and explicit bias in healthcare, the disproportionate referral of women of color to ACS, the challenges of providing medical services to underserved communities, the meaning of informed consent, the diminished rights of people who rely on public services, and the criminalization of poverty. The students found that list almost as overwhelming as the initial problem itself, but identifying the components allowed the students to dig deeper and focus on possible avenues of challenge and advocacy. It was also critically important to make the invisible forces visible, even if the law currently does not provide a remedy. Working on this case also gave the students and me the opportunity to work through more nuanced applications of some of the lawyering concepts that were introduced in their smaller cases, including client-centered lawyering when working on behalf of the community; large-scale fact investigation; transferring their “social justice knowledge” to different contexts; crafting legal and factual narratives that are not only true to the communities’ experience, but can persuade and influence others; and how to develop an integrated advocacy plan. The students frequently asked whether we should even pursue the matter, questioning whether this work was client- centered when it was no longer the most pressing concern for many of the women we met. These doubts opened the door to many rich discussions: can we achieve meaningful social change if we only address immediate crises; can we progress on larger social justice issues without challenging their root causes; how do we recognize and address assumptions advocates may have about what is best for a client; and how can we keep past, present, and future victims centered in our advocacy? The work on the case also forced the clinic students to work through their own understanding of a hierarchy of values. They struggled with their desire to support these community hospitals and the public servants who work there under difficult circumstances on the one hand, and their desire to protect women, potentially through litigation, from discriminatory practices. They also struggled to reconcile their belief that hospitals should take all reasonable steps to protect the health and safety of children, as well as their emotional reaction to pregnant mothers putting their unborn children in harms way by using illegal drugs against the privacy rights of poor and marginalized women. They were forced to pause and think deeply about what justice would look like for those mothers, children, and communities. CONCLUSION America continues to grapple with systemic injustice. Political justice lawyering offers powerful strategies to advance the cause of justice—through integrated advocacy comprising the full array of tools available to social justice advocates, including strategic systemic reform litigation. It is the job of legal education to prepare law students to become effective lawyers. For those aspiring to social justice that should include training students to utilize the tools of political justice lawyers. Clinical legal offers a tremendous opportunity to teach the next generation of racial and social justice advocates how to advance equality in the face of structural inequality, if only it will embrace the full array of available tools to do so. In doing so, clinical legal education will not only prepare lawyers to enact social change, they can inspire lawyers overwhelmed by the challenges of change. In order to provide transformative learning experiences, clinical education must supplement traditional pedagogical tools and should consider political lawyering’s potential to empower law students and communities.

#### Reject monocausal explanations of the world: they ignore complexity/are the product of epistemic closure

Sil and Katzenstein, 10(Rudra, PoliSci@Penn, Peter J., Gov@Cornell, Analytic Eclecticism in the Study of World Politics: Reconfiguring Problems and Mechanisms across Research Traditions Perspectives on Politics, Vol. 8, No. 2 (June 2010), pp. 411-431) // recut CVHS SR

This is not the first call for something resembling eclecticism. In addition to Lindblom and Cohen, numerous scholars have issued pleas for a more practically useful social scienceor, following Aristotle, a "phronetic" social science oriented more toward social commentary and political action than toward inter-paradigm debates.3 In international relations, prominent scholars, some even identified with particular research traditions, have acknowledged the need for incorporating elements from other approaches in order to fashion more usable and more comprehensive forms of knowledge. For example, Kenneth Waltz, whose name would become synonymous with neo realism, argued in his earlier work: "The prescriptions directly derived from a single image [of international rela tions] are incomplete because they are based upon partial analyses. The partial quality of each image sets up a tension that drives one toward inclusion of the others . . . One is led to search for the inclusive nexus of causes."4 An ardent critic of realist theory, Andrew Moravcsik, would have to agree with Waltz on this point: "The outbreak of World Wars I and II, the emergence of international human rights norms, and the evolution of the European Union, for example, are surely important enough events to merit comprehensive explanation even at the expense of theoretical parsimony."5 Similarly, in an important symposium on the role of theory in comparative politics, several prominent scholars emphasized the virtues of an "eclectic combination" of diverse theoretical perspectives in making sense of cases, cautioning against the excessive "simplifications" required to apply a single theoretical lens to grasp the manifold complexities on the ground.6 As far as programmatic statements go, these views are all consistent with the spirit of analytic eclecticism. Whether these positions are readily evident in research practice, how ever, is quite another matter. For the most part, social scientific research is still organized around particular research traditions or scholarly communities, each marked by its own epistemic commitments, its own theoretical vocabulary, its own standards, and its own conceptions of "progress." A more effective case for eclectic scholarship requires more than statements embracing intellectual pluralism or multicaiisal explanation. It requires an alternative understanding of research practice that is coherent enough to be distinguishable from conventional scholarship and yet flexible enough to accommodate a wide range of problems, concepts, methods, and causal arguments. We have sought to systematically articulate such an understanding in the form of "analytic eclecticism," emphasizing its pragmatist ethos, its orientation towards preexisting styles and schools of research, and its distinctive value added in relating aca demic debates to concrete matters of policy and practice. Below, we first offer a brief discussion of the benefits and limitations of research traditions and consider how analytic eclecticism complements existing traditions by seeking to leverage and integrate conceptual and theoret ical elements in multiple traditions. In the next three sec tions, we elaborate on three distinguishing features of eclectic scholarship: its pragmatist ethos; its open-ended approach to identifying problems; and its expansive under standing of causal mechanisms and their complex inter actions in diverse contexts. We then consider a small sample of work in comparative politics and international rela tions that illustrates the combinatorial potential of eclec tic scholarship. The conclusion considers the risks and costs of analytic eclecticism, but views these as acceptable in light of the potential gains of accommodating eclectic approaches that complement and engage tradition-bound research in the social sciences.7 (412)

