## 1AC

I affirm.

### Spikes (0:37)

**(1)** Aff gets RVIs and presumption ground because of rebuttal and double extension time skew and because most people flip neg, and neg has two ways to win on theory, theory and T but the aff only has one, which outweighs epistemological neg presumption arguments because time determines the structure of debate. Time skew outweighs any other standards because we can only make arguments within a certain amount of time. Skep triggers presumption because we evaluate with no offense

**(2)** Neg should C/X check on theory to avoid useless theory and any theory run on a paragraph shell is a counter-interp, as each shell is itself an interp. If neg makes me drop CX checks they cannot run a shell that I could have complied with in CX.

**(3)** Aff doesnt have to spec anything because grammatically the resolution does not ask me to specify – grammar is key because it is how we comprehend fairness and education

**(4)** Reject neg arguments that derive violations/links from the resolution –skews my strat as I have to defend the resolution. This means reasonability on T because multiple terms and definitions skews predictability, which is the brightline. Also, perms are only tests of competition that serve as terminal defense on a K.

**(5)** Neg must defend converse and aff actor meaning no CPs to solve back infinity to 1 burden skew.

### FW (2:13)

First, **I value justice**  - prefer on topic specificity because the res concerns itself with the USCJS.

The difference between justice and morality comes from the ability to distinguish between the end states and the intentions of the action. The only things that are considered under justice are the end states.

Ross,

The difference between morality and justice comes not from the difference between actions and consequences (as between morality and [euergetic](http://www.friesian.com/poly-1.htm) ethics) but from the difference between motives and actions. As Kant noted, the worth of moral action is in the intention, not in what is actually done.The imperative of morality is first of all to act with good will. Even the best of good will, however, does not necessarily produce right action --the saying is that the path to hell is paved with good intentions. And even ill will does not necessarily produce wrong action -- it is really an *ad hominem* fallacy to evaluate an action on the basis of an agent's motive. **The estimation of justice does not primarily concern intentions but what actually *is* done. There is no breach of justice unless some wrong** of negligence, violence, or fraud **has been committed** (in law the *actus reus*). Intention *then* may become an issue in judging the culpability or severity of the wrong (the *mens rea*), as between various degrees of murder, where intention, malice, and forethought progressively increase the severity of the crime (to voluntary manslaughter, second degree murder, and first degree murder, respectively). **If no wrong is committed, then it is not an issue of justice** and motives are irrelevant**.** Even **undoubted wrongs of action may be "merely" moral** ifthey are not very severe or are intrinsically difficult to prove: **willful breach of an informal, oral promise for no good reason will always be a moral wrong, but only if some** financial **loss** (or damage to public standing) **or physical** (**or** even severe enough **psychological) injury** **results will it be a breach of an actionable "**oral **contract" and** so **a judicial wrong.** There are legal rules about the factors (such as the presence of a "consideration") that must be involved if an enforceable contract is judged to exist. Breach of promise will always be *morally* actionable in the sense of voiced moral reproach or damage to personal relationships. SK

Next,we must always be able to change the conceptions of what is “just” so that it can adapt according to our time. There is significant difference between various human cultures, and to assert one type as “just” is nonsensical, as we view justice through the lens of our society.

Spirkin explains,

**The group is the first shaper of the personality, and the group itself is shaped by society.** *The unity of man and society.* **A person's whole intellectual make-up bears the clear imprint of the life of society as a whole.** **All his practical activities are individual expressions of the historically formed social practice of humanity.** The implements that he uses have in their form a function evolved by a society which predetermines the ways of using them. When tackling any job, we all have to take into account what has already been achieved before us. The wealth and complexity of the individual's social content are conditioned by the diversity of his links with the social whole, the degree to which the various spheres of the life of society have been assimilated and refracted in his consciousness and activity. This is why the level of **individual development is an indicator of the level of development of society, and vice versa**. But **the individual** does not dissolve into society. He **retains his** unique and independent **individuality and makes his contribution to the social whole**: **just as society itself shapes human beings, so human beings shape society.** The individual is a link in the chain of the generations. **His affairs are regulated** not only by himself, but also **by the social standards.**SK

The only real generality one can make about a just society is that it values human life, or else it would die out, which makes it the only binding factor between them. Otherwise, we would be unable to view morals or evaluate moral impacts and there only would be skepticism because there would be no way to determine societal values. This means that my framework precludes, as the resolution is talking about a society which means that its values are constantly changing in order to guide action.

