### 1AC – Advantage – Overdoses

#### Drug Overdoes from addictive opioids are rooted in patents – they incentivize companies to aggressively market and overprescribe them which leads to huge amounts of people becoming addicted

Vertinsky 8-2 [Liza Vertinsky, Associate Professor, Project Leader for Global Health Law & Policy Project, Global Health Faculty Fellow, Emory University School of Law, 8-2-2021, “To Address the Overdose Epidemic, Tackle Pharma Industry Influence” The Harvard Law Petrie-Flom Center, Accessed 8-18-2021, <https://blog.petrieflom.law.harvard.edu/2021/08/02/opioids-pharma-regulatory-capture/> ww

A recently released government report estimates that 93,000 people died from drug overdose in 2020. This estimate reflects a jump in the death toll of almost 30% from 2019 to 2020, with opioids as a primary driver.¶ In response, President Biden has called for historic levels of funding for the treatment and prevention of addiction and drug overdose.¶ Transforming mental health and addiction services is a critical part of tackling the overdose crisis, but it is not enough, on its own, to address this epidemic, or to prevent a future one. We must also alter the conditions that fueled expanded use, and abuse, in the first place. As I argue in Pharmaceutical (Re)capture, a forthcoming article in the Yale Journal of Health Policy, Law and Ethics, this includes a change in how we regulate markets for prescription drugs.¶ To truly combat the epidemic, I suggest, we have to understand how pain became such a lucrative business and how regulators failed to protect the public health as the market for prescription opioids grew. Then, we need to put this understanding to work in the redesign of pharmaceutical regulation.¶ Although an increase in the illegal use of synthetic opioids, such as fentanyl, accounts for many of the current overdose deaths, the overdose epidemic has its roots in the increased prescribing of opioids. As I describe in a case study of the opioid epidemic, these are drugs that have been developed through the direct and indirect use of public funds, incentivized by government grants of patent, data, and market exclusivities, approved for use by the U.S. Food and Drug Administration, prescribed by state-licensed physicians, paid for by highly regulated public and private insurers, and otherwise subject to government approval and oversight. I show how this epidemic emerged as the result of an intertwined evolution of medical approaches to treating pain, growth of the business of treating pain, and patient beliefs about the appropriate treatment of pain, an evolution largely driven by those with the largest financial stakes in opioid prescriptions and sales.¶ Pharmaceutical (Re)capture provides a framework for understanding the multi-faceted ways in which the largest industry players influence the operation of pharmaceutical markets, and uses this framework to expose the limitations of current regulatory approaches.¶ In an ideal world, regulations are designed to protect the public interest, but, in reality, special interests can sometimes dominate regulatory decisions – a phenomenon generally referred to as regulatory capture. While helpful in explaining why regulators may sometimes fail to adequately protect the public interest, this concept is too narrow to encompass broader forms of industry influence over all material aspects of pharmaceutical markets and their regulation.¶ Instead, I develop the concept of pharmaceutical capture to encompass the myriad of ways in which the largest corporate actors influence markets for prescription drugs, with the market for prescription opioids as a particularly salient example.¶ Pharmaceutical capture occurs when the magnitude and scope of corporate influence is significant enough to alter the incentive structures, and corresponding decisions, of a sufficient number of pharmaceutical industry stakeholders in ways that ensure that relevant markets yield the outcomes desired by the industry captors. Understanding how pharmaceutical capture occurs is an essential first step in improving the effectiveness of regulatory strategies in pharmaceutical markets.¶ Although recent court settlements with some of the largest manufacturers and distributors of opioids have resulted in industry payouts of as much as $26 billion, these payments pale in comparison to the profits reaped from opioid sales. More importantly, the court settlements do little to change the market conditions that allowed for the growth of opioid profits at the expense of public health. With the exception of Purdue, which is now in the midst of a bankruptcy reorganization, major manufacturers and distributers of opioids continue to operate in much the same fashion as they did before, with court settlements operating more like parking tickets than drivers of change. Indeed, some of the very companies that benefitted from opioid sales are now reaping profits from the sale of treatments for addiction. Even the addiction treatment industry now has its own share of problems arising from the increasing demand for, and profitability of, addiction treatment services.¶ I conclude that an effective regulatory response towards the opioid epidemic must be geared towards addressing, and curtailing, pharmaceutical capture. Drawing lessons from the sophisticated corporate strategies used to influence market design, I offer three guiding principles for regulatory redesign. The first is the need for a holistic, systemic approach to regulation to replace current fragmented approaches. The second is the need to recalibrate key underlying policy assumptions about pharmaceutical markets and their appropriate regulation. The third is the need to make regulation more robust to corporate interests through strategies that narrow the divergence of private interests from the public interest, make capture more costly, and/or provide greater resources and rewards for regulating in the public interest.

#### Patents created the opioid crisis – Patents reward companies that make addictive drugs, and market exclusivity allows for aggressive marketing that allowed over prescription of opioids.

Hemel & Ouellette 20[Daniel J Hemel, Assistant professor of law and Ronald H.Coase Research scholar@ university of Chicago law school. Lisa Larrimore Ouellette, Associate professor of law and Justin M. January-June 2020, “Innovation institutions and the opioid crisis” Journal of Law and the Biosciences, Volume 7, Issue 1, <https://doi.org/10.1093/jlb/lsaa001> ww

