### 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 – up to 80% of all new patents are not new drugs but old ones.

Feldman 2 Robin Feldman 18, May your drug price be evergreen, Journal of Law and the Biosciences, Volume 5, Issue 3, December 2018, Pages 590–647, <https://doi.org/10.1093/jlb/lsy022> Arthur J. Goldberg Distinguished Professor of Law, Albert Abramson ’54 Distinguished Professor of Law Chair, and Director of the Center for Innovation (Study Notes: Presenting the first comprehensive study of evergreening, this article examines the extent to which evergreening behavior—which can be defined as artificially extending the protection cliff—may contribute to the problem. The author analyses all drugs on the market between 2005 and 2015, combing through 60,000 data points to examine every instance in which a company added a new patent or exclusivity.)//sid

The study results demonstrate definitively that the pharmaceutical industry has strayed far from the patent system's intended design. The patent system is not functioning as a time-limited opportunity to garner a return, followed by open competition. Rather, companies throughout the industry seek and obtain repeated extensions of their competition-free zones. Moreover, the incidence of such behavior has steadily increased between 2005 and 2015, especially on the patent front and for certain highly valuable exclusivities. Most troubling, the data suggest that the current state of affairs **is harming innovation** in tangible ways. Rather than creating new medicines—sallying forth into new frontiers for the benefit of society—drug companies are focusing their time and effort extending the patent life of old products. This, of course, is not the innovation one would hope for. The greatest creativity at pharmaceutical **companies should be in the lab, not in the legal department**.115 The following sections describe the results obtained through our analysis in detail, but below are the key takeaways from the study: Rather than creating new medicines, pharmaceutical companies are recycling and repurposing old ones. In fact, 78% of the drugs associated with new patents in the FDA’s records were not new drugs coming on the market, but existing drugs. In some years, the percentage reached as high as 80%. Adding new patents and exclusivities to extend the protection cliff is particularly pronounced among blockbuster drugs. Of the roughly 100 best-selling drugs, more than 70% extended their protection at least once, with more than 50% extending the protection cliff more than once. Looking at the full group, almost 40% of all drugs available on the market created additional market barriers by having patents or exclusivities added to them.

#### 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

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.

#### 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 pate**nts 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.

#### 1] 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: 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 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.

#### 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: Fwk

#### The standard is maximizing expected well-being. – we will spec – Hedonistic act Utilitarianism

#### Prefer:

#### 1] Pleasure and pain are intrinsic value and disvalue

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**Pleasure** is not only one of the three primary reward functions but it also **defines reward.** As homeostasis explains the functions of only a limited number of rewards, the principal reason why particular stimuli, objects, events, situations, and activities are rewarding may be due to pleasure. This applies first of all to sex and to the primary homeostatic rewards of food and liquid and extends to money, taste, beauty, social encounters and nonmaterial, internally set, and intrinsic rewards. Pleasure, as the primary effect of rewards, drives the prime reward functions of learning, approach behavior, and decision making and provides the **basis for hedonic theories** of reward function. We are attracted by most rewards and exert intense efforts to obtain them, just because they are enjoyable [10]. Pleasure is a passive reaction that derives from the experience or prediction of reward and may lead to a long-lasting state of happiness. The word happiness is difficult to define. In fact, just obtaining physical pleasure may not be enough. One key to happiness involves a network of good friends. However, it is not obvious how the higher forms of satisfaction and pleasure are related to an ice cream cone, or to your team winning a sporting event. Recent multidisciplinary research, using both humans and detailed invasive brain analysis of animals has discovered some critical ways that the brain processes pleasure [14]. Pleasure as a hallmark of reward is sufficient for defining a reward, but it may not be necessary. A reward may generate positive learning and approach behavior simply because it contains substances that are essential for body function. When we are hungry, we may eat bad and unpleasant meals. A monkey who receives hundreds of small drops of water every morning in the laboratory is unlikely to feel a rush of pleasure every time it gets the 0.1 ml. Nevertheless, with these precautions in mind, we may define any stimulus, object, event, activity, or situation that has the potential to produce pleasure as a reward. In the context of reward deficiency or for disorders of addiction, homeostasis pursues pharmacological treatments: drugs to treat drug addiction, obesity, and other compulsive behaviors. The theory of allostasis suggests broader approaches - such as re-expanding the range of possible pleasures and providing opportunities to expend effort in their pursuit. [15]. It is noteworthy, the first animal studies eliciting approach behavior by electrical brain stimulation interpreted their findings as a discovery of the brain’s pleasure centers [16] which were later partly associated with midbrain dopamine neurons [17–19] despite the notorious difficulties of identifying emotions in animals. Evolutionary theories of pleasure: The love connection BO:D Charles Darwin and other biological scientists that have examined the biological evolution and its basic principles found various mechanisms that steer behavior and biological development. Besides their theory on natural selection, it was particularly the sexual selection process that gained significance in the latter context over the last century, especially when it comes to the question of what makes us “what we are,” i.e., human. However, the capacity to sexually select and evolve is not at all a human accomplishment alone or a sign of our uniqueness; yet, we humans, as it seems, are ingenious in fooling ourselves and others–when we are in love or desperately search for it. It is well established that modern biological theory conjectures that **organisms are** the **result of evolutionary competition.** In fact, Richard Dawkins stresses gene survival and propagation as the basic mechanism of life [20]. Only genes that lead to the fittest phenotype will make it. It is noteworthy that the phenotype is selected based on behavior that maximizes gene propagation. To do so, the phenotype must survive and generate offspring, and be better at it than its competitors. Thus, the ultimate, distal function of rewards is to increase evolutionary fitness by ensuring the survival of the organism and reproduction. It is agreed that learning, approach, economic decisions, and positive emotions are the proximal functions through which phenotypes obtain other necessary nutrients for survival, mating, and care for offspring. Behavioral reward functions have evolved to help individuals to survive and propagate their genes. Apparently, people need to live well and long enough to reproduce. Most would agree that homo-sapiens do so by ingesting the substances that make their bodies function properly. For this reason, foods and drinks are rewards. Additional rewards, including those used for economic exchanges, ensure sufficient palatable food and drink supply. Mating and gene propagation is supported by powerful sexual attraction. Additional properties, like body form, augment the chance to mate and nourish and defend offspring and are therefore also rewards. Care for offspring until they can reproduce themselves helps gene propagation and is rewarding; otherwise, many believe mating is useless. According to David E Comings, as any small edge will ultimately result in evolutionary advantage [21], additional reward mechanisms like novelty seeking and exploration widen the spectrum of available rewards and thus enhance the chance for survival, reproduction, and ultimate gene propagation. These functions may help us to obtain the benefits of distant rewards that are determined by our own interests and not immediately available in the environment. Thus the distal reward function in gene propagation and evolutionary fitness defines the proximal reward functions that we see in everyday behavior. That is why foods, drinks, mates, and offspring are rewarding. There have been theories linking pleasure as a required component of health benefits salutogenesis, (salugenesis). In essence, under these terms, pleasure is described as a state or feeling of happiness and satisfaction resulting from an experience that one enjoys. Regarding pleasure, it is a double-edged sword, on the one hand, it promotes positive feelings (like mindfulness) and even better cognition, possibly through the release of dopamine [22]. But on the other hand, pleasure simultaneously encourages addiction and other negative behaviors, i.e., motivational toxicity. It is a complex neurobiological phenomenon, relying on reward circuitry or limbic activity. It is important to realize that through the “Brain Reward Cascade” (BRC) endorphin and endogenous morphinergic mechanisms may play a role [23]. While natural rewards are essential for survival and appetitive motivation leading to beneficial biological behaviors like eating, sex, and reproduction, crucial social interactions seem to further facilitate the positive effects exerted by pleasurable experiences. Indeed, experimentation with addictive drugs is capable of directly acting on reward pathways and causing deterioration of these systems promoting hypodopaminergia [24]. Most would agree that pleasurable activities can stimulate personal growth and may help to induce healthy behavioral changes, including stress management [25]. The work of Esch and Stefano [26] concerning the link between compassion and love implicate the brain reward system, and pleasure induction suggests that social contact in general, i.e., love, attachment, and compassion, can be highly effective in stress reduction, survival, and overall health. Understanding the role of neurotransmission and pleasurable states both positive and negative have been adequately studied over many decades [26–37], but comparative anatomical and neurobiological function between animals and homo sapiens appear to be required and seem to be in an infancy stage. Finding happiness is different between apes and humans As stated earlier in this expert opinion one key to happiness involves a network of good friends [38]. However, it is not entirely clear exactly how the higher forms of satisfaction and pleasure are related to a sugar rush, winning a sports event or even sky diving, all of which augment dopamine release at the reward brain site. Recent multidisciplinary research, using both humans and detailed invasive brain analysis of animals has discovered some critical ways that the brain processes pleasure. Remarkably, there are pathways for ordinary liking and pleasure, which are limited in scope as described above in this commentary. However, there are **many brain regions**, often termed hot and cold spots, that significantly **modulate** (increase or decrease) our **pleasure or** even **produce the opposite** of pleasure— that is disgust and fear [39]. One specific region of the nucleus accumbens is organized like a computer keyboard, with particular stimulus triggers in rows— producing an increase and decrease of pleasure and disgust. Moreover, the cortex has unique roles in the cognitive evaluation of our feelings of pleasure [40]. Importantly, the interplay of these multiple triggers and the higher brain centers in the prefrontal cortex are very intricate and are just being uncovered. Desire and reward centers It is surprising that many different sources of pleasure activate the same circuits between the mesocorticolimbic regions (Figure 1). Reward and desire are two aspects pleasure induction and have a very widespread, large circuit. Some part of this circuit distinguishes between desire and dread. The so-called pleasure circuitry called “REWARD” involves a well-known dopamine pathway in the mesolimbic system that can influence both pleasure and motivation. In simplest terms, the well-established mesolimbic system is a dopamine circuit for reward. It starts in the ventral tegmental area (VTA) of the midbrain and travels to the nucleus accumbens (Figure 2). It is the cornerstone target to all addictions. The VTA is encompassed with neurons using glutamate, GABA, and dopamine. The nucleus accumbens (NAc) is located within the ventral striatum and is divided into two sub-regions—the motor and limbic regions associated with its core and shell, respectively. The NAc has spiny neurons that receive dopamine from the VTA and glutamate (a dopamine driver) from the hippocampus, amygdala and medial prefrontal cortex. Subsequently, the NAc projects GABA signals to an area termed the ventral pallidum (VP). The region is a relay station in the limbic loop of the basal ganglia, critical for motivation, behavior, emotions and the “Feel Good” response. This defined system of the brain is involved in all addictions –substance, and non –substance related. In 1995, our laboratory coined the term “Reward Deficiency Syndrome” (RDS) to describe genetic and epigenetic induced hypodopaminergia in the “Brain Reward Cascade” that contribute to addiction and compulsive behaviors [3,6,41]. Furthermore, ordinary “liking” of something, or pure pleasure, is represented by small regions mainly in the limbic system (old reptilian part of the brain). These may be part of larger neural circuits. In Latin, hedus is the term for “sweet”; and in Greek, hodone is the term for “pleasure.” Thus, the word Hedonic is now referring to various subcomponents of pleasure: some associated with purely sensory and others with more complex emotions involving morals, aesthetics, and social interactions. The capacity to have pleasure is part of being healthy and may even extend life, especially if linked to optimism as a dopaminergic response [42]. Psychiatric illness often includes symptoms of an abnormal inability to experience pleasure, referred to as anhedonia. A negative feeling state is called dysphoria, which can consist of many emotions such as pain, depression, anxiety, fear, and disgust. Previously many scientists used animal research to uncover the complex mechanisms of pleasure, liking, motivation and even emotions like panic and fear, as discussed above [43]. However, as a significant amount of related research about the specific brain regions of pleasure/reward circuitry has been derived from invasive studies of animals, these cannot be directly compared with subjective states experienced by humans. In an attempt to resolve the controversy regarding the causal contributions of mesolimbic dopamine systems to reward, we have previously evaluated the three-main competing explanatory categories: “liking,” “learning,” and “wanting” [3]. That is, dopamine may mediate (a) liking: the hedonic impact of reward, (b) learning: learned predictions about rewarding effects, or (c) wanting: the pursuit of rewards by attributing incentive salience to reward-related stimuli [44]. We have evaluated these hypotheses, especially as they relate to the RDS, and we find that the incentive salience or “wanting” hypothesis of dopaminergic functioning is supported by a majority of the scientific evidence. Various neuroimaging studies have shown that anticipated behaviors such as sex and gaming, delicious foods and drugs of abuse all affect brain regions associated with reward networks, and may not be unidirectional. Drugs of abuse enhance dopamine signaling which sensitizes mesolimbic brain mechanisms that apparently evolved explicitly to attribute incentive salience to various rewards [45]. Addictive substances are voluntarily self-administered, and they enhance (directly or indirectly) dopaminergic synaptic function in the NAc. This activation of the brain reward networks (producing the ecstatic “high” that users seek). Although these circuits were initially thought to encode a set point of hedonic tone, it is now being considered to be far more complicated in function, also encoding attention, reward expectancy, disconfirmation of reward expectancy, and incentive motivation [46]. The argument about addiction as a disease may be confused with a predisposition to substance and nonsubstance rewards relative to the extreme effect of drugs of abuse on brain neurochemistry. The former sets up an individual to be at high risk through both genetic polymorphisms in reward genes as well as harmful epigenetic insult. Some Psychologists, even with all the data, still infer that addiction is not a disease [47]. Elevated stress levels, together with polymorphisms (genetic variations) of various dopaminergic genes and the genes related to other neurotransmitters (and their genetic variants), and may have an additive effect on vulnerability to various addictions [48]. In this regard, Vanyukov, et al. [48] suggested based on review that whereas the gateway hypothesis does not specify mechanistic connections between “stages,” and does not extend to the risks for addictions the concept of common liability to addictions may be more parsimonious. The latter theory is grounded in genetic theory and supported by data identifying common sources of variation in the risk for specific addictions (e.g., RDS). This commonality has identifiable neurobiological substrate and plausible evolutionary explanations. Over many years the controversy of dopamine involvement in especially “pleasure” has led to confusion concerning separating motivation from actual pleasure (wanting versus liking) [49]. We take the position that animal studies cannot provide real clinical information as described by self-reports in humans. As mentioned earlier and in the abstract, on November 23rd, 2017, evidence for our concerns was discovered [50] In essence, although nonhuman primate brains are similar to our own, the disparity between other primates and those of human cognitive abilities tells us that surface similarity is not the whole story. Sousa et al. [50] small case found various differentially expressed genes, to associate with pleasure related systems.