Thus, the standard is **preventing death.**

Prefer for Three Reasons:

**One**, each individual wills themselves to live, which precludes their capacity to rationalize, and is their first motivation. Thus, this (a) takes out the fallacy of origin, as live is intrinsically valuable as it is an end to strive towards, but also (b) proves the inherent desires of individuals comes first. Each wills unconsciously to live.

Estlund, [Estlund, David M. *The Oxford Handbook of Political Philosophy*. New York: Oxford UP, 2012. Print. SK]

Further, Hobbes's (in)famous mechanistic materialism commits him, he thinks, to a broadly egoistic psychological theory according to which **each person is motivated** (either always or "predominantly") **by his or her own perceived best interest** (Kavka 1986, 50-51). For Hobbes, this implies especially that **each person**, unless confused by religious (or other) claptrap, **seeks above all to stay alive**. Finally, we are, I---Hobbes thinks, entitled to infer that, **because [of this]** each always seeks his or her own continued existence, **each may be presumed to consent to any arrangement that is necessary to staying alive**. If others seek authority over us and are able to kill us, we may therefore be to consent to their authority over us: "Every man is supposed to promise obedience to him in whose power it is to save or destroy him (Hobbes 1968, 254; xx, para. 5). And as such **presumed consent to the authority of the powerful still counts as free and binding, because the only "impediment" to our will is the internal** (even if supremely influential) impediment of our **fear of death**. Thus: Hobbes's reputation as a defender of the doctrine that "might makes right" turns out to be a half-truth. **Another's might** (i.e., his power to dispose of us at will) in fact "**makes our binding** (even if only Eltesllmed) **consent to his authority**, and that authority, is turn, **[which] renders his actions toward us rightful**. **All political consent**, Hobbes claim: " **proceed[s] from fear of death**," whether the society begins in a "free" contract (by “institution”) or by conquest (by “acquisition”). SK

This also does not imply the fallacy of origin; we value life because it allows us to give rise to other values.

Rasmussen,

In so far as one chooses, regardless of the choice, one choose (value) man's life. **It makes no sense to value some X without also valuing that which makes the valuing of X possible.** notice that **this is different from saying "that which makes X possible").** If one lets X be equivalent to "death" or "the greatest happiness for the greatest number," one is able to have such a valuation only because of the precondition of being a living being. **Given that life is a necessary condition for valuation**, **there is no other way we can value something without also** (implicitly at least) **valuing that** which makes valuation possible. SK

This argument is that life makes the valuing of other things possible, not the other things possible in themselves, meaning that it inherently should be valued, and is a prerequisite to any other value.

**Two,** We should utilize the aff fw of preventing death as the one for the round if it is fair and educational as this preserves most of the 1AC because I'm forced to speak first and define a starting point for debate, so not using this as the framework gets rid of all AC offense,

O’Donnell**,** [“And the Twain Shall Meet: Affirmative Framework Choice and the Future of Debate” Timothy M. O’Donnell Director of Debate University of Mary Washington. SK**]**

There are several reasons why **the affirmative should get to** choose the **frame**work for **the debate.** **First,** AFC **[this]** **preserves the value of the first affirmative constructive speech**. **This speech is the starting point** for the debate. It is a function of necessity. The debate must begin somewhere if it is to begin at all. Failure to grant AFC is a denial of the service rendered by the affirmative team’s labor when they crafted this speech. Further, **if the affirmative does not get to pick the starting point, the opening speech** act **is** essentially **rendered meaningless** while the rest of the debate becomes a debate about what we should be debating about.

**Three,** Death is the worst ontological harm so it outweighs.

Paterson– [Department of Philosophy, Providence College, Rhode Island (Craig, “A Life Not Worth Living?”, Studies in Christian Ethics, <http://sce.sagepub.com>]

Contrary to those accounts, I would argue that it is death per se that is really the objective evil for us, not because it deprives us of a prospective future of overall good judged better than the alter- native of non-being. It cannot be about harm to a former person who has ceased to exist, for no person actually suffers from the sub-sequent non-participation. Rather, death in itself is an evil to us because it ontologically destroys the current existent subject — it is the ultimate in metaphysical lightening strikes.80 The evil of death is truly an ontological evil borne by the person who already exists, independently of calculations about better or worse possible lives. Such an evil need not be consciously experienced in order to be an evil for the kind of being a human person is. Death is an evil because of the change in kind it brings about, a change that is destructive of the type of entity that we essentially are. Anything, whether caused naturally or caused by human intervention (intentional or unintentional) that drastically interferes in the process of maintaining the person in existence is an objective evil for the person. What is crucially at stake here, and is dialectically supportive of the self-evidency of the basic good of human life, is that death is a radical interference with the current life process of the kind of being that we are. In consequence, death itself can be credibly thought of as a ‘primitive evil’ for all persons, regardless of the extent to which they are currently or prospectively capable of participating in a full array of the goods of life.81 In conclusion, concerning willed human actions, it is justifiable to state that any intentional rejection of human life itself cannot therefore be warranted since it is an expression of an ultimate disvalue for the subject, namely, the destruction of the present person; a radical ontological good that we cannot begin to weigh objectively against the travails of life in a rational manner. To deal with the sources of disvalue (pain, suffering, etc.) we should not seek to irrationally destroy the person, the very source and condition of all human possibility.82