Opioid overdoses killed an estimated 46,802 people in the US in 2018.1 That is a very slight decline from the previous year, but it is still a stunning number. To put that figure in perspective, more Americans now die from opioid over doses than from motor vehicle accidents2 or from the AIDS epidemic at its peak.3 Over one-third of US adults are estimated to have used prescription opioids in 2015, and nearly 5 percent to have misused them.4 The ubiquity of opioids not only put those patients who had prescriptions at risk of addiction but also unleashed a flood of pills that could be used and abused by family members and friends.5 Prescription opioids further fed into the spread of other opioids—including heroin, the use of which increased almost five - fold in a decade,6 and fentanyl, a synthetic opioid that has seen an even more dramatic and deadly surge.7 The economic costs of the epidemic are staggering, likely topping $500 billion annually.8 Without a doubt, the opioid crisis is among the primary policy challenges facing the US today. Two dominant narratives have emerged in scholarly and popular commentary on the opioid crisis's causes. One narrative casts opioid abuse as a 'disease of despair'-a by-product of poverty and lack of economic opportunity that has hit hardest in deindustrializing regions.9 This account may capture some important social trends, but identifying causal mechanisms behind the growth in opioid overdoses has proven challenging. '0 Econometric evidence suggests that overdoses have more to do with the availability and cost of drugs than with regional economic trends. As one prominent health economist recently wrote, 'efforts to improve local economies, while desirable for other reasons, are not likely to yield significant reductions in overdose mortality.'"¶ A second narrative-which we refer to as the 'disease of deception' account- emphasizes the role of pharmaceutical companies in hiding addiction risks from the public even as they aggressively marketed opioids for ever-broader uses. The chief antagonists in this narrative are members of the Sackler family that owned and ran Purdue Pharma, the maker of the now-infamous opioid drug OxyContin." The disease-of-deception narrative draws strong support from documents that have surfaced in litigation against Purdue Pharma revealing that company officials knew shortly after OxyContin's introduction in 1996 that the drug was being abused widely-yet concealed that information from the public."¶ Even Purdue Pharma's most withering critics do not allege that the company's cover-up was the sole cause of the opioid crisis, however. Widespread OxyContin abuse was a front-page news story as early as 2001 , when the opioid epidemic was still in its nascent stage. ' 4 '[N]o prescription drug in the last 20 years has been so widely abused so soon after its release as OxyContin,' the New York Times reported in May 200] , citing officials at the federal Drug Enforcement Administration (DF.A).'5 Talk radio host Rush Limbaugh drew greater attention to OxyContin in 2003 when he acknowledged on air that he had become addicted to prescription painkillers." And in 2007, a full decade before the annual death toll from opioid abuse reached its peak, Purdue Pharma and three of its executives entered a widely publicized guilty plea to federal criminal charges of misbranding charges related to the company's concealment of OxyContin's addictive properties. '7 None of this is to suggest that Purdue Pharma and other pharmaceutical companies that marketed prescription opioids are immune from blame for the current crisis. They are not. But deception alone cannot explain how opioids continued to inundate American medicine cabinets long after the addiction risks were widely publicized.¶ How did opioids overwhelm a nation well aware of their addictive properties, claiming victims across the socioeconomic spectrum? To understand that, one must understand not only how opioid manufacturers aggressively marketed their wares and why physicians profligately prescribed these drugs but also why alternative pain management strategies failed to emerge and why opioid antidotes and abuse treatments were so much slower to spread. Purdue Pharma and 'pill mills' play a part in this story," but so does Medicaid's 'best price' mandate and the National Institutes of Health's (N IH) allocation of research funding. Comprehending the origins and persistence of the crisis requires a deep dive into the organizations and policies that drove the opioid wave as well as those that failed to produce a robust response.¶ This article takes up that task. We suggest that the opioid epidemic is, in important respects, a disease of design. By this, we do not mean to suggest that the opioid crisis is the outgrowth of any single person's grand plan. What we mean instead is that the design of institutions created conditions that allowed the crisis to arise and proliferate. We focus in particular on the design of innovation institutions-the legal arrangements that structure the production and allocation of knowledge goods. '9 These include not only intellectual property law (patents, trade secrets, trademarks, regulatory exclusivity, etc.), but also the regulatory structures of the Food and Drug Administration (FDA) that determine whether knowledge goods can reach the market and the public benefit programs like Medicare and Medicaid that subsidize access to knowledge goods."¶ The design of innovation institutions enabled the opioid epidemic in a number of ways. First, US innovation institutions produced powerful incentives for pharmaceutical firms to develop and commercialize highly addictive prescription pain medicines while imposing weaker constraints on the rollout of new and more addictive products. Second, systems for allocating access to medical technologies promoted the use of addictive medicines while creating barriers to access for addiction treatments. Third, innovation institutions allowed-and indeed, encouraged-manufacturers of opioid antidotes to charge sky-high prices for products that, if more widely accessible, likely could have saved the lives of thousands of opioid overdose victims. Fourth, even while encouraging the rapid diffusion of addictive opioids, innovation institutions failed to sufficiently reward firms for formulating, refining, or popularizing alternative treatments for addiction or for the underlying problem of chronic pain. Again, no one sat down and designed the system to work this way. But a series of institutional design choices-some conscious, others unconscious-allowed a perfect storm to coalesce.¶ Some of these design flaws are relatively familiar. Intellectual property (IP) is an innovation institution that relies on signals of social value generated by market mechanisms, and market-generated signals can yield inefficient allocations of goods in the presence of externalities. Addictive pain medications generate negative externalities, and overdose and addiction treatments produce positive externalities, so it is perhaps unsurprising that America ended up with too many addictive prescription opioids and too few overdose and addiction treatments. Furthermore, IP distorts investments in research and development toward patentable technologies like pharmaceuticals," so it is no surprise that the patent-centric US innovation institutions resulted in a nation awash in pills but wanting for alternative pain treatments.¶ In other respects, our examination of the role of innovation institutions in the opioid epidemic challenges traditional understandings of IP in particular, and innovation institutions more broadly. The conventional view posits that IP policy's fundamental trade-off is between innovation and access, or what economists call dynamic efficiency and allocative efficiency.22 IP incentivizes the development and commercialization of new and better products (the dynamic-efficiency benefit), but it also encourages IP holders to raise prices and restrict access (the allocative-inefficiency cost). The opioid epidemic presents a contrasting image of IP’s potential consumption-expanding effects. Opioid patents induced investments in efforts to create demand for products that consumers did not previously believe they wanted." This demand-creation effect was especially powerful because the patented product was habit-forming-Purdue's lower prices for OxyContin in the short term could thus raise consumption in the long term.24 And this problem was exacerbated by the effective cost often being lowered through prescription drug insurance. Although scholars typically view the increased use of patented technologies as a welfare gain, the example of prescription opioids illustrates that patents' consumption-expanding effects can be pernicious. ¶ Ideally, the government would counteract the biases embedded in the patent system through other innovation institutions, including regulations, taxes, and government directed financial rewards such as grants and prizes. For example, market-based prizes in the form of insurance reimbursement policies appear to be a particularly promising intervention.2S But in the context of pain treatment, the federal government's non-patent interventions exacerbated the skew toward prescription opioids and away from other pain management and mitigation strategies. At the same time, government policies created barriers that limited access to addiction treatments. Additionally, and paradoxically, the federal governments subsidies for opioid antidotes may have reduced access to these lifesaving products, challenging the view that demand-side subsidies are a solution to the patent system's pitfalls.¶ Recognizing the role of America's innovation institutions in the opioid epidemic helps inform the search for paths out of the current crisis, but it is essential to emphasize that no magic-bullet policy will bring the opioid epidemic to an end. The proliferation of prescription opioids was both a function of incentives generated by the current innovation ecosystem and a response-misguided as it may have been-to the very real problem of chronic pain afflicting an estimated one in five US adults." Any comprehensive effort to curtail opioid abuse will require interventions aimed at addressing chronic pain in ways that do not put patients at risk of addiction. The solution likely will involve regulated use of opioids by the populations for which they are justified as well as both existing and novel nonaddictive analgesics." At the same time, wider access to existing non-pharmacological pain treatments such as acupuncture, physical therapy, exercise, meditation, and cognitive behavioral therapy may do as much to mitigate the overuse of prescription opioids as any pharmacological leap." Moreover, any comprehensive national strategy to contain the opioid epidemic also will require interventions aimed at individuals already in the throes of addiction (medically known as 'substance use disorder' or 'opioid use disorder').29 Initiatives at the federal, state, and local levels suggest progress in this regard, though still on a scale far too small relative to the problem that they aim to solve.30¶ This article is an attempt to understand how innovation institutions are bound up in the opioid crisis, how they might help to bring the crisis to an end, and what lessons the opioid crisis offers for innovation policy going forward. Part II investigates the relationship between innovation institutions and the sky-high rates of opioid use, abuse, and overdose. Part 111 draws on insights from the study of innovation policy and comparative institutional analysis to evaluate the ways in which innovation institutions can respond to the opioid epidemic. For example, distortions caused by patent law might be addressed through interventions in areas such as FDA regulation, tort law, and antitrust. And direct public support can address problems on both the incentive and allocation side of innovation policy. As we discuss, there are significant political hurdles to reform, although it is at least promising that opioid misuse is now being viewed as a public health problem. Finally, Part IV asks what lessons we can learn from the opioid crisis for innovation policy more broadly.

