I affirm. Part A is the substantive overview –

First, affirming is harder so a tie means I’m better, presume aff. Out of over 12000 rounds last year affs won over 7% fewer rounds[[1]](#footnote-1). Prefer stats since they determine whether analytics about side bias *actually* have any effect.

Second, to affirm means “**to say that something is true.**”[[2]](#footnote-2) To negate means **“to deny the truth of”** which impliestruth testing is the only paradigm consistent with textuality, which means it is the only paradigm you have jurisdiction to use since when you sign the ballot you are saying the better debating was done by the aff.

Third, every statement including the resolution includes implicit assumptions, which means the res can be rephrased as a conditional statement for any one of these functioning as the antecedent. Indicting the resolution’s assumptions is denying its antecedents, rendering it true as per logicians consensus. SEP[[3]](#footnote-3),

Conditional statement: an “if p, then q” compound statement (ex. If I throw this ball into the air, it will come down); p is called the antecedent, and q is the consequent.  A conditional asserts that if its antecedent is true, its consequent is also true; any conditional [statement] with a true antecedent and a false consequent must be false.  For any other combination of **true** and false antecedents and consequents, the conditional statement is true.

At worst indicting assumptions renders the resolution incoherent since it becomes nonsensical and that certainly doesn’t make it false.

Fourth, neuroscience proves there’s no such thing as free will or choices, which the resolution assumes. **Coyne:**

Jerry Coyne, [Professor in the Department of Ecology and Evolution at The [University of Chicago](http://content.usatoday.com/topics/topic/Organizations/Schools/University+of+Chicago)], “Why You Don’t Really Have Free Will,” *USAToday*, January 1st, 2012. SM

And that's what neurobiology is telling us: **Our brains are** simply meat computers that, like real computers, are **programmed by our genes** and experiences to convert an array of inputs into a predetermined output. Recent experiments involving **brain scans show that** when a subject "decides" to push a button on the left or right side of a computer, the **choice can be predicted** by brain activity **at least** ***seven seconds*** **before the subject is consciously aware of having made it.** (These studies use crude imaging techniques based on blood flow, and I suspect that future understanding of the brain will allow us to predict many of our decisions far earlier than seven seconds in advance.) "**Decisions**” made like that **aren't conscious** ones. And if our choices are unconscious, with some determined well before the moment we think we've made them, then **we don't have free will** in any meaningful sense. Psychologists and neuroscientists are also showing that the experience of will itself could be an illusion that evolution has given us to connect our thoughts, which stem from unconscious processes, and our actions, which also stem from unconscious process. We think this because our sense of "willing" an act can be changed, created, or even eliminated through brain stimulation, mental illness, or psychological experiments. The ineluctable scientific conclusion is that although we *feel* that we're characters in the play of our lives, rewriting our parts as we go along, in reality **we're puppets performing scripted parts** written by the laws of physics.

Part B is framing –

These are not just preempts – this is my position. The resolution is a question of doctor’s obligations and the function of doctors is consistency with medical ethics codes.

First, **dictionary.com** defines right as **a just claim or title.** <http://dictionary.reference.com/browse/right>

This means the resolution a question of medical ethics, with the doctor and not the government as the actor because to have a claim to a medical choice imposes on obligation on the agents who implement medical procedures, that is, doctors. Prefer this approach to the topic –

.1. Medical ethics is key on this topic – **Kipnis:**

Kenneth Kipnis (University of Hawaii @ Manoa). “Pediatric Ethics and Responsibility for Children: Clearing the Ground”, APA Newsletter, Fall 2002, Volume 02, Number 1. <https://c.ymcdn.com/sites/www.apaonline.org/resource/collection/250A3149-F981-47C2-9379-618149806E75/v02n2Medicine.pdf.> AS