The preservation of life is an intrinsic good that everyone has an obligation to meet – any argument not grounded in this intrinsic good are useless independent of it.

### Contention 1 is Trust

#### Adolescent medical autonomy is necessary to adolescent patient-physician trust – spills over into adulthood.

Raugust ‘09, [“The Essential Components of a Trusting Adolescent Patient-Physician Relationship”, Jordan D. Raugust BSc, University of Alberta Medicine, Class of 2009. SK]

**A physician-patient relationship is built upon a foundation of trust**. If this foundation deteriorates, severe constraints will be placed upon the physician’s ability to serve as an advocate for their patient’s health. The premise for **this** assertion **lies primarily in the physician’s duty to respect patient autonomy in medical decision making**. Patients have a right to determine the time when their sensitive information is revealed to others, and whether it is to be revealed at all [1]. **This reality is never more apparent than with adolescent patients;** **many of whom choose to forgo medical treatment in fear of a breach of confidentiality** [2]. **Adolescents are** immersed in a period where they are **transitioning from childhood to becoming a mature adult**, capable of making autonomous decisions. **If a distrust of the medical community occurs, they may terminate their relationship with physicians into adulthood, eliminating the capacity for a physician to act as an advocate for their well-being**. For this reason, **the absence of a legally defined age for consent to medical treatment is useful in establishing an optimal physician-patient relationship**. Common law recognizes that adolescents under the legal age of majority, who are deemed suf­ciently mature, may have the capacity to consent to medical treatment with the same autonomy as adults [3]; a stance supported by the CMA’s Code of Ethics [4]. Therefore, **the critical element is the patient’s capacity to understand and decide, rather than their age.** A trusting relationship is of utmost importance if physicians are to positively impact the health of sexually active adolescents. Teens who choose not to discuss their sexual behavior with their parents, may consult a health care provider for sexual health care services. However, they will only do this if con­dentiality is assured. Without assurance of con­dentiality, the patient may withdraw trust and terminate the relationship; forfeiting the positive impact of their physician toward their well-being. **A patient’s capacity is only as good as the accompanying disclosure** [5]. Therefore, it is essential for the physician to disclose information that a reasonable person in the patient’s position would require in order to make an informed decision; including the purpose, risks and bene­ts of a treatment [6].SK

#### Patient trust is necessary to prevent disease outbreaks

Jacobs [Alice, Director, Cardiac Catheterization Laboratory and Interventional Cardiology Professor of Medicine, Boston University School of Medicine) “Rebuilding an Enduring Trust in Medicine” Circulation. 2005; 111: 3494-3498]