Furthermore, the dopaminergic interneurons located in the human neocortex were absent from the neocortex of nonhuman African apes. Such differences in neuronal transcriptional programs may underlie a variety of neurodevelopmental disorders. In simpler terms, the system controls the production of dopamine, a chemical messenger that plays a significant role in pleasure and rewards. The senior author, Dr. Nenad Sestan from Yale, stated: “Humans have evolved a dopamine system that is different than the one in chimpanzees.” This may explain why the behavior of humans is so unique from that of non-human primates, even though our brains are so surprisingly similar, Sestan said: “It might also shed light on why people are vulnerable to mental disorders such as autism (possibly even addiction).” Remarkably, this research finding emerged from an extensive, multicenter collaboration to compare the brains across several species. These researchers examined 247 specimens of neural tissue from six humans, five chimpanzees, and five macaque monkeys. Moreover, these investigators analyzed which genes were turned on or off in 16 regions of the brain. While the differences among species were subtle, **there was** a **remarkable contrast in** the **neocortices**, specifically in an area of the brain that is much more developed in humans than in chimpanzees. In fact, these researchers found that a gene called tyrosine hydroxylase (TH) for the enzyme, responsible for the production of dopamine, was expressed in the neocortex of humans, but not chimpanzees. As discussed earlier, dopamine is best known for its essential role within the brain’s reward system; the very system that responds to everything from sex, to gambling, to food, and to addictive drugs. However, dopamine also assists in regulating emotional responses, memory, and movement. Notably, abnormal dopamine levels have been linked to disorders including Parkinson’s, schizophrenia and spectrum disorders such as autism and addiction or RDS. Nora Volkow, the director of NIDA, pointed out that one alluring possibility is that the neurotransmitter dopamine plays a substantial role in humans’ ability to pursue various rewards that are perhaps months or even years away in the future. This same idea has been suggested by Dr. Robert Sapolsky, a professor of biology and neurology at Stanford University. Dr. Sapolsky cited evidence that dopamine levels rise dramatically in humans when we anticipate potential rewards that are uncertain and even far off in our futures, such as retirement or even the possible alterlife. This may explain what often motivates people to work for things that have no apparent short-term benefit [51]. In similar work, Volkow and Bale [52] proposed a model in which dopamine can favor NOW processes through phasic signaling in reward circuits or LATER processes through tonic signaling in control circuits. Specifically, they suggest that through its modulation of the orbitofrontal cortex, which processes salience attribution, dopamine also enables shilting from NOW to LATER, while its modulation of the insula, which processes interoceptive information, influences the probability of selecting NOW versus LATER actions based on an individual’s physiological state. This hypothesis further supports the concept that disruptions along these circuits contribute to diverse pathologies, including obesity and addiction or RDS.

#### 2] These are important consequences—disregarding the destruction of the planet is antithetical to the purpose of radical resistance

Moten and Kelley, 17—professor of Performance Studies at New York University AND Gary B. Nash Professor of American History at UCLA (Fred and Robin D.G., “Robin D.G. Kelley & Fred Moten In Conversation,” transcribed from <https://www.youtube.com/watch?v=fP-2F9MXjRE>, 31:49-55:57, dml)

MOTEN: Well, first of all, I just want to say how much I appreciate having a chance to be here with all of you tonight, and thank you, Rinaldo, and, uh, Alicia, and Afua, of course. Robin, as always, uh, an honor to be, have a chance to hang out with you, and uh, and to learn from you, and um, let me see. Um, well, I tend to think of Black studies not so much as an academic discipline or confluence of disciplines but as the atmosphere in which I grew up, and so, and I love that, that atmosphere. I love the way that it felt, and I love the way that it smelled, and I love the flavors, and I love the sounds, and I love the movements. Um, and so, it is, again, something that I think has a certain place, maybe, in the university, and what it meant, what it has meant for Black studies to take that place in the university has had both, has been both good and bad. I think it’s probably done much more for the university than it has for Black studies, and, and that’s something worth thinking about. And I don’t say that because I’m trying to advocate some withdrawal from the university of Black studies, but I’m thinking that, you know, that at this stage of the game in having done the work of attempting to actually bring, um, the university into some sense of its own, of what ought to be its own intellectual mission, Black studies has the right to look out for itself now, for a little bit, um, and I think it’s worth it to do that. And insofar as Black studies has earned a right to look out for itself, what that really means, I think, is that Black studies has earned the right to try again to take its fundamental responsibility, which is to be, uh, a place where we can look out for the Earth. Um, I think that Black studies has a fundamental and specific, though not necessarily exclusive mission, and that mission is to try to save the Earth, or at least to try to save, not, well, on the most fundamental level to save the Earth, and on a secondary level, to try to save the possibility of human existence on the Earth. Um, and I know that’s a big statement, and I don’t wanna take up all the time, but I’m happy to try to say more about what I think I mean by that later on, but, um, but I think maybe it’s important just to leave that big statement out there for a minute, and just to make sure that you know that I knew that I said it when I said it.