Clinical Ethics: A fourth context involves pediatric clinical ethics: specifically, **the circumstances under which a physician should** act to **override a parental decision**. We have already alluded to one case in which the parents demanded that a physician administer abusive treatments, treatments that imposed burdens without an expectation of compensating benefits. Here the Hippocratic duty “above all, to do no harm” should suffice. Physicians have a duty to reject such demands. But how physicians and hospitals should respond to refusals of medically indicated treatment by the children themselves or by their parents or guardians **is a[n]** quite different **issue.** (A further complication occurs when a mature minor disagrees with a parental decision). Under what circumstances should physicians operating within a liberal society (a society committed to respecting substantial differences in orientation and values) either disregard such refusals, treating the minor directly or, if time permits, seek to have the refusal overturned in court? While the criteria the courts use in deciding to appoint guardians will be relevant to a medical decision to seek a court order, **the medical profession**, collectively, **has a**n ethical **duty to** try to **get** the **courts and legislature to adopt criteria** that are **consistent with medical ethics.** Notwithstanding the central involvement of doctors, it is not the case that physicians have the legal authority to impose treatment against the will of the minor’s parents, except under rare, emergency circumstances. At the hospitals at which I have worked the standard procedure is to ask the administration to direct the hospital attorney to petition the family court for a hearing to appoint a guardian. In Honolulu, a family court judge carries a beeper for this purpose at all times. Emergency hearings can be convened in hours. If the motion is granted, the parents’ authority over the child will be partially suspended and delegated to another individual—the guardian—**who will** then **have the authority to give or withhold consent to medical treatment in the interest of the child.** Conceived as **[is] a problem in medical ethics**, the bottom-line issue is when to seek in this way to suspend or terminate a parent’s legal authority to give or withhold consent to a minor’s treatment. While it is not possible to set out a rule here, there are three factors that should generally carry weight in medically honoring a refusal of medical treatment by or on behalf of a minor: the decisional capacity of the minor, the burden and risk of treatment, and the effectiveness of treatment.

Impacts – **A.** My interp gets us the core of the topic lit which is crucial to fairness and education since it’s the basis of our substantive prep, without which we could not access the ballot or have educational clash **B.** Even if government action is important we should still focus on medical ethics since Kipnis explicitly specifies that doctors have a duty to force the law to be consistent with medical ethics.

2. It’s the only way to avoid FX T plans – if the res is a question of government action then the aff can defend a policy that merely leads to doctors giving adolescents medical choices, for example, repealing some parental restriction or creating some agency. However my interp entails that doctors are directly obligated, otherwise affs could read any plan that somehow ends up increasing medical autonomy as a consequence, which is bad since **A.** it kills disad ground since disads are prepped with uniqueness on the condition of medical choices in the squo, but FX T plans have no stable uniqueness since the plan only affects medical choices as the result of an indirect link chain. DA ground key to clash and reciprocity since otherwise the AC isn’t turnable and **B.** severly underlimits the topic – plan ground is exploded and neg topical CPs are incentivized. Destroys predictability, which is key to preparing args.

3. Debatability – the neg is the status quo, so there are no studies reviewing whether doing the aff actually makes doctors follow through with the laws imposed by the plan. My interp solves since we skip the solvency issue and speak directly about a doctors obligations. Debatability key to fairness since otherwise there’s no way for us to determine who did the better debating, also key to being able to clash.

Second, ought to is defined as functionally being supposed to do something based on the factual nature of the agent. **Macintyre:**

Alasdair MacIntyre, [After Virtue](http://www.amazon.com/After-Virtue-Study-Moral-Theory/dp/0268035040/), 1981

Yet in fact the alleged unrestrictedly general logical principle on which everything is being made to depend is bogus- and the scholastic tag applies only to Aristotelian syllogisms. There are several types of valid arguments in which some element may appear in a conclusion which is not present in the premises. A.N. Prior’s counter-example to this illustrates its breakdown adequately; **from** the premise **‘He is a sea captain’; the conclusion may be** validly **inferred that ‘He ought to do whatever a sea-captain ought to do’.** This counter-example not only shows that there is no general principle of the type alleged; but **it** itself **shows** what is at least **a grammatical truth—an ‘is’ premise can** on occasion **entail an ‘ought’ conclusion. From** such factual premises as **‘This watch is** grossly **inaccurate** and irregular in time-keeping’ and ‘This watch is too heavy to carry about comfortably’, **the** evaluative **conclusion** validly **follows that ‘This is a bad watch’.** From such factual premises as ‘He gets a better yield for this crop per acre than any farmer in the district’, ‘He has the most effective programme of soil renewal yet known’ and ‘His dairy herd wins all the first prizes at the agricultural shows’, the evaluative conclusion validly follows that ‘He is a good farmer’. Both of these arguments are valid because of the special character of the concepts of a watch and of a farmer. Such concepts are functional concepts; that is to say, **we define** both **‘watch’** and ‘farmer’ **in terms of** purpose of **function** which a watch or a farmer are characteristically expected to serve. It follows that the concept of **a watch cannot be defined independently of the concept of a good watch** nor the concept of a farmer independently of that of a good farmer; and that the criterion of something’s being a watch and the criterion of something’s being a good watch.