Each year we gather at these Sessions, the world’s largest meeting of scientists and healthcare professionals dedicated to the basic, clinical, and population science of cardiovascular disease and stroke. We gather to learn and to teach, to meet today’s experts and tomorrow’s leaders, to review the new scientific discoveries, and to exchange ideas with colleagues and friends. To be sure, we will learn about the emerging science and clinical practice of cardiovascular disease over the next four days. But there is an internal disease of the heart that confronts us as scientists, as physicians, and as healthcare professionals. It is a threat to us all—insidious and pervasive—and one that we unknowingly may spread. This threat is one of the most critical issues facing our profession today. How we address this problem will shape the future of medical care. This issue is the erosion of trust. **Lack of trust is a barrier between our intellectual renewal and our ability to deliver this new knowledge** to our research labs, to our offices, **to** the bedside of our **patients, and to the public**. **Trust is a vital, unseen, and essential element in diagnosis, treatment, and healing.** So it is fundamental that we understand what it is, why it’s important in medicine, its recent decline, and what we can all do to rebuild trust in our profession. **Trust is intrinsic to the relationship between citizens** around the world **and** the **institutions** that serve their needs: government, education, business, religion, and, most certainly, **[in] medicine**. Albert Einstein recognized the importance of trust when he said, “Every kind of peaceful cooperation among men is primarily based on mutual trust.”1 **In our time, trust has been broken, abused, misplaced, and violated**. The media have been replete with commentaries, citing stories of negligence, corruption, and betrayal by individuals and groups in the public and private sectors, from governments to corporations, from educational institutions to the Olympic Organizing Committee. These all are front-page news. Perhaps the most extreme example is terrorism, in which strangers use acts of violence to shatter trust and splinter society in an ongoing assault on our shared reverence for human life. Unfortunately, we are not immune in our own sphere of cardiovascular medicine. The physician-investigator conflicts of interest concerning enrollment of patients in clinical trials, the focus on medical and nursing errors, the high-profile medical malpractice cases, the mandate to control the cost of health care in ways that may not be aligned with the best interest of the patient—all of these undermine trust in our profession. At this time, when more and more public and private institutions have fallen in public esteem, restoring trust in the healthcare professions will require that we understand the importance of trust and the implications of its absence. Trust is intuitive confidence and a sense of comfort that comes from the belief that we can rely on an individual or organization to perform competently, responsibly, and in a manner considerate of our interests.2 It is dynamic, it is fragile, and it is vulnerable. Trust can be damaged, but it can be repaired and restored. It is praised where it is evident and acknowledged in every profession. Yet it is very difficult to define and quantify. Trust is easier to understand than to measure. For us, trust may be particularly difficult to embrace because it is not a science. Few instruments have been designed to allow us to evaluate it with any scientific rigor. Yet, **trust is inherent to our profession,** precisely **because patients turn to us in their most vulnerable moments, for** knowledge about their **health and disease**. We know trust when we experience it: when we advise patients in need of highly technical procedures that are associated with increased risk or when we return from being away to learn that our patient who became ill waited for us to make a decision and to discuss their concerns, despite being surrounded by competent colleagues acting on our behalf. Many thought leaders in the medical field understand the importance of trust.3 When asked whether **the public health system could be overrun by public panic over SARS and bioterrorism,** Centers for Disease Control and Prevention Director Julie Gerberding replied, “You can manage **[if] people** if they **[do not] trust [medical professionals]** you. We’ve put a great deal of effort into improving state and local communications and scaled up our own public affairs capacity…we’re building credibility, competence and trust.”4 Former Health and Human Services Secretary Donna Shalala also recognized the importance of trust when she said, “**If we are to keep testing new medicines and new approaches to curing disease, we cannot compromise the trust** and willingness **of patients** **to participate in clinical trials**.”5 These seemingly intuitive concepts of the importance of trust in 21st century medicine actually have little foundation in our medical heritage. In fact, a review of the early history of medicine is astonishingly devoid of medical ethics. Even the Codes and Principles of Ethics of the American Medical Association, founded in 1847, required patients to place total trust in their physician’s judgment, to obey promptly, and to “entertain a just and enduring sense of value of the services rendered.”6 Such a bold assertion of the authority of the physician and the gratitude of the patient seems unimaginable today. It was not until the early 1920s that role models such as Boston’s Richard Cabot linked patient-centered medical ethics with the best that scientific medicine had to offer,6 and Frances Weld Peabody, the first Director of the Thorndike Memorial Laboratory at the Boston City Hospital, crystallized the ethical obligation of the physician to his patient in his essay “The Care of the Patient.”7 In one particularly insightful passage, Peabody captures the essence of the two elements of the physician’s ethical obligation: He must know his professional business and he must trouble to know the patient well enough to draw conclusions, jointly with the patient, as to what actions are indeed in the patient’s best interest. He states: “The treatment of a disease may be entirely impersonal: The care of the patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of casesboth diagnosis and treatment are directly dependent on it.” Truly, as Peabody said, “The secret to the care of the patient…is in caring for the patient.”7 This concept that links the quality of the physician-patient relationship to health outcomes has indeed stood the test of time. **Trust** has been shown to be important in its own right. It **is essential to patients**, **in their willingness to seek care, their willingness to reveal sensitive information, their willingness to submit to treatment,** and their willingness to follow recommendations. They must be willing for us to be able. Furthermore, it is unclear why **the widely documented and pervasive racial and ethnic inequalities in health care and health status exist**, but perceptions of healthcare professionals’ style and **[because of low] trust** may play a role.8 Several investigators have suggested that **lower levels of trust in our current healthcare system among people of color, particularly African Americans, may help to explain their lower rates of** seeking preventive services and receiving **surgical treatment when compared with Caucasians**.9 **Trust is** not only vital for the practice of medicine, it is **the** **moral glue of society.** As noted by H.L. Mencken, “For it is mutual trust, even more than mutual interest, that holds human associations together.”10 Unfortunately, in many sectors of society, trust is at historically low levels.SK