#### IPP rewards addictive medicines and punishes alternative medicines – the plan shifts patients towards non addictive meds through reducing the amount of opioids

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While our primary focus in this article is on the ways in which America's innovation institutions have contributed to the opioid crisis and can hasten its end, the opioid epidemic also yields lessons for innovation scholars that apply to other areas of public health and scientific knowledge.¶ The stories of OxyContin, Suboxone, and Evzio confirm some truths that we have long known about the IP system. IP is an effective innovation incentive for aggregating dispersed information about consumers' willingness to pay for new knowledge goods-but when markets fail, so too will IP. Two familiar reasons why markets fail to produce socially optimal outcomes are (1) the externalization of harms and (2) the externalization of benefits. OxyContin is an example of a product that generates negative externalities, and-unsurprisingly-we ended up with too much OxyContin. Suboxone and Evzio are examples of products that generate positive externalities, and-unsurprisingly-we have ended up with too little of these drugs. ¶ America's apparent underinvestment in non-pharmacological pain treatments likewise fits into our existing mental models. Non-pharmacological pain treatments such as yoga and acupuncture are almost inevitably nonexcludable and ineligible for patent protection. Our innovation ecosystem is well designed to reward patentable technologies, such as pharmaceuticals, and poorly structured to support the development of processes and practices such as checklists, cognitive behavioral therapy, and alternative medicine317¶ Yet in other ways, our study of the opioid crisis has challenged our beliefs about innovation policy and led us toward new insights. In this final part, we highlight five lessons from the opioid context for innovation policy more broadly: ¶ First, we think that the traditional view of IP as a trade-off between dynamic efficiency and allocative efficiency is less accurate than we once believed.3'8 In the case of OxyContin, patent protection appears to have encouraged Purdue Pharma's extraordinary investment in demand creation. Aggregate data on the consumption of patented and post-patent pharmaceuticals suggest that the OxyContin story is not an outlier in this regard.3 '9 Especially when a pharmaceutical manufacturer follows a relatively standard pricing strategy (such that the product is available to Medicaid and Medicare beneficiaries and is included in most private health plan formularies), above- marginal-cost pricing seems less likely to prevent the vast majority of US patients from gaining access than conventional IP models suggest.¶ Second, and relatedly, the fact that IP encourages demand creation should affect our view of IP's overall welfare effects. Do we want to encourage patentees to create demand for products for which demand does not currently exist? There are, perhaps, cases in which the answer is yes-for example, Eli Lilly's promotion of Prozac arguably generated greater attention toward untreated depression.32Â° But we should be aware that the patent system creates incentives for firms to promote products that consumers did not know they wanted (and indeed might not have needed).321¶ Third, the interaction between IP and addiction can be particularly pernicious. As we sought to illustrate in Section ll.B.l, firms have an especially strong incentive to promote habit-forming products-perhaps by initially charging below-marginal-cost prices-if they anticipate that they can maintain a medium- to long-term monopoly over that product. When the habit-forming nature of a product generates negative externalities, as is the case for medical addiction, the combination of this effect with the more general demand-creation incentives can have devastating social consequences. It is possible that this misalignment of IP rewards with social welfare could be addressed by reforms internal to IP. For example, Michael Risch has called for a revitalization of patent law's utility requirement to deny patents on inventions from which society reaps no benefit (even if the innovator can reap significant profits).322 Margo Bagley has suggested legislative restrictions on patentable subject matter to revive moral utility doctrine and move away from the US's current (and distinctively American) 'patent first, ask questions later' approach. As another example, Ted Sichelman suggests that patent law remedies should be reformed to better reflect the social value, not market value, of an invention.32" But, non-LP innovation institutions also have an important- and perhaps paramount-role to play in correcting the 11' systems biases.325 ¶ A fourth lesson from the opioid crisis for other areas of innovation policy is that the notion that government subsidies can promote access to IP-protected products turns out to be less than clear-cut. Medicaid's best-price mandate incentivizes pharmaceutical firms to charge higher prices to the private sector, and as the number of patients covered by Medicaid increases, so too does the incentive for firms to set private sector prices with Medicaid in mind. This is not an argument against Medicaid expansion, and removing the best-price mandate without creating an alternative means to control government drug spending would lead to different (and perhaps worse) pathologies. But, it does suggest that government subsidies should be designed with attention to their impact on private pharmaceutical pricing. ¶ Indeed, in a world without Medicaid's best-price mandate or other limits on incentives to offer discounts to some purchasers, pharmaceutical firms might seek to maximize profits through price discrimination (ie seeking to ensure that every consumer who values a product at more than its marginal cost will be charged her willingness to pay and no more). Perfect price discrimination entails no deadweight loss. Medicaid changes the incentive to engage in price discrimination, however, because the lowest price charged to other purchasers becomes the ceiling for Medicaid reimbursement. The limit on charging CMS more than the 'usual and customary charges to the general public' has a similar effect.326 In such cases, IP does lead to serious allocative inefficiencies, but the inefficiencies are because of the way IP interacts with other government policies. To be sure, perfect price discrimination will almost never be possible, and deadweight loss in the IP system is inevitable. But the opioid crisis illustrates that subsidies can do as much to increase deadweight loss as to reduce it.¶ Finally, and notwithstanding our criticisms of the IP system, we again emphasize that non-IP innovation incentives and allocation mechanisms are imperfect. ln the case of the opioid epidemic, CMS created powerful non-IP incentives for hospitals to prescribe more opioids.327 That turned out to be a disaster. The root causes of this particular policy failure are unclear, but we should be cognizant in our critique of certain aspects of market-based IP policies that the grass is not always greener on the non-market side.