#### Colonialism isn’t inevitable – your theory foreclose liberation and reify Settler Dominance

Busbridge 18—Research Fellow at the Centre for Dialogue, La Trobe University (Rachel, “Israel-Palestine and the Settler Colonial ‘Turn’: From Interpretation to Decolonization,” Theory, Culture & Society Vol 35, Issue 1, 2018, dml)//Re-cut by Elmer

The prescription for decolonisation—that is, a normative project committed to the liberation of the colonised and the overturning of colonial relationships of power (Kohn & McBride, 2011: 3)—is indeed one of the most counterhegemonic implications of the settler colonial paradigm as applied to IsraelPalestine, potentially shifting it from a diagnostic frame to a prognostic one which offers a ‘proposed solution to the problem, or at least a plan of attack’ (Benford & Snow, 2000: 616). What, however, does the settler colonial paradigm offer by way of envisioning decolonisation? As Veracini (2007) notes, while settler colonial studies scholars have sought to address the lack of attention paid to the experiences of Indigenous peoples in conventional historiographical accounts of decolonisation (which have mostly focused on settler independence and the loosening of ties to the ‘motherland’), there is nevertheless a ‘**narrative deficit**’ when it comes to **imagining settler decolonisation**. While Veracini (2007) relates this deficit to a matter of conceptualisation, it is apparent that the **structural perspective** of the paradigm in many ways **closes down possibilities** of **imagining the type of social** and **political transformation** to which the **notion of decolonisation aspires**. In this regard, there is a **worrying tendency** (if not **tautological discrepancy**) in settler colonial studies, where the **only solution to settler colonialism is decolonisation**—which a faithful adherence to the paradigm **renders largely unachievable**, if not **impossible**. To understand why this is the case, it is necessary to return to Wolfe’s (2013a: 257) account of settler colonialism as guided by a ‘zero-sum logic whereby settler societies, for all their internal complexities, uniformly require the elimination of Native alternatives’. The structuralism of this account has immense power as a means of mapping forms of injustice and indignity as well as strategies of resistance and refusal, and Wolfe is careful to show how transmutations of the logic of elimination are complex, variable, discontinuous and uneven. Yet, in seeking to elucidate the logic of elimination as the overarching historical force guiding settler-native relations there is an operational weakness in the theory, whereby such a logic is simply there, omnipresent and manifest even when (and perhaps especially when) it appears not to be; the settler colonial studies scholar need only read it into a situation or context. It thus **hurtles from the past** to the **present** into the **future**, never to be fully extinguished until the native is, or until history itself ends. There is thus a **powerful ontological** (if not metaphysical) **dimension** to Wolfe’s account, where there is such thing as a ‘**settler will**’ that **inherently desires the elimination of the native** and the distinction between the settler and native **can only ever be categorical**, founded as it is on the ‘primal binarism of the frontier’ (2013a: 258). It is here that the differences between earlier settler colonial scholarship on Israel-Palestine and the recent settler colonial turn come into clearest view. While Jamal Hilal’s (1976) Marxist account of the conflict, for instance, engaged Palestinians and Jewish Israelis in terms of their relations to the means of production, Wolfe’s account brings its own ontology: the bourgeoisie/proletariat distinction becomes that of settler/native, and the class struggle the struggle between settler, who seeks to **destroy** and **replace the native**, and native, who **can only ever push back**. Indeed, if the settler colonial paradigm views history in similar teleological terms to the Marxist framework, it **does not offer** the same hopeful vision of a liberated future. After all, settler colonialism has **only one story to tell**—‘either **total victory** or **total failure**’ (Veracini, 2007). Veracini’s attempt to disaggregate different forms of settler decolonisation is revealing of the difficulties that come along with this zero-sum perspective. It is significant to note that beyond settler evacuation (which may decolonise territory, he cautions, but not necessarily relationships) the picture he paints is a relatively bleak one. For Veracini (2011: 5), claims for decolonisation from Indigenous peoples in settler societies can take two broad forms: an ‘anticolonial rhetoric expressing a demand for indigenous sovereign independence and self-determination… and an “ultra”-colonial one that seeks a reconstituted partnership with