KELLEY: Okay, well, actually I wanna echo, uh, Fred’s sentiments, that it’s really an honor to be here, in this space. Um, this is the second time that we’ve had kind of a public conversation, and it’s always packed, you know, and it’s always a lot of people, and expectations are always high, and one of my favorite things on the planet, besides just talking to my daughters, talking to Fred Moten, um, you know, and it’s just really, you know, I learn so much from it, and in fact, let me just begin by saying that one of the pieces that Rinaldo was referring to was an essay I wrote called, uh, “Black Study, Black Struggle,” which was entirely inspired by, uh, Fred Moten and Stefano Harney’s, uh, book, “The Undercommons.” It was a way of the application of the notion of the undercommons to understanding what was happening at that moment, which in, in the fall of 2015, there was like an explosion of, um, Black protests on, on campus, and, you know, I won’t repeat what’s in the article, uh, but it, it’s not an accident that some of those struggles, uh, were products of what was happening in the streets. In other words, what happened in Ferguson, and what happened in Baltimore, what happened all over the country, and what happened in places like here in Toronto, were the catalyst for, um, a kind of explosion on campuses, where, uh, students were trying to figure out their place in the university. They’re dealing with racism, and microaggressions on university campuses, uh, they’re dealing with a, a kind of deracinated, you know, curriculum where ethnic studies wasn’t what it was, in its inception. Um, and, I was also dealing with, or many of us were also dealing with, uh, a culture of, and I hate to put it this way, but a culture of anti-intellectualism in, in a different sort of way. I mean, universities are often anti-intellectual, in that they actually disavow certain forms of knowledge and put other knowledge above that, which is an anti-intellectual position by the way. Um, but then when you’re assaulted by that all the time, uh, sometimes you end up mirroring that culture. And you’re saying “well I’m not gonna read this, I’m not gonna read that, because so-and-so wrote it,” as opposed to saying that there’s nothing off the table, uh, that Black studies, and Fred knows this ‘cause he repeats it more than I do, that our mutual, uh, teacher, Cedric Robinson, who paraphrased C. L. R. James, said you know, Black studies is a critique of Western civilization, and if that is the case, then we both have to dismantle it, recognize the weak edifice upon which it’s built, but also know everything that’s happening within it. But anyway, let me just back up, um, so, I just, so the three points I wanna make in reference to the question, one is that, uh, social movements have always been the catalyst for Black studies. When Fred was talking about, you know, Black studies as, as, uh, kinda, kinda like a way of life, as an atmosphere in which he grew up and which I grew up and many of us grew up, that’s so true. I never thought about it that way, but, you know, that’s so true. And in fact, um, if anything, Black Studies is not a multidiscipline but a project, a project for liberation, whatever that means, and liberation is an ongoing project. Um, Ruthie Gilmore, uh, who was at USC, uh, with me and Fred, had come up with this idea of renaming ethnic studies “liberation studies.” And, you know, we were actually serious about that, we were like, trying to figure out how to do that, and never filled it, but it reminds us that, you know, it’s not about, um, it’s not about a body. It’s not about bodies. It’s about ideas, and about the future, you know. It’s about recognizing the past and the construction of a new future. And so I think, in that respect, in order to understand the future of Black studies, we gotta understand the movements that produced it—that, that the Movement for Black Lives, that, um, uh, We Charge Genocide, that Black Youth Projects 100—all these struggles that erupted have, in fact, uh, pointed the way for Black Studies. The problem is, is that what gets constituted as the institutional space of Black studies, in many cases, isn’t really that. And I hate to bring people down, because we’re supposed to be up, right? But there are a lot of departments that I wouldn't call Black studies departments that have that name, you know, there are a lot of, there's a lot of scholarship that goes on that has no relationship at all to the project of transformation, or to people, to actual people in community. And one of the important things to always remember is that, um, we wouldn't have Black studies if it wasn't—in the United States, that is, I'm talking about the US—if it wasn't for Watts, if it wasn't for Detroit in 67, and if it wasn't for those kinds of urban rebellions, if it wasn't for the struggles in the South, that's where Black studies comes from. Uh, and so it moves into the university as a, as a transformative project. Um, it's not—and that's why I think there was a disconnect between some of the, the protests and what was happening in the academy. Finally, there’s this question of, of ethnic studies versus, or against, or for, or within or bedded in Black studies. And one of the things that, that I think a lot of us are trying to figure out is to deepen the relationship between indigenous studies and Black studies. Um, to understand that this was what I call second wave ethnic studies in the 1990s was itself a project that was, believe it or not, in a, a response to neoliberalism. And I think we don't always see that because we, we tend to read backwards in the 1990s and 1980s as, like, ethnic studies as identity politics in the narrowest sense of the word, that somehow this was about producing a sense of, of pride and a sense of identity devoid of the question of power. But if you actually look at the struggles for ethnic studies in the 80s and 90s, it was all about power. That, that what we think of as comparative or critical ethnic studies was, wasn't about the celebration of difference. It wasn't liberal multiculturalism. It was an assault on a neoliberal turn. And we, we sometimes forget that and, and, and then we write the history. And so I think I want to at some point talk more about that, but I think that's something to remember, because, right now, if we don't have Black studies as a critique in response to the neoliberal neofascist turn, then it's sort of worthless. You know, it's going to continue to exist. Maybe not in the academy though. So I'll just stop there.

WALCOTT: So, um, Robin, where you ended, and, and where Fred began, it’s a, is a good segue into getting you, both of you, to talk about the work that you've been doing around questions of Palestinian struggle and freedom. Fred, the work that, the tremendous work that you did in the ASA, um, American Studies Association, for which the Association is still living true, and, and Robin the work that you continue to do with um, um, with faculty for Palestine. But I'm thinking about Fred's provocation here that Black studies about saving the Earth and if Black studies is indeed about saving the Earth, which I'm very willing to fall right into right now, you know, first to kind of maybe think about this relationship between the struggle and, and freedom of Palestine and the relationship between ongoing settler colonialisms globally, because it seems to me that one of the most powerful things that, um, the kind of Black studies that has taken to the streets recently has done is to make those kinds of concerns present, right? BLM visits to Palestine, BLM in Toronto, always making sure that the invocation of the politics of settler colonialism is a part of a political organizing, and, um, their intimate relations with indigenous communities. So maybe this is a way for us to begin to talk about what's really at stake in this contemporary political moment where, um, or, or a radical politics, a politics that wants to think a different kind of future formation, is grappling with, um, settler colonialism in various kinds of ways. But Palestine being central to that, given that we know as we sit in this university is that often, um, what we call our senior administrators have an entirely different relationship with the question of freedom for Palestine.

MOTEN: Well, um, first, I mean, the work I did around, um, you know, the ASA’s, um, you know, decision to endorse the academic and cultural boycott of Israel was really minimal and minor compared to a lot of other people who were really out front, um, and, and have been working tirelessly for that for many, many years. Um, and I think, you know, the, my contribution was more, you know, rhetorical in many ways in, in, in, and, and maybe, maybe theoretical only in the most minimal sense, in the sense that what I wanted to do was a couple of things. First, to recognize that, um, you know, let's say that the conditions of what people call modernity, um, in, in, in, in, or global modernity, that the fundamental conditions that make that up are, you know, settler colonialism. And I think we can talk about settler colonialism in ways that are broader than the normal way that we usually think of them as a set of violent and brutal relations between Europe and the rest of the world. Because I think it's really important. And, and, and again, our, our mutual friend and mentor Cedric Robinson, pointed this out emphatically, and in brilliant ways early on, that settler colonialism is also an intra-European affair. Um, and it's important to understand that. It's important to understand this historic relationship between settler colonialism in the enclosure of the commons, um, which is part and, part of the origins of, of what we now know or understand as capitalism. But if we understand that settler colonialism, that the transatlantic slave trade, um, and that, you know, the emergence of a set of philosophical formulations that essentially provide for us some modern conception of self that has as its basis a kind of possessive, heteronormative, patriarchal individuation, right? That's what it is to be yourself on the most fundamental level. You know, and if you ask anybody in the philosophy department, they'll tell you that that's true, you know, and they won’t be joking, right, that, um, that, these, that these constitute the basis of, of our modernity. But for most of the people who live in the world, actually for everybody who lives in the world, although most of the people in live in the world are actually able to both recognize this and say this, that modernity is a social and ecological disaster that we live, that we now attempt to survive. Okay? And if we take that up, then part of what's at stake is that we recognize that feminist and queer interventions against heteronormative patriarchy, that Black interventions against the theory and practice of slavery, which is ongoing, that indigenous interventions against settler colonialism constitute the general both practical and intellectual basis for not only our attempts to survive, but also our attempts to, as I said before, save the Earth. And, and I put it in terms that the great poet Ed Roberson puts it; not just to save the Earth, but to see the Earth before the end of the world. And this is an emergency that we're in now and it's urgent. Um, and I believe that there’s a specific convergence of black thought and indigenous thought that situates itself precisely in relation to, and is articulated through, the interventions of queer thought and feminist thought that we want to take up. And, and it, and it strikes me as, for me at least, it's, it's a way of taking up a kind an—it's, it’s a way of imagining how one might be able to, how we might be able to walk more lightly on the Earth. To honor the Earth as we walk on it, as we stand on it. To not stomp on it, to not stomp all over it, where every step you take is a claim of ownership. And, and this is one way to put it, would be to not so presumptuously imagine that the Earth can be reduced to something so paltry and so viciously understood as what we usually call home. This is part of the reason why the queer and the feminist critique is so important. It's a critique of a general problematic notion of domesticity. It's like another way of being on the Earth that doesn't allow you in some vicious and brutal way to claim that it is yours, right? Um, this is important and this is so, you know, often the methods that we use to claim the Earth as ours involved fences, borders. This manifests itself on a private level from household to household, but it also manifests itself on a national level, and at the level of the nation state, and it's not an accident that settler colonial states take it upon themselves to imagine themselves to be the living embodiment of the legitimacy of the nation state as a political and social form. For me, there's two reasons to be in solidarity with the people of Palestine. One is because they're human beings and they're being treated with absolute brutality, but the other is that there's a specific resistance to Israel as a nation state. And for my money, to be perfectly clear about this, I believe that this nation state of Israel is itself an artifact of antisemitism. If we thought about Israel and Zionism, not just as a form of racism that results in the displacement of Palestinians, but if we also think about them as artifacts of the historic displacement of Jews from Europe, right, in the same way that we might think of, let's say Sierra Leone or Liberia as artifacts of racist displacement, okay. If we think about it that way, okay, and another, and the reason I'm saying this is just to make sure that you know that there's a possible argument against the formulation that criticism of Israel is anti-Semitic when we know that Donald Trump is a staunch supporter, that people like Pat Robertson in the United States are staunch supporters that help us to the fact that you can be deeply anti-Semitic and support the state of Israel. These things go together. They're not antithetical to one another. So that it becomes important for us to be able to suggest that resistance to the state of Israel is also resistance to the idea of the legitimacy of the nation state. It's not an accident that Israel has taken upon itself, that when Israel takes upon itself, when the defense of Israel manifests itself as a defense of its right to exist, this is important. It's a defense, not just of Israel's right to exist, but of the nation state as a political form’s right to exist. And nation states don't have rights. What they're supposed to be are mechanisms to protect the rights of the people who live in them, and that has almost never been the case, and to the extent that they do protect the rights of the people who live in them, it's in the expense, it's at the expense of the people who don't, okay. So part of what's at stake, one of the reasons why it's at, it's important to pay particular attention to this issue, why we ought to resist the ridiculous formulation that singling out Israel at this moment is itself anti-Semitic is because it's important to recognize that Israel is the state. [KELLEY: Right.] MOTEN: For reasons that I think are totally bound up with antisemitism, right? Israel is the state that, insofar as it makes the claim about its right to exist, is also making the claim about the nation state’s right to exist as such. It's this, it's that same kind of argument that, I remembered the—and I'm sorry to keep going on so long, but there's—there's those formulations that people often make about Black people in it or indigenous people as if they were the essence of the human, right, so that every time Black people or indigenous people do something that supposedly we're not supposed to do, it constitutes a violation to the very idea of the human. Right, because somehow as a function of the nobility of our suffering, we constitute the very idea of humanity, right? And there's nothing more brutal, right? Nothing more vicious than having been being consigned to that position. Similarly, Israel as a function of anti-Semitism has now been placed in the position of protecting the very idea of the nation state. So for me, first and foremost, it's important to have solidarity with the Palestinian people, but second of all, it's important to actually have some solidarity with the Jewish people insofar as they can and must be separated from the Israeli state because ultimately the fate of the Jewish people, if it is tied to this, to the nation state of Israel, will be more brutal than anything that has yet been done or can be imagined, and I mean everything that you think I mean when I say that.