And the function of doctors is consistency with medical ethics codes, which set the practice rules for the profession, **Snyder:**

Lois Snyder, JD, for the Ethics, Professionalism and Human Rights Committee, American College of Physicians. “ACP Ethics Manual Sixth Edition”. <https://www.acponline.org/running_practice/ethics/manual/manual6th.htm>, (2012). AS

The Manual raises issues and presents general guidelines.In applying these guidelines, physicians should consider the circumstances of the individual patient and use their best judgment. Physicians have **moral and legal obligations**, and the two **may not be concordant**. Physician participation in torture is legal in some countries but is never morally defensible. Physicians must keep in mind the distinctions and potential conflicts between legal and ethical obligations and seek counsel when concerned about the potential legal consequences of decisions. **We refer to** the law in this Manual for illustrative purposes only; this should not be taken as a statement of the law or the legal consequences of actions, which can vary by state and country. Physicians must develop and maintain an adequate knowledge of key components of the laws and regulations that affect their patients and practices. **Medical** and professional **ethics** often **[which] establish positive duties** (that is, what one should do) to a greater extent than the law. Current understanding of medical ethics is based on the principles from which positive duties emerge. These principles include beneficence (a duty to promote good and act in the best interest of the patient and the health of society) and nonmaleficence (the duty to do no harm to patients). Also included is respect for [and] patient autonomy—the duty to protect and foster a patient's free, uncoerced choices [(6)](https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#ref-6). From the principle of respect for autonomy are derived the rules for truth-telling. The **relative weight granted to** these **principles** and the conflicts among them often **account for the ethical dilemmas that physicians face.** Physicians who will be challenged to resolve those dilemmas must have such virtues as compassion, courage, and patience. In addition, considerations of justice must inform the physician's role as citizen and clinical decisions about resource allocation. The principle of distributive justice requires that we seek to equitably distribute the life-enhancing opportunities afforded by health care. How to accomplish this distribution is the focus of intense debate. More than ever, concerns about justice challenge the traditional role of physician as patient advocate. The environment for the delivery of health care continues to change. Sites of care are shifting, with more care provided in ambulatory settings while the intensity of inpatient care increases. The U.S. health care system does not serve all of its citizens well, and major reform has been needed. Health care financing is a serious concern, and society's values will be tested in decisions about resource allocation. Ethical issues attract widespread public attention and debate. Through legislation, administrative action, or judicial decision, government is increasingly involved in medical ethics. The convergence of various forces—scientific advances, patient and public education, the Internet, the civil rights and consumer movements, the effects of law and economics on medicine, and the heterogeneity of our society—demands that physicians clearly articulate the ethical principles that guide their behavior in clinical care, research, and teaching, or as citizens or collectively as members of the profession. It is crucial that a responsible physician perspective be heard as societal decisions are made. From genetic testing before conception to dilemmas at the end of life, physicians, patients, and their families are called upon to make difficult decisions. The 1970s saw the development of bioethics as a field. Important issues then (and now) include informed consent, access to health care, genetic screening and engineering, and forgoing life-sustaining treatment. These and other issues—physician-assisted suicide, technological changes, and the physician as entrepreneur—challenge us to periodically reconsider such topics as the patient–physician relationship, relationships with family caregivers [(7)](https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#ref-7), decisions to limit treatment, conflict of interest, physician–industry relations, changing communication modalities, and confidentiality. **This Manual was written for** our colleagues in **medicine.** The College believes that the Manual provides the best approach to the challenges addressed in it. We hope it stimulates reasoned debate and serves as a reference for persons who seek the College's position on ethical issues. Debates about medical ethics may also stimulate critical evaluation and discussion of law and public policy on the difficult ethical issues facing patients, physicians, and society. Medicine is not a trade to be learned, but a profession to be entered [(1)](https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#ref-1). A profession is characterized by a specialized body of knowledge that its members must teach and expand, by a code of ethics and a duty of service that put patient care above self-interest, and by the privilege of self-regulation granted by society [(8)](https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#ref-8). Physicians must individually and collectively fulfill the duties of the profession. While outside influences on medicine and the patient–physician relationship are many, the ethical **foundations of the profession must remain in sharp focus** [(9)](https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#ref-9).