#### Leads to extinction and state collapse.

Morris ‘13, [professor of history at Stanford University, 3/22/**2013** (Ian, “The Measure of Civilization: How Social Development Decides the Fate of Nations,” Carnegie Council, Lexis)]

There are several periods when we get discontinuities, when we get collapses in social development scores. You can see several very clear examples on this graph. When we look back at the history of what happens when we get these great collapses in social development, every time we see the same five forces involved: Mass migrations that the societies of the day cannot cope with. This is always in the mix. The mass migrations often lead to huge epidemic diseases, as previously separate disease pools get merged. **Epidemic diseases** regularly killing half the population, it would seem, tend to **lead to state failure**. Governments cannot cope with catastrophe on this scale. **The collapse of the governments** tends to **lead to breakdown in long-distance trade**. **Famines ensue**, many, many **more people die**. And then, always there in the mix in some way, although it varies in every case, is climate change. It always plays into this. Now, I'm sure you don't need me to tell you these are forces that plenty of people are talking about as threats we are facing in the early 21st century. It seems to me perfectly possible that **[if so, it is possible that] the 21st century is going to see** another **collapse of the kind** we have seen so many times in the past. So in some ways it's possible the **21st century might be a rerun of what has happened many times before**—**but with** one big difference: We now have **nuclear weapons**, which ancient people didn't have. The Romans would have loved nuclear weapons. Luckily, they didn't have them. I think **if we do stumble into a collapse on** the **[that] scale** that I'm talking about here, we should seriously expect **there is a possibility of these being used**. It's quite possible that **the 21st century will see a disaster that dwarfs anything we have seen earlier.** sk

And, a violation of any life carries an infinite magnitude of death because you kill any possible future human generations from that life. So if there are competing death claims, because the impact will always be infinity, we would presume under the framework.

### Contention 2 is Runaway Youth

#### A large group of adolescents are homeless and runaway youth – they have a higher risk of contracting HIV

Meade and Slesnick ‘02, [J Psychol. Author manuscript; available in PMC 2008 Jun 18. Published in final edited form as: J Psychol. 2002 Jul; 136(4): 449–463. doi: 10.1080/00223980209604171 PMCID: PMC2430768 NIHMSID: NIHMS52982 Ethical Considerations for Research and Treatment With Runaway and Homeless Adolescents MELISSA A. MEADE and NATASHA SLESNICK. SK]

**HOMELESS AND RUNAWAY YOUTH represent a large**, distressed **subgroup of adolescents** in need of research and treatment attention. **One in eight children will run away before** reaching **age 18** (Nye & Edelbrock, 1980), and this figure increases to one in four for single-parent households and households with more than eight persons. These youth present with high rates of clinical depression (ranging from 29% to 83.6%; Shaffer & Caton, 1984; Unger, Kipke, Simon, Montgomery, & Johnson, 1997; Yates, MacKenzie, Pennbridge, & Cohen, 1988), high rates of psychotic symptoms (Mundy, Robertson, Robertson, & Greenblatt, 1990), and other affective and anxiety disorders (Shane, 1991). Runaway and homeless youth also show higher rates of alcohol and drug use than children who live at home (Forst & Crim, 1994), with reported rates of substance-use problems ranging from 70% to 95% (Booth & Zhang, 1997; Rotheram-Borus et al., 1989; Shaffer & Caton, 1984; Yates et al., 1988). **These youth** often **engage in illegal activities**, including prostitution, theft, truancy, and the sale and distribution of narcotics (Deisher, Farrow, Hope, & Litchfield, 1989; McCarthy & Hagan, 1992). Intravenous drug use, compromised judgment due to drug use, and **risky sexual practices place them at increased risk for contracting HIV** (Rotheram-Borus, Feldman, Rosario, & Dunne, 1994). SK

#### Autonomous medical choice is key to prevent these threats – requiring parental consent undermines the functionality of services.