### 1AC: Underview

#### 1AR theory – a) AFF gets it because otherwise the neg can engage in infinite abuse, making debate impossible, b) drop the debater – the short 1AR irreparably skewed from abuse on substance and time investment on theory, c) no RVIs – the 6-minute 2nr can collapse to a short shell and get away with infinite 1nc abuse via sheer brute force and time spent on theory, d) Competing Interps – 1AR Interps aren’t bidirectional and the neg should have to defend their norm since they have more time. Fairness is a voter – its intrinsic to debate, key to test the truth of any argument that says fairness doesn’t’ matter. Education is a voter it’s why schools fund debate Also, aff theory outweighs neg theory or T: ¼ of the 1AR versus 1/7 of the 1NC.

#### Disparities within health are not ontological but formed and maintained by social norms upheld by legal indifference – solving the discriminatory practices of public health is uniquely key as a starting point

Matthew 18, Dayna Bowen. Just medicine: A cure for racial inequality in American health care. NYU Press, 2018. (Resident senior fellow in the Center for Health Policy, who works at the University of Colorado School of Law, the Colorado School of Public Health, and the Center for Bioethics and Humanities at the University of Colorado Health Sciences Center specializes in health and behavioral sciences and her research interests include public health law, poverty, and ethics in health professions)//Elmer

For the past thirty years, medical doctors, social scientists, psychologists, policy analysts, jurists, and a wide spectrum of health care providers have been studying and discussing health inequality in America. Meanwhile, by one estimate, 83,570 minority patients die annually due to health care disparities. Black and brown patients consistently receive inferior medical treatment—fewer angiographies, bypass surgeries, organ transplants, cancer tests, and resections, less access to pain treatment, rehabilitative services, asthma remedies, and nearly every other form of medical care—than their white counterparts. Yet minority patients are sicker and more likely to die than whites from a wide range of diseases and illnesses for which we have data. Certainly, this picture is complicated. For example, health and illness for all racial and ethnic groups follow a social gradient so that minority populations, which disproportionately occupy low socioeconomic strata, also predictably suffer relatively worse health outcomes than whites do. Although it is popular to blame the poor for the their poor healthy by pointing to risky health behaviors, careful studies of nationally representative populations conclude that the significantly higher prevalence of cigarette smoking, alcohol consumption, obesity, and physical inactivity are only one aspect of the relationship between lower socioeconomic status and poor health. Moreover, behavioral disparities must not be taken out of their societal context where unequal exposure to the stress of discrimination, inequitable access to healthy food and built environments, and inferior access to resources generally are integrally associated with many racial and ethnic differences in health behavior. In fact, racial and ethnic differences in health treatment and outcomes persist in multiple studies even after controlling for differences in insurance status, income, education, geography, and socioeconomic status. Researchers have identified numerous structural and individual determinants of these disparities at all levels. These include socioeconomic circumstances such as poverty, inferior education, and segregated housing conditions along with lack of access to healthy food choices or recreational facilities; systemic and organizational contributors such as medical practice settings and sources of insurance; and geographic proximity to care. The economic and social conditions called “social determinants of health” often drive patient-specific contributors to poor health such as poor family health history, diet, and low physical activity. All have been shown to contribute to the disparity of health outcomes experience by ethnic and racial minority patients in the United States. However, this book is about the single most important determinant of health disparities that is not being widely discussed in straightforward terms: this determinant is racial and ethnic discrimination against minority patient populations, an uncontrovertibly significant contributor to health inequality. The evidence that the majority of Americans involuntarily harbor anti-minority prejudices makes it impossible, even immoral, not to examine the impact of unconscious racism on health and health care. Therefore, this book makes a thorough examination of the scientific evidence that does exist to confirm that providers discriminate against patients and patients discriminate against providers. This cycle of discrimination produces inequality throughout the health care system. The inequality itself is not news. But the fact that it is avoidable challenges the complacency that allows the racial and ethnic discrimination that produces them to persist. This book calls for providers, patients, scientists, and jurists to face the uncomfortable truth that although overt racism, prejudice, and bigotry may have subsided in America, racial and ethnic injustice, unfairness, and even segregation in American health care have not. The most tragic proof that racial and ethnic injustice is alive and well is the phenomenon we politely call “health disparities.” The message of this book is that a significant cause of these health disparities is the unconscious racial and ethnic bias that infects our delivery system. Implicit racial and ethnic biases in health care are harmful, avoidable, and unjust. This book charts a way to deal with health and health care disparities as injustices, not merely as inevitable byproducts of human nature or a phenomenon subordinate to biological and social differences. Instead, the argument made here is that health inequality due to unconscious discrimination is a structural malady in need of a system cure. This book lays bare a disturbing contradiction. On one hand, injustice and inequality are anathema to our professed national identity. Yet on the other hand, unconscious bias has become an entrenched and acceptable social norm, empirically demonstrated to control decision-makers not only in health care, but in civil and criminal justice proceedings, law enforcement, employment, media, and education. Unconscious racism has become the new normal. Thus, to defeat inequality due to unconscious racism in health care, individuals as well as institutions must realign themselves away from this social norm that is incongruous with the core underlying values to which our nation’s doctors, patients, and health care professionals expressly aspire. The solutions this book proposes are comprehensive; they have their origin in law, and to some this may seem radical. But they are solutions grounded in a historical and empirical record. The solutions are further supported by original, qualitative interviews reported here. These narratives allow doctors, nurses, and patients to bring their voices and real-life experiences to bear on a worthy cause: achieving justice and equity in American health care. Chapter 1 recounts the historical origins of legally enforced discrimination that have laid the structural foundations for African, Asian, Hispanic, and Native Americans to suffer inferior health outcomes in the United States since this country’s inception. I argue that law has directly influenced the differences in health and health care experiences between minorities and whites throughout our nation’s history. When laws enforced slavery, segregations, and nationalism, minority health fared poorly. During the periods of our history when civil rights laws were effectively used to desegregate health care and promote equal access, health care disparities improved. Today, however, traditional civil rights laws have become irrelevant in the effort to bring justice to health care. Those antidiscrimination laws punish only outright bigotry and the most virulent forms of racism. Now that these forms of overt racism are out of vogue and mostly absent from the health care system, the rule of law has been neutralized and no longer controls racial discrimination. Therefore, the great American traditional of running two separate and unequal medical systems for white and non-white patients is back. Chapter 2 explains the nature and evidence of discrimination in contemporary health care. The quantitative and qualitative data gathered in this chapter explain that health care providers unintentionally discriminate against racial and ethnic minority patients—and that their unintentional discrimination directly and substantially contributes to ethnic and racial health care disparities. Moreover, the evidence also shows that patients hold implicit biases and thus react to providers discrimination through the lens of their own experiences with race bias and inequity. The result is a viciously reciprocal cycle of miscommunication between doctors and patients that ultimately harms patients’ health. When patients perceive or experience discrimination arising from implicit biases, they often respond rationally by seeking to minimize the reoccurrence of the offense. Thus, minority patients are more likely to switch providers, less likely to follow up on or adhere to their doctors’ advice, and more likely to generally distrust their providers. Decreased patient satisfaction and decreased continuity of care follow, to the detriment of minority health outcomes. Much of the current discourse on health disparities “blames the victim,” charging patients with non-adherence and with poor diet and living choices or alleging the existence of biologically based justifications for inequality. My analysis of patient bias does not belong to this genre. Instead, I employ the evidence that patients unconsciously react negatively to unconscious racism to explain how implicit bias is a culprit on both sides of the clinical encounter, which occurs within a structurally unsound environment that in turn reinforces bias. Chapter 3 presents a preponderance of evidence showing that providers’ disparate treatment of their minority patients is closely associated with their implicit racial and ethnic biases. This chapter identifies physicians’ unconscious racism as a primary contributor to health disparities. Chapters 4, 5, and 6 present the Biased Care Model, one of this book’s core contributions to advance our understanding of health and health care disparities. The Biased Care Model organizes the best social science literature on implicit bias into a conceptual framework to answer important, but hitherto unresolved questions raised by the Institute of Medicine in its landmark 2003 report on American health disparities. Specifically, the Biased Care Model identifies the mechanisms by which implicit biases affect disparate health outcomes. The model explains how health providers continue to discriminate against minority patients even as polls and surveys tell us that most Americans, especially doctors, are decidedly not racists. The model’s mechanisms are grounded in empirical literature and are supported by the voices of doctors and patients whose interviews confirm the presence and influences of implicit biases in their clinical experiences. Thus, the rich qualitative and quantitative data that supports the Biased Care Model spans three chapters. Chapter 4 describes the impact implicit biases have before a physician and patient meet, chapter 5 discusses the role of implicit biases during the clinical encounter, and chapter 6 examines the mechanisms that permit implicit biases to continue contributing to health disparities even after the clinical encounter ends. The questions these chapters confront are tough, and the facts are uncomfortable. The answers the Biased Care Model provides fill an important void in our understanding of the way health inequalities evolve, and thus they lay the foundation for fashioning evidence-based policy solutions. Chapter 7 introduces an evidentiary “game changer” in the discourse about addressing implicit bias in health care. This chapter explains the social science evidence that implicit racial and ethnic biases are malleable. Contrary to popular fiction, unconscious racism is neither inevitable nor unalterable. This chapter is full of evidence that confirms that the habit of acting out of one’s implicit racial biases can be changed. Therefore, the chapter concludes, health care providers and the institutions that employ them can be held morally responsible for addressing the inequities these biases cause. This chapter opens the way for structural responses to the health disparity crisis. The next chapter explains why responding to this crisis is not only a moral responsibility, but also appropriately a legal one.