#### Purdue’s OxyContin release proves

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In the early 1990s, MS Contin, a controlled-release form of morphine sulfate, was generating millions of dollars in sales for Purdue Pharrna.32 But MS Contin no longer had IP-protected exclusivity,33 and Purdue expected generic competition to eat into its profits." The firm pivoted to a new pain treatment market strategy. In November 1993, the US Patent and Trademark Oflice (PTO) granted Purdue's application for Patent No. 5,266,331, which claimed a controlled-release form of the opioid oxycodone.35 Just over 2 years later, in December I995, the FDA approved Purdue's application to market OxyContin for treatment of chronic pain.36 Purdue's strategy, according to its 1996 budget plan, was 'to switch patients who would have been started on MS [Contin] to OxyContin, as quickly as possible.'37 ¶ The new drug would prove to be a commercial blockbuster. Purdue Pharma set the price of OxyContin at levels that put it within reach even of patients who lacked prescription drug coverage: $1.25 per l0-milligram tablet as of 2000.38 The number of OxyContin prescriptions dispensed nationwide each year reached 6 million that year, bringing in over $1 billion in sales." Thanks to its patent rights, Purdue Pharma controlled the entire controlled-release oxycodone market until 2005.40 Due to a temporary patent litigation loss, generics briefly captured up to a third of the market in terms of number of prescriptions, but Purdue ultimately prevailed in litigation and forced competitors out of the market by 2010." In 2010, Purdue also engaged in 'product hopping'42 by replacing its original OxyContin formulation with a new 'abuse-deterrent t' formulation, which is protected until 2030 by later-expiring patents (The new crush-resistant formulation seems to have been only moderately effective at deterring abuse44) By 2018, Purdue Pharma's all-time total OxyContin revenue topped $35 billion."¶ To be clear, OxyContin is just one of several prescription opioids that have contributed to America's overdose epidemic. In a recently released federal database, Purdue ranked fourth among prescription opioid manufacturers from 2006 to 2012, with just over 3 per cent of the market-" This small market share likely understates Purdue's role in the epidemic, however. OxyContin was for a time the 'drug of choice among abusers,'47 and it still appears to be the most abused single-entity prescription painkiller." Approximately l4.l per cent of adults who reported misuse of a prescription pain reliever in 2015 said they misused OxyContin specifically. Moreover, there is some evidence to suggest that oxycodone is more prone to abuse than other common opioids." A recent empirical study of cross-state variation in OxyContin exposure concluded that 'the recent heroin epidemic is largely due to the reformulation of OxyContin.'5 ' Additionally, some of Purdue's efforts to promote controlled-release oxycodone may have had spillover effects on other opioid products." Our focus on OxyContin should not be misinterpreted as a monocausal explanation for what is in fact an epidemic with multiple and converging root causes. Rather, its prominence makes it a useful example for illustrating the relationship between opioids and innovation institutions. But before we turn to this relationship, we introduce two other illustrative drugs-each of which might have done more to contain the epidemic had it been more widely distributed: Suboxone and Evzio.

#### The plan spurs on innovation for non-opioid pain killers

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Conventionally, innovation scholars have focused on patent law as the main policy tool to increase production of new knowledge goods.226 Patents, at least in theory, leverage private information from market actors about the value and viability of potential projects and provide strong incentives for investments in promising ideas.227 But as emphasized in Section ll.B, these same features of the patent system encouraged the development and commercialization of prescription opioids. Given the patent system's pro-pharmaceutical skew-and, in particular, its bias toward addictive goods-one natural response might be to write all patents as a potential solution to a problem that, in many respects, is a product of too many pills.¶ We think that would be a mistake. As awareness grows among physicians and patients about the addiction risk associated with prescription opioids, demand for nonaddictive pain treatments will increase too. The patent system will generate strong financial incentives for pharmaceutical and biotech firms to invest in the development of non-opioid painlkillers,228 abuse-resistant opioids,'229 drugs that can be used to 230 and easier delivery methods for the overdose antidote naloxone.23' treat addiction, (Indeed, many firms already have.232) There is, to be sure, something unseemly about the very firms that fueled the spread of prescription opioids also profiting from the problem they helped create. Many Americans were thus understandably outraged to learn that Purdue Pharma has filed for a patent on a drug that could 'help wean addicts from opioids,' given that Purdue had helped to hook some of those same people on opioids in the first place.233 It would be an even crueler irony, though, if the patent system failed to reward investments in innovations that could bring the opioid epidemic under control and thereby encouraged the proliferation of prescription opioids but not the development of solutions to addiction.¶ Of course, these powerful patent incentives still may be subject to the same distortions described in Part 11. Patents also skew research toward treatments that require repeated use-and thus generate steady streams of revenue-rather than preventatives which are effective after a single administration.7"l'4 Patent law may therefore be more helpful, for example, in encouraging the development of nonaddictive painkillers than in the development of anti-addiction vaccines.235 Patent law likewise will do little to facilitate research and development directed at ideas that are difficult for a single firm to commodify—for example, reducing the default number of pills per prescription,236 informing doctors when their patients overdose,237 or encouraging the use of alternative pain treatments such as physical or behavioral therapy.238 Patents are also ineffective incentives for non-pharmaceutical addiction recovery tools such as mobile phone reminders that track the number of days that a patient has remained substance-free,239 for creative ideas like using reverse motion detectors in clinic bathrooms (ie devices that detect lack of motion) to prevent fatal overdoses,240 and for research on the comparative value of supervised drug use clinics241 or different drug court protocols or streamlined ER-to-outpatient transfers for preventing relapse.242¶ Episodes such as Indivior’s effort to undermine the tablet form of Suboxone243 highlight the need to consider broad changes to patent law and its interactions with FDA regulatory law, antitrust law, tort law, and other institutions that might cabin its pathologies.244 These changes, however, may take years to formulate and implement. In the meantime, the opioid epidemic’s daily death toll reminds us of ‘the fierce urgency of now.’245 While patents may play a role in promoting the development and commercialization of opioid alternatives, antidotes, and addiction treatments, we think it is clear enough that America will not patent its way out of the opioid crisis. Policymakers will need to look elsewhere for solutions.

### 1A – Solvency – non-opioid spec

#### Plan: The Member Nations of the World Trade Organization Should Terminate current and ban secondary patents for medicines

#### Ask in cross for further Specification – I will meet reasonable interps we should avoid a theory debate.

TAF 20 [The Arnold Foundation “'Evergreening' Stunts Competition, Costs Consumers and Taxpayers” Published: September 24, 2020] [https://www.arnoldventures.org/stories/evergreening-stunts-competition-costs-consumers-and-taxpayers/] [TAF: Philanthropy dedicated to tackling problems in the US. Team of more than 90 subject matter experts in Houston, with offices in New York and DC.]