Meade and Slesnick 2, [J Psychol. Author manuscript; available in PMC 2008 Jun 18. Published in final edited form as: J Psychol. 2002 Jul; 136(4): 449–463. doi: 10.1080/00223980209604171 PMCID: PMC2430768 NIHMSID: NIHMS52982 Ethical Considerations for Research and Treatment With Runaway and Homeless Adolescents MELISSA A. MEADE and NATASHA SLESNICK. SK]

The fact that states vary in allowing adolescents to consent alone to treatment reflects the aforementioned controversy concerning adolescent competency to consent. The questions raised in the debate over adolescent consent to research apply in treatment settings as well. **In** cases in which parents are unavailable to provide consent, as is **the case for many homeless and runaway youth, consent to treatment alone may be necessary to receive services**. Otherwise, these youth likely will not receive needed medical or mental health intervention. **Treatment offers the potential to reduce imminent threats to homeless youths’ safety**. **Requiring parental consent** for psychological intervention **may prevent mental health workers from providing such services**. For example, service providers can facilitate youths’ transition from the streets into more stable housing, reducing risks associated with living on the streets. Participating in psychotherapy also may reduce youths’ symptoms of depression. The need for this is underscored by the high rates of attempted suicide in this population (McCarthy & Hagan, 1992; Shane, 1991; Smart & Walsh, 1993). Also, **therapists can assist youth to reduce** drug and alcohol problems as well as related dangers, including drug and alcohol overdose, street violence, and **HIV exposure**.

#### HIV is a Zoonotic disease that could go worldwide – every infection increases the risk.

Karesh et al 12 – [Dr William B Karesh, Prof Andy Dobson DPhil, Prof James O Lloyd-Smith PhD, Juan Lubroth DVM h, Matthew A Dixon MSc i, Prof Malcolm Bennett PhD j, Stephen Aldrich BA k, Todd Harrington MBA k, Pierre Formenty DVM l, Elizabeth H Loh MS a, Catherine C Machalaba MPH a, Mathew Jason Thomas MPH m, Prof David L Heymann MD i n (1/12/2012, "Ecology of zoonoses: natural and unnatural histories," www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61678-X/fulltext, ADL)]