Chapter 8 answers the question that will plague many health care providers who read this book, especially those who are sympathetic to the cause of justice and equality in health care: Why do we need a law to deal with implicit bias? The short answer is that other avenues will simply not work. Political efforts at universalizing access, regulatory efforts at enforcing cultural competency, and private efforts at “doing the right thing” have all failed. At best, these well-intentioned efforts have only reinforced the culture in which it is assumed that explicit racial motives have little remaining influence on health disparities today. Implicit biases are not entirely impervious to these programs and policies, but the public health policy literature helps to explain why they are insufficient solutions. The more complete answer is that health care disparities are rooted in structural inequities and therefore require a structural solution. Consequently, the legal reforms I propose will change the context in which health care is delivered and shift the social norm that has tolerated health inequality for far too long. The policy problem presented by health care disparities has both the good and bad fortune to be a late-comer to the list of complex practical conundrums that fundamentally challenge broad constitutionally protected American values such as racial equality and justice, but require interventions at the intersection of law and science to solve. For example, law has joined with scientific expertise to help regulate the evolving challenges presented by climate change, genetically modified foods. and pharmacogenomics just to name a few examples. Accordingly, chapter 8 makes the case for strengthening legal interventions to promote health equality. Chapter 9 proposes concrete reforms founded on legal and scientific solutions to the problem of racial and ethnic health disparities. This chapter challenges current antidiscrimination law’s “naive” assumption that humans act solely in accordance with their explicit and conscious intentions. In fact, the scientific evidence indicates that we all act much more consistently with our unconscious and implicit intentions. I compare the assumptions about human behavior that underlie the current law to what we know about real human behavior as it impacts health and health care, and I argue that antidiscrimination law should better match reality. I conclude with an appeal for action directed towards the four stakeholder groups I hope to impact most: social scientists, health care providers, law and policy-makers, and patients. I ask each group to consider its role in eradicating health inequality and to consider this book’s broader implications for the fight for racial and ethnic equality beyond health care. While my focus here is on unconscious racism, I do not overlook other determinants of health disparities that will not succumb to legal remedies. Changing only the law will not solve the socioeconomic disparities that lie at the foundation of our society and produce the poor health experienced by many poor people. Yet neither do I use the complexity of the problem and its causes as an excuse to avoid forthrightly addressing the pervasiveness of discriminatory health care. I also cannot shrink from confronting implicit racial bias due to a seemingly paralyzing fear that doing so is the equivalent of charging health care providers with outright racism and bigotry. The cure for this paralysis is an accurate understanding that implicit and unconscious biases are facts of American life that contradict and work against most Americans’ true intentions. Physicians are no exception; they need not be racist to discriminate against racial minorities. Nevertheless, discrimination due to implicit bias must be addressed because it unnecessarily decreases the quality and length of life of people in this country who are not white. Distinguishing overt from unconscious racism frees us to honestly and candidly address the problem of providers’ implicit bias. In the process. we will see that the scientific evidence is legally sufficient to warrant or even mandate reform of antidiscrimination law. I reach one primary conclusion in this book. It is that the presently available social science evidence associating implicit racial and ethnic bias with health disparities provides a morally compelling and legally sufficient basis for legal action. A sufficient stack of “further research” –the social scientist’s beloved refrain—could not be generated fast enough to slow the devastating effects of implicit bias on the lives of tens of thousands of minority patients each year. Ignoring health disparities due to discrimination is costly. In addition to the nearly 84,000 people of color who needlessly lose their lives annually due to health disparities, there are significant economic burdens imposed by health care discrimination. A 2009 report by the Joint Center for Political and Economic Studies estimated that eliminating health disparities would have reduced direct medical care expenditures by $229.4 billion and indirect costs due to illness and premature death by approximately $1 trillion during 2003-2006. Therefore, the pages that follow unite the medical, neuroscientific, psychological, and sociological expertise on the issue of implicit bias and health disparities with the powerful influence of explicit and enforceable rules of law to devise an effective and innovative plan to reduce implicit biases in health care and eliminate the inequity they cause so that all in America can enjoy a just, humane health care system, regardless of color, race, or national origin.

#### Monopolization and high drug prices is pharmaceutical capitalism.

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.

#### Yes sustainability -- Tech Innovation drives dematerialization

McAfee 19, Andrew. More from Less: The Surprising Story of How We Learned to Prosper Using Fewer Resources—and What Happens Next. Scribner, 2019. <https://drive.google.com/file/d/1SdXDFeq9gbuG7zVAP-vzCXgbALIm9W9d/view?usp=sharing> (Cofounder and codirector of the MIT Initiative on the Digital Economy at the MIT Sloan School of Management, former professor at Harvard Business School)//Elmer

Partial excludability is a beautiful thing. It provides strong incentives for companies to create useful, profit-enhancing new technologies that they alone can benefit from for a time, yet it also ensures that the **new techs will eventually "spill over**"—that with time they’ll diffuse and get adopted by more and more companies, even if that's not what their originators want. Romer equated tech progress to the production by companies of nonrivalrous, partially excludable ideas and showed that these ideas cause an economy to grow. What's more, he also demonstrated that this **idea-fueled growth** doesn't have to slow down with time. It's **not constrained by** the size of the **labor** force, the amount of natural **resources**, or other such factors. Instead, economic growth is limited only by the idea-generating capacity of the people within a market. Romer called this capacity "human capital" and said at the end of his 1990 paper, "The most interesting positive implication of the model is that an economy with a larger total stock of human capital will experience faster growth." This notion, which has come to be called "increasing returns to scale," is as powerful as it is counterintuitive. Most formal models of economic growth, as well as the informal mental ones most of us walk around with, feature decreasing returns—growth slows down as the overall economy gets bigger. This makes intuitive sense; it just feels like it would be easier to experience 5 percent growth in a $1 billion economy than a $1 trillion one. But Romer showed that as long as that economy continued to add to its human capital—the overall ability of its people to come up with new technologies and put them to use—it could actually grow faster even as it grew bigger. This is because the stock of useful, nonrivalrous, nonexcludable ideas would keep growing. As Romer convincingly showed, economies run and grow on ideas. The Machinery of Prosperity Romer's ideas should leave us optimistic about the planetary benefits of digital tools—hardware, software, and networks—for three main reasons. First, countless examples show us how good these tools are at fulfilling the central role of technology, which is to provide "instructions that we follow for combining raw materials." Since raw materials cost money, profit-maximizing companies are particularly keen to find ways to use fewer of them. So they use digital tools to come up with beer cans that use less aluminum, car engines that use less steel and less gas, mapping software that removes the need for paper atlases, and so on and so on. None of this is done solely for the good of the earth—it's done for the pursuit of profit that's at the heart of capitalism—yet it benefits the planet by, as we've seen, causing us to take less from it. Digital tools are technologies for creating technologies, the most prolific and versatile ones we've ever come up with. They're machines for coming up with ideas. Lots of them. The same piece of computer-aided design software can be used to create a thinner aluminum can or a lighter and more fuel-efficient engine. A drone can be used to scan farmland to see if more irrigation is needed, or to substitute for a helicopter when filming a movie. A smartphone can be used to read the news, listen to music, and pay for things, all without consuming a single extra molecule. In the Second Machine Age, the global stock of digital tools is increasing much more quickly than ever before. It's being used in countless ways by profit-hungry companies to combine raw materials in ways that use fewer of them. In advanced economies such as America's, the cumulative impact of this combination of capitalism and tech progress is clear: **absolute dematerialization** of the economy and society, **and thus a smaller footprint on our planet**.

#### Only reinvigorating innovation solves high drug prices -- topples drug monopolies.

Engelberg 19 [Alfred B. Engelberg is a retired intellectual property lawyer and philanthropist. During his legal career, he was a patent examiner at the US Patent Office, a patent trial attorney at the US Department of Justice, and a member of the New York City law firm of Amster, Rothstein, and Engelberg. February 28, 2019. “A Shortfall In Innovation Is The Cause Of High Drug Prices”. <https://www.healthaffairs.org/do/10.1377/hblog20190228.636555/full/>] Dhruv

A System That Generates Profits Rather Than Research And Innovation

Each year the drug industry loses revenues because the monopolies on older medicines expire and they become available as low-cost generics. For at least the [last decade, revenue declines](https://www.nytimes.com/2011/03/07/business/07drug.html) have been large because blockbuster drugs for treating cholesterol, blood pressure, diabetes, depression and acid reflux have all become generic. Generic versions of Lipitor, Nexium, Prozac and many other blockbusters are now taken by millions of patients every day. In contrast, new drugs launched during the last decade are mostly specialty and orphan drugs that are taken by far fewer patients.  Despite their high initial prices, these drugs don’t generate enough revenue to replace the revenue lost from blockbuster monopoly expirations.

To avoid reporting lower revenue and profits, drug manufacturers have been imposing large annual price increases, often 10 percent or more, on all drugs that remain protected by monopolies.  The cumulative effect has been to double or triple the price of top-selling branded drugs such as Humira, Lyrica, Lantus and many others. That is why US drug prices are the highest in the world.   Here is what the IQVIA (formerly IMS) annual [reports](https://structurecms-staging-psyclone.netdna-ssl.com/client_assets/dwonk/media/attachments/590c/6aa0/6970/2d2d/4182/0000/590c6aa069702d2d41820000.pdf?1493985952) on medicine use show for the decade from 2008-2017:

Lost revenue from monopoly expirations was [$185 billion](http://www.piapr.org/clientuploads/PRESENTATIONS/IQVIA_Institute_2018_and_Beyond.pdf) whereas revenue gained from new medicines was only $169 billion.