Reasons to prefer – 1. Real world education – ought statements are context based since different groups or agents are bound to different purposes. We create them and thus decide what they do, so my interp key to real world understanding of obligations. Also, medical ethics is key since we’ll all be sick or know sick people at some point meaning everyone deals with those issues. Even if philosophy is good I outweigh **A.** we always have the same util vs. deont debate on any resolution, my interp lets us talk about the topic **B.** framework debates in LD have devolved into blippy assertions alongside triggers that prevent real philosophical discussion.

2. Debatability – philosophy is irresolvable since no theory is true **A.** any moral principle requires a justification, and a justification for the justification, and so on, so debates about morality are either inevaluable infinite logical regressions or just unweighable assertions of principles **B.** these claims have been argued for thousands of years so 45 minutes is unlikely to lead us anywhere and **C.** normative claims establish rules for actions. But, for any rule, we need a rule to know how to interpret the rule, i.e., when I point my finger there’s no non arbitrary way to decide if I am pointing in the direction of wrist to fingertip or from fingertip to wrist. This means rules are infinitely interpretable, undermining morality. Crossapply debatability key to fairness and education.

3. Reciprocity- under my interp the burdens are 1-1 and reciprocal, the aff proves the resolution is consistent with medical ethics and the neg proves it’s inconsistent. We don’t have to worry about permissibility ground or other issues that create strategy skews and detract from education.

Part C is offense. The AMA’s guidelines establish the importance of adolescent autonomy and confidentiality, which exclude parental involvement. They are very explicit that parental restrictions may not be a barrier to treatment, **AMA:**

A merican Medical Association, “H-60.965 Confidential Health Services for Adolescents”. <https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.organduri=/resources/html/PolicyFinder/policyfiles/HnE/H-60.965.HTM.> AS

**Our AMA**: (1) **reaffirms** that **confidential care for adolescents** is critical to improving their health; (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law; (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, **parental consent or notification should not be a barrier to care**; (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements); (5) encourages physicians to **offer adolescents an opportunity for examination and counseling apart from parents.** The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician; (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis; (7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice; (8) encourages health care payers to develop a method of listing of services which **preserve**s **confidentiality for adolescents;** and (9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help **eliminate laws which restrict** the availability of **confidential care.**(CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14)

Impacts – **A.** outweighs on explicitness – the guideline’s give a direct order which is preferable to arguments about how the neg may indirectly meet medical ethics **B.** confidentiality comes first – whether or not a procedure is private is black and white not continuous which means that the condition of being confidential is a side constraint.

The APHA explicitly recognizes parental involvement can be harmful and that policies should not compel involvement, **APHA:**

American Public Health Association, “Adolescent Access to Comprehensive Confidential Reproductive Health Care”, January 1, 1990. Policy Number: 9001. AS