**More than 60% of human infectious diseases are caused by pathogens shared with wild or domestic animals**. **Zoonotic disease organisms include those that are endemic in human populations or enzootic in animal populations with frequent cross-species transmission to people**. Some of these diseases have only emerged recently. Together, these organisms are responsible for a substantial burden of disease, with endemic and enzootic zoonoses causing about a billion cases of illness in people and millions of deaths every year. Emerging zoonoses are a growing threat to global health and have caused hundreds of billions of US dollars of economic damage in the past 20 years. We aimed to review how zoonotic diseases result from natural pathogen ecology, and how other circumstances, such as animal production, extraction of natural resources, and antimicrobial application change the dynamics of disease exposure to human beings. In view of present anthropogenic trends, a more effective approach to zoonotic disease prevention and control will require a broad view of medicine that emphasises evidence-based decision making and integrates ecological and evolutionary principles of animal, human, and environmental factors. This broad view is essential for the successful development of policies and practices that reduce probability of future zoonotic emergence, targeted surveillance and strategic prevention, and engagement of partners outside the medical community to help improve health outcomes and reduce disease threats. This is the first in a Series of three papers about zoonoses Introduction Pathogens shared with wild or domestic animals cause more than 60% of infectious diseases in man.1 Such pathogens and diseases include leptospirosis, cysticercosis and echinococcosis, toxoplasmosis, anthrax, brucellosis, rabies, Q fever, Chagas disease, type A influenzas, Rift Valley fever, severe acute respiratory syndrome (SARS), Ebola haemorrhagic fever, and the original emergence of **HIV**.2—6 **[is a] Zoonotic diseases** are often categorised according to their route of transmission (eg, vector-borne or foodborne), pathogen type (eg, microparasites, macroparasites, viruses, bacteria, protozoa, worms, ticks, or fleas), or degree of person-to-person transmissibility.7 The greatest burden on human health and livelihoods, amounting to about 1 billion cases of illness and millions of deaths every year, is caused by endemic zoonoses that are persistent regional health problems around the world.2 Many of these infections are enzootic (ie, stably established) in animal populations, and transmit from animals to people with little or no subsequent person-to-person transmission—for example, rabies or trypanosomiasis. Other zoonotic pathogens can spread efficiently between people once introduced from an animal reservoir, leading to localised outbreaks (eg, Ebola virus) or global spread (eg, pandemic influenza). Zoonoses made up most of the emerging infectious diseases identified in people in the past 70 years **which**, although relatively rare compared with endemic zoonoses, **are a substantial threat to global health and have caused economic damage exceeding hundreds of billions** of US dollars in the past 20 years.8, 9 Apart from the appearance of a pathogen for the first time in human beings, the distinction between endemic and emerging zoonoses can be viewed as temporal or geographical. An endemic disease in one location would be regarded as an emerging disease if it crossed from its natural reservoir and entered the human or animal populations in a new geographical area, or if an endemic pathogen evolved new traits that created an epidemic (eg, drug resistance). Key messages Nearly two-thirds of human infectious diseases arise from pathogens shared with wild or domestic animals **Endemic and enzootic zoonoses cause about a billion cases of illness in people and millions of deaths every year, and emerging zoonoses are a rising threat to global health, having caused hundreds of billions** of US dollars of economic damage in the past 20 years Ecological and evolutionary perspectives can provide valuable insights into pathogen ecology and can inform zoonotic disease-control programmes Anthropogenic practices, such as changes in land use and extractive industry actions, animal production systems, and widespread antimicrobial applications affect zoonotic disease transmission Risks are not limited to low-income countries; as global trade and travel expands, zoonoses are increasingly posing health concerns for the global medical community Ecological, evolutionary, social, economic, and epidemiological mechanisms affecting zoonoses' persistence and emergence are not well understood; such information could inform evidence-based policies, practices, and targeted zoonotic disease surveillance, and prevention and control efforts Multisectoral collaboration, including clinicians, public health scientists, ecologists and disease ecologists, veterinarians, economists, and others is necessary for effective management of the causes and prevention of zoonotic diseases Transmission of pathogens into human populations from other species is a natural product of our relation with animals and the environment. The emergence of zoonoses, both recent and historical, can be considered as a logical consequence of pathogen ecology and evolution, as microbes exploit new niches and adapt to new hosts. The underlying causes that create or provide access to these new niches seem to be mediated by human action in most cases, and include changes in land use, extraction of natural resources, animal production systems, modern transportation, antimicrobial drug use, and global trade. Although underlying ecological principles that shape how these pathogens survive and change have remained similar, people have changed the environment in which these principles operate. Domestication of animals, clearing of land for farming and grazing, and hunting of wildlife in new habitats, have resulted in zoonotic human infection with microorganisms that cause diseases such as rabies, echinococcosis, and the progenitors of measles and smallpox that had historically affected only animal populations through changes in contact and increased transmission opportunities from animals to people.10—12 As human societies have developed, each era of livestock revolution presented new health challenges and new opportunities for emergence of zoonotic pathogens.13 In the past few decades, accelerating global changes linked to an expanding global population have led to the emergence of a striking number of newly described zoonoses, including hantavirus pulmonary syndrome, monkeypox, SARS, and simian immunodeficiency virus (the animal precursor to HIV). Some of these **zoonoses, such as HIV, have become established as substantial new human pathogens that circulate persistently without repeat animal-to-person transmission**. SARS could have established, but was contained by rapid global response to its emergence;14 other zoonoses, such as Ebola virus and Nipah virus, have not become established because of local control efforts or their intrinsic inability to transmit efficiently between people. However, others such as hantavirus pulmonary syndrome, which is enzootic in rodents in many locations, cause sporadic and infrequent clusters of infections in human beings.15 In all cases, these emerging **zoonoses are defined by** their relatively recent appearance (or detection) in a population or, in some cases, **an amplification of transmission that increases the incidence, prevalence, or geographical distribution of previously rare pathogens**.15 Emergence of a zoonosis depends on several factors that often act simultaneously to change pathogen dynamics. The capacity of a pathogen to transmit or spread in a population is commonly quantified by the basic reproduction number, or R0 (panel 1). In addition to inherent properties of the pathogen, **factors affecting emergence or spread include** environmental factors or changes in land use, human population growth, **changes to human behaviour** or social structure, international travel or trade, microbial adaptation to drug or vaccine use or to new host species, and breakdown in public health infrastructure.17 With more than a billion international travellers every year, **infected individuals could potentially spread zoonotic diseases anywhere in the world.** Thus, with the emergence of new infectious diseases and the chronic presence of known zoonotic diseases in many low-income and middle-income countries that might or might not be adequately diagnosed or reported, zoonoses are increasingly relevant to the global medical community. SK

#### New findings of a mutated aggressive strain confirms this.

Nguyen ’15, [New Aggressive HIV Strain Found in Cuba Mar 1, 2015 | Colleen Nguyen | Outbreak News. SK]

**A new and aggressive strain of HIV**, which can develop into AIDS within three years of infection, **has been discovered in Cuba** [1]. Researchers raise concerns that **the strain’s accelerated progression is so rapid, that antiretroviral treatment may come too late** [1]. The study came in response to Cuban clinicians reporting an ‘increasing trend’ of rapid progression AIDS cases in Cuba and results were recently published in EBioMedicine on January 28, 2015 [1,2]. SK

#### Zoonotic diseases lead to extinction

Quammen, [award-winning science writer, long-time columnist for *Outside* magazine, writer for National Geographic, Harper's, Rolling Stone, the New York Times Book Review and others, 9/29/**2012** (David, “Could the next big animal-to-human disease wipe us out?,” The Guardian, pg. 29, Lexis) ]