Increases in invoice prices – the list prices often used to determine patient cost-sharing -- generated $187 billion. Net revenue -- the revenue remaining after deducting rebates and other price concessions -- increased by $106.

Undiscounted spending on prescription pharmaceuticals grew $167 billion (58 percent) from $286 to $453 billion, while the number of prescriptions filled with a brand-name medicine fell 59 percent, from over 1 billion to fewer than 450 million per year.

Generic drug use rose from 72 percent to 90 percent of all prescriptions.

Many commentators, including an article by [Hernandez et. al](https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05147) in the January 2019 issue of Health Affairs, have noted that price increases have been an important factor in the rising cost of drugs. What this data makes clear is that without the enormous price increases on a shrinking market for new medicines, the industry’s revenues and profits would have remained essentially flat for a decade.  In addition, but for these price increases, the overall cost of prescription drugs would have declined over the last decade as a result of the large increase in the percentage of prescriptions filled with a generic medicine.

Price increases largely fueled profits rather than additional research spending. According to the [GAO](https://www.gao.gov/assets/690/688472.pdf), profit margins grew to over 20 percent for the largest drug companies, more than double the average profit margin of the largest 500 industrial companies. Yet, from 2008 to 2014 research spending increased by only $8 billion and PhRMA companies [report](https://www.statista.com/statistics/265085/research-and-development-expenditure-us-pharmaceutical-industry/) a total of $18 billion in increases from 2015 to 2017. Moreover, the bulk of the industry’s spending was on later-stage development of new drugs acquired from 3rd parties. This suggests that drug manufacturers have become increasingly dependent on federally funded research at academic medical centers to seed a drug development pipeline.

Over the past 40 years, drug manufacturers successfully lobbied for longer monopolies, claiming that this would spur greater investment in research.  Legislation providing for patent term extensions of up to 5 years and market exclusivities of 5 to 12 years have lengthened the average monopoly period from less than 8 years to [over 14 years](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2109854) for the top-selling drugs.  The length of these monopolies has been augmented by a variety of monopoly abuses including pay-for-delay patent settlements, denying generic manufacturers access to the samples needed to gain approval for competitive products, and “patent evergreening,” i.e. obtaining numerous secondary patents of dubious quality to delay competition.   Longer monopolies appear to be a substitute rather than an incentive for innovation because they make it easier for manufacturers to earn profits without the risk and cost of investing in the discovery of new medicines.

#### Refuse to categorize biomedicine as completely bad – medicine and disease are not stable categories.

Parens 13, Erik. "On good and bad forms of medicalization." Bioethics 27.1 (2013): 28-35. (Senior Research Scholar at The Hastings Center)//Elmer