Noting that sexually active and/or pregnant **adolescents need** informed, professional counseling and **health care regardless** of whether they wish to prevent, continue, or terminate a pregnancy; and Understanding that while **parental involvement in minors' decisions** may be very helpful, it **can** also **be punitive, coercive and/or abusive**;2 and Noting that physicians and other health care professionals have the obligation to provide care that is in the best interest of that patient; and Emphasizing that the threat of compelled **parental notification is a strong disincentive to** an adolescent's **seeking** professional reproductive health care or **advice**;3,4 and Noting that parental involvement laws, whether notification or consent, for adolescent reproductive health care (including contraception, prenatal care, delivery services, postpartum care, or abortion), do not appreciably discourage adolescent sexual activity;3,4 and Further noting that adolescents are particularly vulnerable to misinformation, scare tactics, and other propaganda; and Noting that safe abortion is a component of comprehensive reproductive health care; therefore Urges that public policies and laws concerning adolescent access to reproductive health care, adolescent pregnancy and pregnancy outcome be designed for the primary purposes of preventing unintended pregnancy and providing sensitive, competent, professional health care to all adolescents; Urges that such policies reflect the reality of adolescent sexual activity and take into consideration the demonstrably negative effect of compelled parental involvement on some adolescents' contraceptive behavior; Urges that adequate and proper care for pregnant adolescents includes encouragement to involve a mature adult in decision-making about pregnancy outcome, provided that such involvement is not dictated or compelled; Urges that services for pregnant adolescents include access to safe, legal, and confidential abortion counseling and services, as well as access to affordable, confidential prenatal and postpartum care and contraceptive services; and Urges that a national policy on reproductive health care for adolescents include: Comprehensive health and sexuality education in schools extending from kindergarten through high school; Confidential health services tailored to the needs of adolescents, including sexually active adolescents, adolescents considering sexual intercourse, and those seeking information, counseling, or services related to preventing, continuing, or terminating a pregnancy; Public policies that encourage sexually active and pregnant adolescents to seek professional health care. These **policies** can encourage mature adult involvement (including parental involvement) but **should in no way dictate or compel the specific involvement of parents or guardians in adolescent decisions** regarding their reproductive health.

Means that even if the resolution is a question of government action, you still affirm because the evidence speaks to policymaking as well.

Part D is theory preempts

1. Accept textual aff definitions – don’t read T. **A.** there are multiple interps of the topic and the neg is reactive to the aff, so they can always be prepared to debate under it **B.** as long as there’s ability for neg to win under an interpretation then it allows for fair clash and **C.** the neg can always call for alternate definitions, killing topic discussion cause negs are incentivized to always layer the case debate with T and skews time because 1AR’s are always forced to restart.

2. The neg may only have one unconditional access to the ballot, which is defined as one layer questioning what the judge’s obligation is. Key to aff strategy since any other interp allows the neg to set up conditional routes to the ballot forcing me to engage all of them. The 2NR becomes much easier since they could go for any route and win the round on that making the 2AR impossible. Key to fairness since you need a coherent strat to win the round.

3. The neg must concede to the affirmative’s choice of role of the ballot for this round – that means you can’t contest truth testing. Prefer this interp **A.** other interps allow the NC to introduce an entirely new layer that the 1AR cannot establish adequate footing on due to the 13-7 time skew of a 1AR restart, means we can’t engage under their new role of the ballot anyways **B.** only my interpretation permits substantive discussion since when the role of the ballot is contested, every single round becomes a procedural debate about what role of the ballot is preferable and **C.** switch side debate links turns reasons to prefer alternate roles of the ballot – my interp forces debaters to debate under different roles of the ballot increasing clash and depth because superficial responses aren’t made on multiple layers of the flow. In addition to linking into fairness each one of these standards are an independent reason why my interp leads to more clash under any role of the ballot.

4. According to google debate is defined as **“a formal discussion on a particular topic** in a public meeting or legislative assembly, **in which opposing arguments are put forward.”**

This means **A.** a topic is key to meeting what it means to be debating and **B.** clashing is constitutive of debating.

5. Redefine the aff under neg T or theory because **A.** competing mutually exclusive interps make it possible for the neg to always read theory to avoid substance since the aff enters blind and, **B.** T interps are just paradigms for how we debate so winning one isn’t a reason to exclude my offense if it still is applicable. **C.** time skew makes it so that it impossible to win theory and substance in the 1AR. Re-evaluating my offense under their interp solves by bringing the round to one layer. This also means drop the neg on theory since I can’t beat back an abusive NC strategy if I need to win theory and substance too.

1. http://vbriefly.com/side-bias/ [↑](#footnote-ref-1)
2. Merriam Webster Dictionary, “affirm” [↑](#footnote-ref-2)
3. http://www.stanford.edu/~bobonicha/dictionary/dictionary.html Abbreviated Dictionary of Philosophical Terminology An introduction to philosophy Stanford University [↑](#footnote-ref-3)