As the Evergreen Drug Patent Search makes clear, the positive impact of Hatch-Waxman has been steadily and severely eroded by a regulatory system vulnerable to increasingly sophisticated forms of manipulation. “You might say that the patent and regulatory system has been weaponized,” Feldman said. “When billions of dollars are at stake, there’s a lot of money available to look for ways to exploit the legal system. And companies have become adept at this, as our work has found.” There are several key steps that Congress could take to restore the balance between innovation and competition that is the key to a successful prescription drug regulatory process. These may include: Imposing restrictions on the number of patents that prescription drug manufacturers can defend in court to discourage the use of anticompetitive patent thickets. Limiting the patentability of so-called secondary patents — which don’t improve the safety or efficacy of a drug — through patent and exclusivity reform. Reforming the 180-day generic exclusivity, which can currently be abused to block other competitive therapies. “The Evergreen Drug Patent Search provides the publicly available, evidence-based foundation that defines the extent of the problem, and it can be used to develop policies that solve the problem of anti-competitive patent abuses,” said Kristi Martin, VP of Drug Pricing at Arnold Ventures. “Our incentives have gotten out of whack,” Martin said. “The luxury of monopoly protection should only be provided to innovations that provide meaningful benefits in saving lives, curing illnesses, or improving the quality of people’s lives. It should not be provided to those gaming the system. If we can change that, we can save consumers, employers, and taxpayers many billions of dollars while increasing the incentives for pharmaceutical companies to achieve breakthroughs."

#### The plan is key – Other stratagies can’t solve patent abuse

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The US opioid epidemic seems to many to have come out of nowhere, and there’s been much finger-pointing in recent years about how this state of affairs came to be. Some have argued that inadequate mental healthcare is to blame. Others have postulated that doctors were naively over prescribing them as a way to quickly treat pain and please their patients. But, according to a recently published draft report, at least some of the blame should be attributed to the way pharmaceutical companies have manipulated patent extensions over the past decade.¶ In the 1970s and 80s, doctors were looking for better ways to control pain, and many believed opioids a good, non-addictive option. In the 1990s, drug manufacturers began aggressively marketing the painkillers to doctors and patients. Soon, patients (or their loved ones who stole their pills) were developing tolerances for low doses, and graduated to abusing the drugs by crushing them and either snorting or liquefying and injecting the powders, or turning to heroin, often fatally. By the time the science caught up in the early 2000s, it was too late: Thousands of people were addicted to opioids. Opioids have killed over 560,000 people in the US since 2000. Last month, president Donald Trump declared the crisis a public health emergency.¶ Pharmaceutical companies profited from this demand, and the exclusive rights they had to make these compounds. This allowed them to pump even more money into marketing, which inevitably led to doctors prescribing more of them.¶ From the moment a drug company patents a compound, it has 20 years of exclusive manufacturing and selling rights on it. In theory, a company’s monopoly on a drug dissolves after its patents expire and generics flood the market. But drug companies usually file for patents in the discovery stages as a way of staking their territory in the field. The approval process for drugs from the US Food and Drug Administration involves lengthy clinical trials, which usually take around 12 years—meaning that manufacturers typically only get to actually sell their drugs exclusively for about eight years before generics come onto the market. So they often seek ways to extend this exclusive period.¶ Perhaps the most common way is to change a drug ever so slightly. For example, a company can file a new patent if it makes a version of a drug with a slightly different dosage, or with a different way it’s released in the body over time.¶ “Our patent system doesn’t require something to be better, just different,” says Robin Feldman, the director of the Institute for Innovation Law at the University of California Hastings College of Law. “Rather than creating new medicines, pharmaceutical companies are largely recycling and repurposing [drugs].” The manufacturer can then hold off generic competition for a few more years. Competitors (or anyone else) could theoretically make the case in court that these compounds aren’t actually different, but the legal battle would likely be too costly and time consuming to be worth it.¶ Feldman, together with Connie Wang, a law student at Stanford University, meticulously went through a decade’s worth of versions of the US Food and Drug Administration’s “Orange Book” and US Patent and Trademark Office website listings to investigate the relationship between patent filings, exclusivity extensions, and drug approvals. They found that of the 100 best-selling drugs from 2005 to 2015, about 80% had a patent extension filed on them at least once. About 50% of these drugs had multiple extensions.¶ That, Feldman argues, can create a dangerous cycle. “The immense monopoly profits allow drug companies like Purdue to aggressively market their drugs to doctors,” explains Feldman. “Physicians preferentially prescribe these particular drugs. Where drugs are addictive and problematic, that’s dangerous.”¶ Purdue Pharma is the company behind one of the most popular prescription opioids. OxyContin first came on the market in 1996 and has since brought in billions of dollars of revenue. Purdue’s patent for OxyContin was originally supposed to expire in 2013. But by making minor tweaks to the drug’s chemical structure to create a slow-release pill the company markets as “abuse-proof,” Purdue has been able to file new patents for OxyContin 13 times with the US Patent and Trademark Office over the past decade, thereby extending its exclusive selling rights on the drug through 2030.¶ Purdue did not respond directly to Feldman’s analysis when forwarded a copy by Quartz, instead providing a statement noting, “One potentially important step towards the goal of creating safer opioid analgesics has been the development of opioids that are formulated to deter abuse. FDA considers the development of these products a high public health priority. Purdue reformulated OxyContin with abuse-deterrent properties recognized by FDA, and the Patent and Trademark Office granted Purdue patents for inventions that went into the development of those properties.”¶ The most prominent example is a patent Purdue filed in 2003 for “abuse-proof” OxyContin. It was made of materials that are harder to crush, and forms a gel that is more viscous and harder to inject. In theory, it would make for a safer alternative to regular OxyContin. However, the same patent claims that “intravenous administration of such a gel would most probably result in obstruction of blood vessels, associated with serious embolism or even death of the abuser.” In all likelihood, people crushing these pills to get high would still seriously harm, if not kill, themselves.¶ Technically, the abuse-proof pills worked: When researchers from Washington University in St. Louis informally surveyed more than 2,500 people taking opioids to see if this pill really was more abuse-proof than before, they found that the number of people who admitted to using it to get high dropped from about 35% to about 13% two years later. However, two thirds of respondents said they had switched to other opioids instead—often heroin, which is less expensive and easy to use.¶ It’s not Purdue’s fault doctors kept prescribing (and overprescribing) these pills in an attempt to alleviate pain, nor that the loved ones of patients often took instead to get high. It’s also not the company’s fault there weren’t better resources for those who found themselves addicted—drugs like buprenorphine, methadone and naltrexone can help ease addiction, but as recently as 2016, they still weren’t being given to patients in two-thirds of US addiction clinics.¶ That said, Purdue spent many years and huge sums of money convincing doctors that OxyContin was non addictive. In fact, the company has paid over $600 million in fines to federal and state agencies, as well as individual patients, to settle claims that it falsely marketed OxyContin as safe from abuse. Three of the company’s executives pled guilty to “misbranding,” which is a criminal violation.¶ The company is still profiting off “abuse-deterrent” OxyContin. Though there are currently “authorized generics” of OxyContin available, these are made by manufacturers with licenses to use Purdue’s formula. In other words, Purdue makes money off them. And there are currently no approved abuse-deterrent generics in the US. In September of this year, FDA commissioner Scott Gottlieb said that soon the agency plans to issue guidelines to assist companies who are trying to file applications for these types of generics. No word on when that document will be published, however.