the [settler state] and advocates a return to a relatively more respectful middle ground and “treaty” conditions’. While both, he suggests, are tempting strategies in the struggle for change, though ‘ultimately ineffective against settler colonial structures of domination’ (2011: 5), it is the latter strategy that invites Veracini’s most scathing assessment. As he writes, under settler colonial conditions the independent polity is the settler polity and sanctioning the equal rights of indigenous peoples has historically been used as a powerful weapon in the denial of indigenous entitlement and in the enactment of various forms of coercive assimilation. This decolonisation actually enhances the subjection of indigenous peoples… it is at best irrelevant and at worst detrimental to indigenous peoples in settler societies (2011: 6-7). The ‘primal binarism of the frontier’ plays a particularly ambivalent role in Veracini’s (2011: 6) formulation, where the categorical distinction between settler and native obstructs the ‘possibility of a genuinely decolonised relationship’ (by virtue of its lopsidedness) yet is a necessary political strategy to guard against the absorption of Indigenous people into the settler fold, which would represent settler colonialism’s final victory. The battle here is between a ‘settler colonialism [that] is designed to produce a fundamental discontinuity as its “logic of elimination” runs its course until it actually extinguishes the settler colonial relation’ and an anti-colonial struggle that ‘must aim to keep the settler-indigenous relationship going’ (2011: 7). In other words, the categorical distinction produced by the frontier must be maintained in order to struggle against its effects. Given the lack of options presented to Indigenous peoples by Veracini (2014: 315), his conclusion that settler decolonisation demands a ‘radical, post-settler colonial passage’ is perhaps not surprising – although he has ‘no suggestion as to how this may be achieved and [is] pessimistic about its feasibility’. Scholars have long reckoned with the ambivalence of the settler colonial situation, which is simultaneously colonial and postcolonial, colonising and decolonising (Curthoys, 1999: 288). Given the generally dreadful Fourth World circumstances facing many Indigenous peoples in settler societies, it could be argued that there is good reason for such pessimism. The settler colonial paradigm, in this sense, offers an important caution against celebratory narratives of progress. Wolfe (1994), it must be recalled, wrote the original articulation of his thesis precisely against the idea of ‘historical rupture’ that dominated in Australia post-Mabo, and was thus as much a scholarly intervention as it was a political challenge to the idea of Australia having broken with its colonial past. **Nonetheless**, the **fatalism** of the settler colonial paradigm—whereby decolonisation is by and large put beyond the realms of possibility—has seen it come under **considerable critique** for **reifying settler colonialism** as a transhistorical meta-structure where colonial relations of domination are **inevitable** (Macoun & Strakosch, 2013: 435; Snelgrove et al., 2014: 9). Not only does Wolfe’s ontology **erase contingency**, **heterogeneity** and (crucially) **agency** (Merlan, 1997; Rowse, 2014), but its polarised framework effectively ‘**puts politics to death**’ (Svirsky, 2014: 327). In response to such critiques, Wolfe (2013a: 213) suggests that ‘the repudiation of binarism’ may just represent a ‘settler perspective’. However, as Elizabeth Povinelli (1997: 22) has astutely shown, it is in this regard that the **totalising logic** of Wolfe’s structure of invasion **rests on a disciplinary gesture** where ‘**any discussion** which **does not insist** on the polarity of the [settler] colonial project’ is **assimilationist**, worse still, **genocidal** in effect if not intent. **Any attempt** to ‘explore the **dialogical** or **hybrid nature** of colonial subjectivity’—which would entail **working beyond the bounds of absolute polarity**—is **disciplined as complicit** in the settler colonial project itself, leaving ‘the **only nonassimilationist position** one that **adheres strictly** and **solely** to a **critique** of [settler] state discourse’. This gesture not only **disallows the possibility of counter-publics** and **strategic alliances** (even limited ones), but also **comes dangerously close** to ‘**resistance as acquiescence**’ insofar as the settler colonial studies scholar may **malign the structures set in play** by settler colonialism, but only from a safe distance unsullied by the messiness of ambivalences and contradictions of settler and Native subjectivities and relations. Opposition is thus left as our only option, but, as we know from critical anti-colonial and postcolonial scholarship, opposition in itself is not decolonisation.