It can be appropriate to use medical means to prevent suffering and enhance well-being even if the source of the problem is not a disease. Laura Purdy2 For the last thirty or forty years, sociologists have used the term medicalization to refer to the process by which ‘non-medical’ (or ‘life’ or ‘human’) problems become understood and treated as ‘medical’ problems.3 Of course social scientists typically understand themselves to be describing – not evaluating – social processes. Indeed, one of the fathers of medicalization theory, the sociologist Peter Conrad, has stated more than once that the term medicalization is value neutral. In his recent book he writes: ‘While medicalization describes a social process, like globalization or secularization, it does not imply that a change is good or bad.’4 That assertion notwithstanding, when sociologists use the term medicalization, they have traditionally assumed that the process it names is bad. In this paper, I will suggest that we in **bioethics should not make** that **simplifying assumption**, but should instead do the complex work of attempting to **distinguish between good and bad** forms of **medicalization**. That suggestion might sound radical at first, but it isn’t. In fact, into both the sociological and bioethical literatures there has already begun to creep a distinction which does roughly the same work as the distinction I’m getting at with the difference between ‘bad’ and ‘good’ forms of medicalization. I am referring to the distinction between ‘over-medicalization’ (which is assumed to be bad) and ‘medicalization’ (which is assumed to be not bad). In an attempt to deflect the criticism that the term medicalization entails but does not acknowledge the assumption that the process is bad, Conrad writes: ‘While ‘medicalize’ literally means ‘to make medical,’ and the analytical emphasis has been on over-medicalization and its consequences, assumptions of over-medicalization are not a given in the perspective.’5 That is, in the course of attempting to deflect the charge that the sociological analysis takes the badness of medicalization to be ‘a given,’ Conrad tacitly distinguishes between overmedicalization, which is bad, and medicalization, which apparently is not. One can find the same tacit distinction in the bioethics literature. In their argument for distinguishing between using memory-attenuating drugs to respond to Post Traumatic Stress Disorder (which they approve of) and using the same drugs to achieve non-medical purposes (which they do not approve of), Michael Henry and colleagues write: ‘If memory-attenuating drugs prove effective, we argue that the most immediate social concern is the over-medicalization of bad memories and its subsequent exploitation by the pharmaceutical industry.’6 Like Conrad, Henry et al. tacitly distinguish between medicalization and over-medicalization. They approve of the sort of ‘medicalization’ that occurred when we applied the PTSD diagnosis to the once-familiar human problem of shell shock, but disapprove of the sort of ‘over-medicalization’ that a pharmaceutical company might initiate with the creation of a new diagnosis like Bad Memories Syndrome. I am merely suggesting that we should become explicit about what we’re already trying to do: get over **the traditional assumption that medicalization is bad per se**, and try to articulate the difference between good and bad forms of it. In preparation for explicating how such an attempt has actually begun in the context of the debates about using pharmaceuticals to shape our experience of love, I want first to rehearse what I take to be the great insights as well as the blind spots built into the term medicalization. I. THE MEDICALIZATION CHARGE HAS TRADITIONALLY ILLUMINATED AND OBFUSCATED What’s wrong with medicalization? First, construing non-medical (or life or human) problems as medical problems, construing normal human variations as pathological, commits a category mistake. Sadness is a problem that human beings experience when, for example, someone they love dies. Shyness can be an unpleasant state that many people experience upon meeting new people. Short stature can occasion unpleasant feelings in some short individuals. And so on. But, the critic of medicalization observes, neither sadness7 nor shyness8 nor short stature9 is a medical problem. Sadness is a normal, perhaps even essential part of a full human life. The feelings that can go with being sad or shy or short may be difficult, but they are not symptoms of disease; only disease-mongers suggest otherwise. To treat human problems as medical problems, according to the critique, is to make a mistake about the nature of the world. Seeing clearly and living well require us to avoid such a mistake. More specifically, living well requires that we learn to let some sorts of problems be. It requires that we learn to affirm, rather than try to erase, variations in our moods, behaviors, and appearances. In addition to entailing a category mistake, medicalization can have bad consequences. Perhaps the easiest to see is that, insofar as medicalization expands the category of what warrants medical treatment, the cost of medical treatment grows exponentially. While this may be to the advantage of gluttonous purveyors of medical products and services, it makes it ever harder for any government to pay for medical care for all.10 On top of the astronomical direct costs of such interventions are the indirect costs of their side-effects. A second bad consequence is that, insofar as the institution of medicine focuses on human beings as objects (i.e. as bodies), the medicalization process potentially undermines seeing ourselves as subjects; it potentially undermines our ‘subjectivity.’ When we argue, say, against the medicalization of badness – e.g., against treating criminal behavior as the symptom of a psychiatric disorder – we are arguing against the view of ourselves as objects at the mercy of forces beyond ourselves, and for the view of ourselves as subjects who can choose. Similarly, when, for example, we argue against using medical means such as drugs to treat sadness, we are often arguing against the view of ourselves as objects that can be fixed and for the view of ourselves as subjects who can be influenced by reasons.11 The critic of medicalization can accept that we need both ways of understanding ourselves, but worry that the medical way is crowding out the other. This is at least one thing critics are getting at when they suggest that we should use means like psychotherapy before or instead of using drugs. A third bad consequence of medicalization is that, insofar as medicine focuses on changing individuals’ bodies to reduce suffering, its increasing influence steals attention and resources away from changing the social structures and expectations that can produce such suffering in the first place. The idea is that, for example, rather than changing the bodies of shy people with drugs, we could change our expectations of how people behave in novel situations; again, doing so, would exemplify the virtue of learning to affirm natural variation. Further, changing social expectations would be fairer to individuals, who, instead of changing their bodies to better fit dominant norms, could, again, be affirmed in their normchallenging variation.12 Whether critics argue that we are making a category mistake, or are creating a putative need that no government can afford to fulfill, or are undermining understanding ourselves as subjects, or are obscuring understanding the social sources of suffering, the basic idea is that it is bad when the institution of medicine oversteps its proper limits. As someone who is by nature-nurture a critic of medicalization, I think that the preceding worries are insightful and important. But I also want to call attention to what the critique can obfuscate. Specifically, I want to call attention to some of the problematic assumptions that the critique inadvertently entails – where by ‘problematic’ I mean assumptions that contradict or at least are in tension with other assumptions that critics like me tend to embrace. Problematic assumptions built into the notion of medicalization First, the idea of medicalization **depends upon the notion that medicine has ‘proper’ goals,** which are visible to those with knowledge of the essence of medicine. More specifically, while it’s true that broad conceptions of the goals of medicine (such as the World Health Organization’s) 13 are indeed available, one needs a narrow conception of those goals to get traction for the medicalization critique. Without a narrow conception, one can’t restrict the range of the targets that medicine ‘properly’ aims at. **Those** of us **attuned to how** institutional **goals change** over time with the coming and going of more and less savory political interests, however, **will be wary of** an **analysis that assumes knowledge of** a given institution’s ‘proper’ or ‘essential’ or **‘real’ goals**. Peter Conrad fully anticipates such wariness. Indeed, he begins his recent summary of his thinking on medicalization by saying that he will ‘bracket’ the question of whether the conditions he says are medicalized are ‘real’ medical problems.14 To justify setting aside the question of how he knows what a real medical problem is or what the proper goals of medicine are, he makes a distinction. He says that ‘it is the viability of the designation rather than the validity of the diagnosis that is grist for the sociological mill’ (emphasis added).15 He is asserting that when he uses the term medicalization, he does not mean to assume that he knows the difference between valid (or real) medical diagnoses and invalid (or fake) ones; he means only to assume that the new, expanded conceptions of medical problems are ‘viable’. But that distinction does not so much resolve as reintroduce the original concern about essentialism. How does the sociologist know which ‘viable’ diagnoses to investigate as examples of medicalization? To pick them she has to assume that she knows the difference between viable diagnoses that are valid and viable diagnoses that are not; otherwise she would have to investigate all viable medical diagnoses as instances of medicalization – and that is clearly not what is happening. All of which is to say that, the valid/viable distinction seems to depend on the same assumption – about knowing the difference between real and fake medical conditions – that Conrad recognizes is problematic. The specter of inadvertent essentialism remains. The medicalization critique’s narrow conception of the goals of medicine harbors other problematic assumptions as well. For one thing, it usually if not always entails the dualistic notion that the proper target of medical intervention is the disordered body, as distinct from the troubled mind. One familiar variation on this theme suggests that medicine should deal with disorders of the body, not disorders of the mind; or that it should treat disorders that are ‘organic,’ not ones that are context-dependent. For example, in a recent essay Jonah Lehrer recounts the tale of a psychiatrist who was taken aback to notice that, in his enthusiasm for prescribing antidepressants, he had failed to distinguish between suffering rooted in his patients’ dysfunctional bodies and suffering rooted in their minds or social contexts. The psychiatrist’s epiphany came when he asked one of his patients whether her antidepressants were working. She answered, ‘Yes, they’re working great . . . I feel so much better. But I’m still married to the same alcoholic son of a bitch. It’s just now he’s tolerable.’16 Lehrer and the psychiatrist’s point of course is that, because the woman’s problem was rooted in her relationship with her alcoholic husband rather than in her dysfunctional body, it was a mistake to treat her. That line of criticism’s great virtue is that it can be used to shelter some dimensions of human life from the raging storm of medical intervention. But it is important to beware of the lurking mind-body dualism. In the case Lehrer describes, the alternatives seem to be that the source of the woman’s suffering is either her body or her mind (and relationships). If we successfully jettisoned mind-body dualism, however, we would be wary of that disjunction. We might wonder, for example, about the role her embodied mind played in her entering into such a relationship in the first place. Such a question would not aim to blame the victim (!), but to remind us of how staggeringly complex mind-body (-world) interactions are. It would remind us to be on the lookout for an assumption that we would normally reject. Yet another problem with the critics’ narrow conception of the goals of medicine is that it usually entails – whether explicitly or inexplicitly – some notion of normal or species-typical functioning.17 The idea is that that we can look out into nature, discern the line between species typical and atypical functioning (or between behaviors inside and outside of the normal range), and thereby know whether to intervene. If the individual exhibits species-atypical (or ab-normal) functioning, she occupies a disease category and we should intervene, and if her functioning is typical (or normal), she doesn’t occupy a disease category and we shouldn’t intervene. It would be lovely if we could look to nature and discern the line between species-atypical and species-typical functioning, between the categories of disease and health. That way it wouldn’t be our ethical responsibility to decide, based on our understanding of the facts and our values, whether to intervene. We’d just point to nature. Alas, one would be hard pressed today to find a natural scientist who studies the etiology and diagnosis of disease and believes that those lines and categories are there for us to discover. Geneticists, neuroscientists, and others increasingly abandon the species-typicality model, which seeks to discover typical functioning, to embrace an individual-differences model, which seeks to understand why it is that, within populations, there is almost always continuous variation with respect to any trait or cluster of traits. On the individual differences view, what we call disorders are almost always ‘dimensional,’ not ‘categorical.’ As the psychiatric geneticists Ian Craig and Robert Plomin put it: Whereas the species typicality model . . . assumes that mental illness is a broken brain, . . . the individual differences model considers variation as normal. . . . Common mental illness is thought to be the quantitative extreme of the normal distribution.18 According to the individual-differences model (and the dimensional view that goes with it), there is no value-free, readily visible line between behaviors and traits that really are – and really aren’t – disordered. This is unfortunate in at least two very different ways. First, it means that purveyors of cures have ever more grounds to assert that even if we aren’t floridly ill, we’re still ill enough to purchase their cure; they can – and do – argue that we are within in the penumbra of illness.19 Second, it means that the ethical responsibility for deciding whether or not to intervene falls to us and our valueladen interpretations of nature; we can’t rely on the hoped-for, value-free guidance from nature. II. THE PHARMACOLOGICAL CALVINISM CHARGE HAS TRADITIONALLY ILLUMINATED AND OBFUSCATED In principle, the medicalization charge can be used to criticize the use of any means to achieve what is construed to be a non-medical purpose. But in our current context, with the avalanche of ever more pharmaceuticals, the medicalization charge often refers to the use of pharmacological means to deal with some normal human problem. When enthusiasts about self-shaping hear the medicalization charge, they sometimes exasperatedly counter that the critics suffer from ‘pharmacological Calvinism.’ Gerald Klerman first used that now-famous phrase in the early 1970s, in an article in the Hastings Center Report.20 According to Klerman, pharmacological Calvinists think that ‘if a drug makes you feel good, it not only represents a secondary form of salvation but somehow it is morally wrong and the user is likely to suffer retribution with either dependence, liver damage, . . . ,or some other form of medical-theological damnation.’ Klerman continues, ‘Implicit in the theory of therapeutic change is the philosophy of personal growth, basically a secular view of salvation through good works.’21 As Klerman was a psychiatrist, not a theologian, we can set aside his unconventional understanding of Calvinism and try to understand the insight at work in his charge. A less snarky version might read: ‘If pharmacological and psychotherapeutic means can both achieve the same end – improving how one experiences herself and the world – then it is irrational and perhaps inhumane to prefer the more strenuous and expensive means. It’s irrational not to take a shortcut when improving human well-being is the destination.Weshould be slower to imagine that suffering leads to growth and understanding, and quicker to remember that sometimes it just crushes human souls.’ Even if the chances of finding a ‘pharmacological Calvinist’ in the USA today are about as good as spotting a bald eagle in Manhattan, Klerman was surely right to observe that we come from long and particular traditions (originating in both Jerusalem and Athens), which have taught that with suffering comes understanding. Those traditions have valorized the suffering that goes with large and small normal human problems.22 Insofar as those traditions celebrated suffering for which there were no medical remedies, Klerman must be right that at least to some extent those traditions made a virtue of necessity. But he must be wrong to the extent that his charge invites us to ignore the respect in which suffering can be a crucial element in a good human life. To take but one example, which I mentioned above: even the staunchest self-shaping enthusiasts acknowledge the respect in which suffering from the loss of someone we love is ‘proper’ – and as such should be endured rather than erased. (Yes, I did suggest above that the notion of ‘the proper’ can obfuscate and here I amsuggesting that it can illuminate.) Moreover, the charge of pharmacological Calvinism must be wrong to the extent that it ignores how the means we use to reduce the suffering associated with normal problems can matter morally. As critics of medicalization argue, using medical means to solve normal human problems can lure us into thinking that the individual rather than her social context is the source of the problem. It can lure us into attending only to the respect in which we are objects – and ultimately to forgetting that we are also subjects, who can remedy some problems by giving and taking reasons to change our minds and contexts. Klerman’s charge can also obfuscate the fact that different means can emphasize different values in an even more obvious sense. Insofar as means like medications can be cheaper or work more quickly than, say, means like words, they can emphasize the value of efficiency. Insofar as means like words require the giving and taking of reasons between persons, they can emphasize the value of engagement. So, like the medicalization charge, the ‘pharmacological Calvinism’ charge can both help us to think and give us an excuse to stop thinking. If that’s right, we are saddled with a daunting ethical responsibility. By ‘we’ I mean those who think it is important to respond to the suffering of individuals and that it is important to attend to the social roots of that suffering; those who think it is important to consider ourselves as subjects and that we should be grateful for the ways in which considering ourselves as objects can help us to diminish human suffering; and those who worry that medicalization can be bad and believe that choosing for or against ‘medicalization’ full stop could be lazy or unhelpful. By ‘ethical responsibility’ I refer to the responsibility to attempt to distinguish between good and bad forms of medicalization. III. TOWARD A CONVERSATION ABOUT THE DIFFERENCE BETWEEN GOOD AND BAD FORMS OF MEDICALIZATION To start, it helps to remember the respect in which we already do embrace some forms of medicalization. When for example Dostoyevsky wrote The Idiot, the cluster of traits that today we call **epilepsy was called a divine gift**. In the beginning of the 20th century, that cluster of traits was construed as a ‘psychological’ disorder, and today we are **confident that ‘it’ is a proper medical disorder**. None of us criticizes the process whereby that particular constellation of traits was transformed from a divine gift into a medical problem. Nor does any of us criticize the process whereby what today we call **Alzheimer’s** disease **went from** being interpreted as the **moral** problem of ‘senility’ **to** being interpreted as a **medical** [disorder] ~~problem~~. One could counter that these aren’t examples of ‘good’ medicalization. Rather, they are only examples of us overcoming past mistakes: calling epilepsy a disease instead of a divine gift is just an example of aligning our everyday practice with our deeper scientific or medical knowledge. Mistaking epilepsy for a divine gift, goes this argument, is no more interesting than mistaking whales for fish. Fair enough. But this brings us to straightforward, harder-to-dismiss examples to support my suggestion that we should be skeptical about assuming that medicalization is bad, full stop. Many feminists and fellow travelers have in the past, with good reason, lamented the medicalization of everything from childbirth, to menstruation, to menopause.23 More recently, the institution of medicine has brought within its purview ‘labia-plasty,’ which its practitioners say can be used to treat ‘emotional problems such as embarrassment, anxiety, and loss of self-esteem’24 related to the shape of one’s labia minora. The profound, amplysupported concern is that, by bringing ever more normal features of women’s bodies and lives within the purview of medicine, disease mongers diminish women’s power to control their own bodies and, more generally, diminish their ability to flourish. While there may be no better arena than what gets called ‘women’s health’ to witness dis-empowering forms of medicalization, there may also be no better place to see empowering forms. As feminist philosopher Laura Purdy has argued in this journal25 – and others have argued elsewhere26 – a blanket condemnation of medicalizing ‘normal facets’ of women’s (and men’s) lives fails to acknowledge the respect in which women (and men) use medical technologies to gain control over their lives to promote their own flourishing.27 Consider for example the normal human capacity of producing eggs (or sperm), or the normal capacity of bringing a fertilized egg to term. Given that those capacities can’t be construed as symptoms of disease, and given that becoming pregnant when one doesn’t want to is a perennial human problem, we must grant that **using medical technologies** to control those capacities (**from birth control** pills**, to vasectomies**, to IUDs) **are forms of medicalization** – forms of medicalization **that seem good** to many of us. Even many of us who are in general deeply, wholeheartedly critical of the idea that more control is always better, embrace technologies that allow women to determine if and when they will become pregnant. We embrace those technologies not only **because** we believe that **women have a right to self-determination**, but because we know that women who cannot control if and when they become pregnant are at significantly increased risk of living (along with their children) lives blighted by poverty. For this observer, **fertility control counts as a good form of medicalization**. Of course, ‘many of us’ isn’t all of us. Who, though, objects to the process whereby what once was considered chronic pain associated with normal aging came to receive labels like Complex Regional Pain Syndrome (CRPS)?28 Before we could do anything to treat such pain, we construed it as a normal, if difficult part of the aging process. But once it’s technically feasible for healthcare professionals to reduce such pain, the door swings wide open to new diagnostic labels and ‘treatments’. What was once a problem of everyday living becomes a medical problem. It is a classic example of the medicalization process – but, I am suggesting, an example of ‘good’ medicalization. IV. THE MEDICALIZATION OF LOVE In the conclusion of a forthcoming essay, ‘Bioethics and Medicalization,’ the sociologist John Evans, writes: Most scholars of medicalization seem to have reached the normative conclusion that they do not want to live in a world where increasing swaths of human experience are under the logic of medicine. There are, or should be, experiences that use an older logic, which are under the jurisdiction of another profession or under no jurisdiction at all. We can all fear the medicalization of love (emphasis added).29 At work in Evans’s claim, is the at-first seemingly obvious assumption that medicalizing love is bad, full stop. But I want to suggest that even in the case of love, we need to try to distinguish between good and bad forms of medicalization. Indeed, I want to suggest that in the bioethics literature we can already begin to glimpse progress toward making such a distinction. Even mortal academic foes can sometimes agree on the difference between good and bad forms of medicalization In its characteristically heterocentric and fuddy-duddy tone, in Beyond Therapy the President’s Council on Bioethics offers a scenario that makes a deeply important point. They invite us to imagine a young man at a party who is under the influence of Ecstasy and begins a conversation with a woman he has never met before. He tells her that he loves her and wants to marry her. The Council invites us to imagine that the man means what he says ‘insofar as the feeling he now has is indistinguishable from what he might one day feel when he truly falls in love with a woman.’30 Then the Council asks, ‘Should the fact that this man’s feelings are produced by the drug, rather than inspired by the woman, matter?’ The Council argues that it should matter to the woman and to the man. It should matter to her because she wants to be seen as she truly is, not as the drug makes her seem. She wants recognition. And it should matter to him, too, insofar as he should want his love to be real. As the Council puts it, ‘The young man’s drug induced ‘love’ is not just incomplete – an emotion unconnected with knowledge of and care for the beloved. It is also unfounded, not based on anything – not even visible beauty – from which such emotions normally grow.’ Even we post postmodernists are here thrown back on some version of the distinction between the true and false, authentic and inauthentic. Even we have to accept the inescapability of such a distinction in the context of thinking about the sort of love we want for ourselves and for those we love. We want our feelings of love to grow out of knowledge of and care for the other. We want them to grow out of engaging in activities with the person we love. We want the other’s love for us to be chosen freely. We, even we post postmodernists, don’t want to settle for the feelings that grow out of a drug alone. No one familiar with the bioethics literature will be surprised to find this sort of argument in a report by the President’s Council, which is known both for its critique of self-shaping in general and medicalization in particular. It may be more surprising, however, to find a similar argument being made by enthusiasts about technological self-shaping. In a recent paper, Julian Savulescu and Anders Sandberg define a good marital relationship as ‘one which both parties desire and which gives each pleasure, and allows or facilitates each to lead lives which are objectively valuable.’31 To advance their argument, they make a distinction, which reveals an important value commitment they share with their academic foes, The President’s Council. Savulescu and Sandberg distinguish between using a drug to maintain a loving attachment and using a drug to create such an attachment. Specifically, they endorse using technology to maintain a relationship that is founded on shared perceptions of the goodness of the other, and the shared experiences that grow out of such perceptions, but they reject using technology to create the feelings normally associated with such perceptions and experiences. As the President’s Council might put it, we don’t want the illusion of love, we want the real thing. To make their point, Savulescu and Sandberg even use the language of authenticity, which is as unusual for them as it is usual for the Council. They write, ‘The use of drugs to instill a new love is more likely to create inauthentic love, since the causal reasons for the love may lie in the drug . . . , rather than the particular person loved.’ So at least we can say that, insofar as being without love is a normal, human, non-medical problem, and insofar as both sides would oppose using a technology to remedy that problem by creating a love out of whole cloth (i.e. in the absence of the feelings and experiences normally associated with love), it is fair to say that both sides agree that using a technology to create love out of whole cloth would be a bad form of medicalization. The problem is normal but the medical-technological solution is bad. But can both sides agree on a good form of medicalization? Well, Savulescu and Sandberg say that marriage counseling is a perfectly fine way to maintain a love relationship. The President’s Council doesn’t speak directly to this issue, but I see no evidence that they would disagree. Insofar as relationship difficulties are a normal human problem, and insofar as marriage counseling is sometimes done by people with medical degrees, it seems fair to say that both sides could in principle agree that relationship counseling to maintain a marriage relationship could be a good form of medicalization. While both sides might agree that using words (as in counseling) to treat relationship problems is a good form of medicalization – or at least is not a form of ‘overmedicalization’ – things might become more contested if someone proposed using drugs to remedy those problems. For example, would both sides agree that it is a good form of medicalization for marriage counselors to use Ecstasy to facilitate marriage counseling? (This is not hypothetical; Ecstasy has been used for this purpose.)32 30 President’s Council on Bioethics. 2003. Beyond Therapy: Bioetechnology and the Pursuit of Happiness New York, NY, Regan Books: 253. This is of course a variation on Robert Nozick’s famous ‘experience machine’ thought experiment in Anarchy, State, and Utopia. 31 J. Savulescu & A. Sandberg. Neuroenhancement of Love and Marriage: The Chemicals between Us. Neuroethics 2008; 1: 33–44. 32 S. Braun. 2001. Seeking Insight by Prescription. Cerebrum. 1 April. Available at: http://www.dana.org/news/cerebrum/detail.aspx?id=3046 [accessed 20 Jan 2011]. On Good and Bad Forms of Medicalization 34 © 2011 Blackwell Publishing Ltd. We can imagine that whereas the President’s Council might object, Savulescu and Sandberg would not. Indeed, even if Savulescu and Sandberg would oppose the creation of relationships with drugs, their conception of the appropriate use of drugs to maintain a relationship is far more expansive than the Council’s. Indeed, they invite their readers to imagine a woman who takes herself to be in a good and loving relationship with a man who happens to be promiscuous, and then invite us to accept that, in an effort to maintain her relationship, this woman might autonomously choose to take a drug that allowed her to tolerate her husband’s promiscuity. It strikes me that, for Savulescu and Sandberg to be consistent, they should reject the promiscuity-toleration pill on the same grounds that they rejected a pill that created the feelings of love out of whole cloth. In both cases, rather than facilitating engagement with the world as it really is, the pill distances the relevant parties from the world as it is. Again, however, their published article indicates that they could condone a drug that made the promiscuity of one partner tolerable for the other. But even if Savulescu and Sandberg agreed that, to be consistent, they should reject the promiscuity-toleration drug, I am surely not suggesting that they and the President’s Council agree on precisely how to articulate the difference between good and bad forms of medicalization – or between ‘medicalization’ and ‘over-medicalization.’ I am only suggesting that self-shaping critics and selfshaping enthusiasts do agree – at least implicitly – that we should attempt to articulate that difference. Insofar as some forms of medicalization can maintain or facilitate, as opposed to create or thwart, human relationships and experience, both sides – no matter how different their tones – need some version of that distinction. CODA Early on in this paper, I mentioned Jonah Lehrer’s example of the unhappy woman who was married to an alcoholic man. Following Lehrer, I suggested that construing her normal human unhappiness as depression would be a distressingly bad form of medicalization. No matter how much the medication might attenuate her suffering, that could not justify her becoming complicit in cutting herself off from an important feature of her life as it truly was. In that case, however, ‘the alcoholic husband’ was a sort of prop (not unlike ‘the promiscuous husband’ was for Savulescu and Sandberg). Lehrer and I were using the alcoholic husband to try to understand what we thought of the woman using an antidepressant to manage her unhappiness. But now we can ask, What should our attitude be toward her husband? Would it be bad to construe his alcoholism – and his accompanying unhappiness – as a medical disorder? Would it be bad to medicalize his bad behavior? I don’t think it would. Above I rehearsed some of the ever-present, very real social and philosophical dangers associated with medicalizing such behavior. I think, however, that if we remain vigilant about the ever-present dangers associated with the process of medicalization, and if the medical model of alcoholism can help someone to remedy the common human problem of excessive drinking, then medicalizing the alcoholic husband’s bad behavior might be good. To the extent that construing his bad behavior as a ‘medical’ problem can help him to take responsibility for his life and to start engaging in the sorts of meaningful relationships and activities that human beings seem to need and want, this seems to be a good form of medicalization This may make me a prime exhibit for (the sociologist) John Evans’s case that ‘bioethics’ has itself become an ‘engine’ of medicalization.33 And perhaps beginning to say out loud that some medicalization can be good puts us at still greater risk of creating exactly what Goethe feared: a world turned into one huge hospital, where everyone is everybody else’s humane nurse. I don’t dismiss or minimize either of those concerns. On the contrary, they trouble me deeply. But if we are committed to ‘ambiguity and complexity’ (as Evans says sociologists are, and I would say we all should be), if we are committed to helping flesh-and-blood human beings to engage in meaningful activities and relationships, then we might have to try to distinguish between good and bad forms of medicalization. That would take time and energy, and would delay the rest we all desire, but it might also be what we owe each other if flourishing for all is what we’re really after.