### 1AC – Framing

#### Value is justice – defined as acting morally good

#### The Standard is maximizing expected well-being –

#### 1] Binding – pain and pleasure are the only things with intrinsic value and disvalue – if I put my hand on a hot stove I will pull away – ethics must be binding bc if they arent then it’s impossible to generate obligations

#### 2] Actor specificity – Governments have the obligation to maximize the pleasure of their citizens – proven through laws that are designed to stop pain towards other subjects – Drunk driving laws, murder, robbery

#### 3] Probability first – risk logic creates *infinite deferral* and *implodes* in on itself.

Oliver Kessler and Christopher Daase 4-1-2008– Kessler has a PhD in International Relations and is a professor of sociology at The University of Bielefeld. Daase is a professor at the department of political science at the University of Munich. ["From Insecurity to Uncertainty: Risk and the Paradox of Security Politics", Accessible Online at: http://journals.sagepub.com/doi/abs/10.1177/030437540803300206?journalCode=alta] @ AG

The problem of the second method is that it is very difficult to "calculate" politically unacceptable losses. If the risk of terrorism is defined in traditional terms by **probability and potential loss**, then the focus on dramatic terror attacks leads to **the marginalization of probabilities**. The reason is that even the highest degree of improbability becomes irrelevant as the measure of loss goes to infinity.50 The mathematical calculation of the risk of terrorism thus tends to overestimate and to dramatize the danger. This has consequences beyond the actual risk assessment for the formulation and execution of "risk policies": If one factor of the risk calculation approaches infinity (e.g., if a case of nuclear terrorism is envisaged), then there is no balanced measure for antiterrorist efforts, and risk management as a rational endeavor breaks down. Under the historical con- dition of bipolari ty, the "ultimate" threat with nuclear weapons could be balanced by a similar counterthreat, and new equilibria could be achieved, albeit on higher levels of nuclear overkill. Under the new condition of uncertainty, no such rational balancing is possible since knowledge about actors, their motives and capabilities, is largely absent. The second form of security policy that emerges when the deterrence model collapses mirrors the "social probability" approach. It **represents a logic of catastrophe**. In contrast to risk management framed in line with logical probability theory, the logic of catastrophe does not attempt to provide means of absorbing uncertainty. Rather, it takes uncertainty as constitutive for the logic itself; uncertainty is a crucial precondition for catastrophes. In particular, catastrophes happen at once, without a warning, but with major implications for the world polity. In this category, we find the impact of meteorites, Mars attacks, the tsunami in South East Asia, and 9/11. To conceive of terrorism as catastrophe has consequences for the formulation of an adequate security policy. Since catastrophes happen **irrespectively of human activity** or inactivity, **no political action could possibly prevent them.** Of course, there are precautions that can be taken, but the framing of terrorist attack as a catastrophe points to spatial and temporal characteristics that are beyond "ratio- nality." Thus, political **decision makers are exempted from** the **responsibility** to provide security - as long as they at least try to preempt an attack. Interestingly enough, 9/11 was framed as catastro- phe in various commissions dealing with the question of who was responsible and whether it could have been prevented. This makes clear that under the condition of uncertainty, there are no objective criteria that could serve as an anchor for measur- ing dangers and assessing the quality of political responses. For ex- ample, as much as one might object to certain measures by the US administration, it is almost impossible to "measure" the success of countermeasures. Of course, there might be a subjective assessment of specific shortcomings or failures, but there is no "common" cur- rency to evaluate them. As a consequence, the framework of the security dilemma fails to capture the **basic uncertainties**. Pushing the door open for the security paradox, **the main problem** of security analysis then **becomes** the question **how to integrate dangers** in risk assessments and security policies **about which simply nothing is known**. In the mid 1990s, a Rand study entitled "New Challenges for Defense Planning" addressed this issue arguing that "most striking is the fact that we do not even know who or what will constitute the most serious future threat."51 In order to cope with this challenge it would be essential, another Rand researcher wrote, to break free from the "tyranny" of plausible scenario planning. The decisive step would be to create "**discontinuous scenarios** ... in which there is **no plausible audit trail or storyline from current events**"52 These nonstandard scenarios were later called "wild cards" and became important in the current US strategic discourse. They justified the transformation from a threat-based toward a capability- based defense planning strategy.53 The problem with this kind of risk assessment is, however, that **even the most absurd scenarios can gain plausibility**. By constructing a chain of potentialities, improbable events are **linked** and brought into the realm of the possible, if not even the **probable**. "Although the likelihood of the scenario dwindles with each step, the residual impression is one of plausibility."54 This so-called Othello effect has been effective in the dawn of the recent war in Iraq. The connection between Saddam Hussein and AI Qaeda that the US government tried to prove was disputed from the very beginning. False evidence was again and again presented and refuted, but this did not prevent the administration from presenting as the main rationale for war the improbable yet possible connection between Iraq and the terrorist network and the improbable yet possible proliferation of an improbable yet possible nuclear weapon into the hands of Bin Laden. As Donald Rumsfeld famously said: "**Absence of evidence is not evidence of absence.**" This sentence indicates that under the condition of genuine uncertainty, different evidence criteria prevail than in situations where security problems can be assessed with relative certainty.

#### 4] Existential threats distort moral reasoning and ignore ongoing and urgent violence.

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III The body and the emergency Though the body is often presumed to be the most basic unit where urgency might be detected, only some dictionaries link urgency and the body through a ‘medical’ reference to the compelling need to defecate or urinate.5 Focusing on the different meanings of urgency runs the risk of obscuring language categories, but pushing together the two definitions – urgency as the need to defecate and urinate, and urgency as overwhelming force – is useful here, because my aim is to illustrate that the ethical work of urgency has been hijacked by an hierarchical organization of scales of moral deliberation. Specifically, our research suggests that the urgent body is cast as subjective and impulsive, while larger scales, such as the region, state or society, emerge as the scale of a rational ethics. While these are not new arguments about states (Scott, 1998) and their institutions (Foucault, 1995), geographic insights into toileting and securitizations suggest that **technocratic practices both require and perpetuate an ethical distinction between the body and the large-scale future event**, **with the latter emerging as the only legitimate site of urgent claims and thus the dominant subject of moral reasoning**.In research related to contemporary global toileting, the defecating body’s status as a legitimate ethical concern is more likely to be acknowledged when **threatening the sanitation aims of cities and states**. This is perhaps most evident in large metropolitan areas where uneven access to toilets amplifies social inequalities and human suffering (McFarlane, 2013). Jewitt’s (2011) examination of waste management in India and other countries in the Global South reveals that taboos around feces often justify inequality in two ways; first, by creating conditions of precarity through taboos in discussing personal sanitation and toilet practices, and second, by justifying social exclusion on the basis of inferior sanitation practices. The lack of access to sanitation infrastructure can also provide reasons for excluding informally settled populations from ambitiously modernizing cities. In cities like Kampala, Uganda, planners, development workers, and community organizers frame those who cannot use modern toilet facilities as threatening (Terreni-Brown, 2014a). Terreni-Brown (2014b) describes a group of female migrants selling goods outside of a large, upscale mall in Kampala, and their strategies for balancing the lack of access to a toilet with the danger and humiliation of going in the area behind their street-side location. Their desperate pain, induced by waiting hours until they can finally return to a more private location, contrasts with complaints of city planners and NGO workers who point to moral lethargy in the informal settlements that puts the city at risk. The poor, illegal, marginalized body is not a reasonable scale of urgency, nor is it the product of a thoughtful weighing of circumstances; in the face of a morally rational prioritization of a future Kampala, these bodily urgencies literally have no place in the modern city. Though toileting might be thought of as a special case of bodily urgency, geographic research suggests that the body is increasingly set at odds with larger scale ethical concerns, especially large-scale future events of forecasted suffering. Emergency planning is a particularly good example in which the large-scale threats of future suffering can distort moral reasoning. Žižek (2006) lightly develops this point in the context of the war on terror, where in the presence of fictitious and real ticking clocks and warning systems, the urgent body must be bypassed because there are bigger scales to worry about:¶ What does this all-pervasive sense of urgency mean ethically? The pressure of events is so overbearing, the stakes are so high, that they necessitate a suspension of ordinary ethical concerns. After all, displaying moral qualms when the lives of millions are at stake plays into the hands of the enemy. (Žižek, 2006)¶ In the presence of large-scale future emergency, the urgency to secure the state, the citizenry, the economy, or the climate creates new scales and new temporal orders of response (see Anderson, 2010; Baldwin, 2012; Dalby, 2013; Morrissey, 2012), many of which treat the urgent body as impulsive and thus requiring management. McDonald’s (2013) analysis of three interconnected discourses of ‘climate security’ illustrates how bodily urgency in climate change is also recast as a menacing impulse that might require exclusion from moral reckoning. The logics of climate security, especially those related to national security, ‘can encourage perverse political responses that not only fail to respond effectively to climate change but may present victims of it as a threat’ (McDonald, 2013: 49). Bodies that are currently suffering cannot be urgent, because they are excluded from the potential collectivity that could be suffering everywhere in some future time. Similar bypassing of existing bodily urgency is echoed in writing about violent securitization, such as drone warfare (Shaw and Akhter, 2012), and also in intimate scales like the street and the school, especially in relation to race (Mitchell, 2009; Young et al., 2014).¶ As large-scale urgent concerns are institutionalized, the urgent body is increasingly obscured through technical planning and coordination (Anderson and Adey, 2012). The predominant characteristic of this institutionalization of large-scale emergency is a ‘built-in bias for action’ (Wuthnow, 2010: 212) that circumvents contingencies. The urgent body is at best an assumed eventuality, one that will likely require another state of waiting, such as triage (e.g. Greatbach et al., 2005). Amin (2013) cautions that in much of the West, governmental need to provide evidence of laissez-faire governing on the one hand, and assurance of strength in facing a threatening future on the other, produces ‘just-in-case preparedness’ (Amin, 2013: 151) of neoliberal risk management policies. In the US, ‘personal ingenuity’ is built into emergency response at the expense of the poor and vulnerable for whom ‘[t]he difference between abjection and bearable survival’ (Amin, 2013: 153) will not be determined by emergency planning, but in the material infrastructure of the city.¶ In short, the urgencies of the body provide justifications for social exclusion of the most marginalized based on impulse and perceived threat, while large-scale future emergencies effectively absorb the deliberative power of urgency into the institutions of preparedness and risk avoidance. Žižek references Arendt’s (2006) analysis of the banality of evil to explain the current state of ethical reasoning under the war on terror, noting that people who perform morally reprehensible actions under the conditions of urgency assume a ‘tragic-ethic grandeur’ (Žižek, 2006) by sacrificing their own morality for the good of the state. But his analysis fails to note that bodies are today so rarely legitimate sites for claiming urgency. In the context of the assumed priority of the large-scale future emergency, the urgent body becomes literally nonsense, a non sequitur within societies, states and worlds that will always be more urgent.¶ If the important ethical work of urgency has been to identify that which must not wait, then the capture of the power and persuasiveness of urgency by large-scale future emergencies has consequences for the kinds of normative arguments we can raise on behalf of urgent bodies. How, then, might waiting compare as a normative description and critique in our own urgent time? Waiting can be categorized according to its purpose or outcome (see Corbridge, 2004; Gray, 2011), but it also modifies the place of the individual in society and her importance. As Ramdas (2012: 834) writes, ‘waiting … produces hierarchies which segregate people and places into those which matter and those which do not’. The segregation of waiting might produce effects that counteract suffering, however, and Jeffery (2008: 957) explains that though the ‘politics of waiting’ can be repressive, it can also engender creative political engagement. In his research with educated unemployed Jat youth who spend days and years waiting for desired employment, Jeffery finds that ‘the temporal suffering and sense of ambivalence experienced by young men can generate cultural and political experiments that, in turn, have marked social and spatial effects’ (Jeffery, 2010: 186). Though this is not the same as claiming normative neutrality for waiting, it does suggest that waiting is more ethically ambivalent and open than urgency.¶ In other contexts, however, our descriptions of waiting indicate a strong condemnation of its effects upon the subjects of study. Waiting can demobilize radical reform, depoliticizing ‘the insurrectionary possibilities of the present by delaying the revolutionary imperative to a future moment that is forever drifting towards infinity’ (Springer, 2014: 407). Yonucu’s (2011) analysis of the self-destructive activities of disrespected working-class youth in Istanbul suggests that this sense of infinite waiting can lead not only to depoliticization, but also to a disbelief in the possibility of a future self of any value. Waiting, like urgency, can undermine the possibility of self-care two-fold, first by making people wait for essential needs, and again by reinforcing that waiting is ‘[s]omething to be ashamed of because it may be noted or taken as evidence of indolence or low status, seen as a symptom of rejection or a signal to exclude’ (Bauman, 2004: 109). This is why Auyero (2012) suggests that waiting creates an ideal state subject, providing ‘temporal processes in and through which political subordination is produced’ (Auyero, 2012: loc. 90; see also Secor, 2007). Furthermore, Auyero notes, it is not only political subordination, but the subjective effect of waiting that secures domination, as citizens and non-citizens find themselves ‘waiting hopefully and then frustratedly for others to make decisions, and in effect surrendering to the authority of others’ (Auyero, 2012: loc. 123).¶ Waiting can therefore function as a potentially important spatial technology of the elite and powerful, mobilized not only for the purpose of governing individuals, but also to retain claims over moral urgency. But there is growing resistance to the capture of claims of urgency by the elite, and it is important to note that even in cases where the material conditions of containment are currently impenetrable, arguments based on human value are at the forefront of reclaiming urgency for the body. In detention centers, clandestine prisons, state borders and refugee camps, geographers point to ongoing struggles against the ethical impossibility of bodily urgency and a rejection of states of waiting (see Conlon, 2011; Darling, 2009, 2011; Garmany, 2012; Mountz et al., 2013; Schuster, 2011). Ramakrishnan’s (2014) analysis of a Delhi resettlement colony and Shewly’s (2013) discussion of the enclave between India and Bangladesh describe people who refuse to give up their own status as legitimately urgent, even in the context of larger scale politics. Similarly, Tyler’s (2013) account of desperate female detainees stripping off their clothes to expose their humanness and suffering in the Yarl’s Wood Immigration Removal Centre in the UK suggests that demands for recognition are not just about politics, but also about the acknowledgement of humanness and the irrevocable possibility of being that which cannot wait. The continued existence of places like Yarl’s Wood and similar institutions in the USA nonetheless points to the challenge of exposing the urgent body as a moral priority when it is so easily hidden from view, and also reminds us that our research can help to explain the relationships between normative dimensions and the political and social conditions of struggle.¶ In closing, geographic depictions of waiting do seem to evocatively describe otherwise obscured suffering (e.g. Bennett, 2011), but it is striking how rarely these descriptions also use the language of urgency. Given the discussion above, what might be accomplished – and risked – by incorporating urgency more overtly and deliberately into our discussions of waiting, surplus and abandoned bodies? Urgency can clarify the implicit but understated ethical consequences and normativity associated with waiting, and encourage explicit discussion about harmful suffering. Waiting can be productive or unproductive for radical praxis, but urgency compels and requires response. Geographers could be instrumental in reclaiming the ethical work of urgency in ways that leave it open for critique, clarifying common spatial misunderstandings and representations. There is good reason to be thoughtful in this process, since moral outrage towards inhumanity can itself obscure differentiated experiences of being human, dividing up ‘those for whom we feel urgent unreasoned concern and those whose lives and deaths simply do not touch us, or do not appear as lives at all’ (Butler, 2009: 50). But when the urgent body is rendered as only waiting, both materially and discursively, it is just as easily cast as impulsive, disgusting, animalistic (see also McKittrick, 2006). Feminist theory insists that the urgent body, whose encounters of violence are ‘usually framed as private, apolitical and mundane’ (Pain, 2014: 8), are as deeply political, public, and exceptional as other forms of violence (Phillips, 2008; Pratt, 2005). Insisting that a suffering body, now, is that which cannot wait, has the ethical effect of drawing it into consideration alongside the political, public and exceptional scope of large-scale futures. It may help us insist on the body, both as a single unit and a plurality, as a legitimate scale of normative priority and social care.¶ In this report, I have explored old and new reflections on the ethical work of urgency and waiting. Geographic research suggests a contemporary popular bias towards the urgency of large-scale futures, institutionalized in ways that further obscure and discredit the urgencies of the body. This bias also justifies the production of new waiting places in our material landscape, places like the detention center and the waiting room. In some cases, waiting is normatively neutral, even providing opportunities for alternative politics. In others, the technologies of waiting serve to manage potentially problematic bodies, leading to suspended suffering and even to extermination (e.g. Wright, 2013). One of my aims has been to suggest that moral reasoning is important both because it exposes normative biases against subjugated people, and because it potentially provides routes toward struggle where claims to urgency seem to foreclose the possibilities of alleviation of suffering. Saving the world still should require a debate about whose world is being saved, when, and at what cost – and this requires a debate about what really cannot wait. My next report will extend some of these concerns by reviewing how feelings of urgency, as well as hope, fear, and other emotions, have played a role in geography and ethical reasoning.¶ I conclude, however, by pulling together past and present. In 1972, Gilbert White asked why geographers were not engaging ‘the truly urgent questions’ (1972: 101) such as racial repression, decaying cities, economic inequality, and global environmental destruction. His question highlights just how much the discipline has changed, but it is also unnerving in its echoes of our contemporary problems. Since White’s writing, our moral reasoning has been stretched to consider the future body and the more-than-human, alongside the presently urgent body – topics and concerns that I have not taken up in this review but which will provide their own new possibilities for urgent concerns. My own hope presently is drawn from an acknowledgement that the temporal characteristics of contemporary capitalism can be interrupted in creative ways (Sharma, 2014), with the possibility of squaring the urgent body with our large-scale future concerns. Temporal alternatives already exist in ongoing and emerging revolutions and the disruption of claims of cycles and circular political processes (e.g. Lombard, 2013; Reyes, 2012). Though calls for urgency will certainly be used to obscure evasion of responsibility (e.g. Gilmore, 2008: 56, fn 6), they may also serve as fertile ground for radical critique, a truly fierce urgency for now.

#### 5] Maximization through moderation – the best way to stop extinction is by small changes – a more equal, more democratic, less addicted to opioids society is less susceptible to extinction and is the best way to solve – logically if 1 action could stop extinction people would’ve already done it

### 1AC – Underview – Generic

#### 1] 1ar theory is legit, DTD, CI, No RVI’s and the highest layer of the round–

#### A] The neg could be infinitely abusive in the 1nc and I would have no recourse which makes it impossible for the aff to win

#### B] They shouldn’t get an RVI because it encourages them to bait theory in the 1nc and prep it out which makes allows for abuse to be encouraged because they will win it every time.

#### C] They have 6 mins to answer it while I only have 3 mins to flesh it out and make it a voter which means they don’t need the RVI

#### 2] P&P affirm –

#### 1] Statements are true before false since if I told you my name, you’d believe me.

#### 2] Illogical – presuming statements false is illogical since you can’t say things like P and ~P are both wrong.

#### 3] To negate means to deny the truth of, which means if there isn’t offense to deny the truth of you should affirm.

#### 4] Otherwise we’d have to have a proactive justification to do things like drink water.

#### 5] Affirming is harder – aff flex outweighs – 13-7 time skew and 6-minute collapse gives the negative the strategic advantage and forces me to split 1AR time. The NC can up layer, restart the round and have time to generate offense that matters.

#### 3] The neg must check interps in cross, the aff speaks in the dark, and an infinite number of bidirectional interps means that I will always violate something, they need to ask me in cross for us to check

#### 4] I get the RVI on any 1NC theory shell

#### A]Time skew – I only have 4 mins to answer the shells – the shell prob takes 20 seconds to read but at least 40 seconds to answer well enough to not auto lose that means I should get the RVI because it’s the only way for the aff to have any chance of winning

#### B] Deterrence – deters people from reading friv theory and encourages a substantive debate