Infectious disease is all around us. It's one of the basic processes that ecologists study, along with predation and competition. Predators are big beasts that eat their prey from outside. Pathogens (disease-causing agents, such as viruses) are small beasts that eat their prey from within. Although infectious disease can seem grisly and dreadful, under ordinary conditions, it's every bit as natural as what lions do to wildebeests and zebras. But conditions aren't always ordinary. Just as predators have their accustomed prey, so do pathogens. And just as a lion might occasionally depart from its normal behaviour - to kill a cow instead of a wildebeest, or a human instead of a zebra - so a pathogen can shift to a new target. Aberrations occur. When a pathogen leaps from an animal into a person, and succeeds in establishing itself as an infectious presence, sometimes causing illness or death, the result is a zoonosis. It's a mildly technical term, **zoonosis,** unfamiliar to most people, but it **helps clarify the** **biological complexities behind** the ominous headlines about swine flu, bird flu, Sars, **emerging disease**s in general, **and the threat of a global pandemic**. It's a word of the future, destined for heavy use in the 21st century. Ebola and Marburg are zoonoses. So is bubonic plague. So was the so-called Spanish influenza of 1918-1919, which had its source in a wild aquatic bird and emerged to kill as many as 50 million people. All of the human influenzas are zoonoses. As are monkeypox, bovine tuberculosis, Lyme disease, West Nile fever, rabies and a strange new affliction called Nipah encephalitis, which has killed pigs and pig farmers in Malaysia. Each of these zoonoses reflects the action of a pathogen that can "spillover", crossing into people from other animals. Aids is a disease of zoonotic origin caused by a virus that, having reached humans through a few accidental events in western and central Africa, now passes human-to-human. This form of interspecies leap is not rare; about 60% of all human infectious diseases currently known either cross routinely or have recently crossed between other animals and us. Some of those - notably rabies - are familiar, widespread and still horrendously lethal, killing humans by the thousands despite centuries of efforts at coping with their effects. **Others are new and inexplicably sporadic, claiming a few victims or a few hundred, and then disappearing for years. Zoonotic pathogens can hide.** The least conspicuous strategy is to lurk within what's called a reservoir host: a living organism that carries the pathogen while suffering little or no illness. **When a disease seems to disappear between outbreaks, it's often still lingering nearby**, within some reservoir host. A rodent? A bird? A butterfly? A bat? To reside undetected is probably easiest wherever biological diversity is high and the ecosystem is relatively undisturbed. The converse is also true: ecological disturbance causes diseases to emerge. Shake a tree and things fall out. Michelle Barnes is an energetic, late 40s-ish woman, an avid rock climber and cyclist. Her auburn hair, she told me cheerily, came from a bottle. It approximates the original colour, but the original is gone. In 2008, her hair started falling out; the rest went grey "pretty much overnight". This was among the lesser effects of a mystery illness that had nearly killed her during January that year, just after she'd returned from Uganda. Her story paralleled the one Jaap Taal had told me about Astrid, with several key differences - the main one being that Michelle Barnes was still alive. Michelle and her husband, Rick Taylor, had wanted to see mountain gorillas, too. Their guide had taken them through Maramagambo Forest and into Python Cave. They, too, had to clamber across those slippery boulders. As a rock climber, Barnes said, she tends to be very conscious of where she places her hands. No, she didn't touch any guano. No, she was not bumped by a bat. By late afternoon they were back, watching the sunset. It was Christmas evening 2007. They arrived home on New Year's Day. On 4 January, Barnes woke up feeling as if someone had driven a needle into her skull. She was achy all over, feverish. "And then, as the day went on, I started developing a rash across my stomach." The rash spread. "Over the next 48 hours, I just went down really fast." By the time Barnes turned up at a hospital in suburban Denver, she was dehydrated; her white blood count was imperceptible; her kidneys and liver had begun shutting down. An infectious disease specialist, Dr Norman K Fujita, arranged for her to be tested for a range of infections that might be contracted in Africa. All came back negative, including the test for Marburg. Gradually her body regained strength and her organs began to recover. After 12 days, she left hospital, still weak and anaemic, still undiagnosed. In March she saw Fujita on a follow-up visit and he had her serum tested again for Marburg. Again, negative. Three more months passed, and Barnes, now grey-haired, lacking her old energy, suffering abdominal pain, unable to focus, got an email from a journalist she and Taylor had met on the Uganda trip, who had just seen a news article. In the Netherlands, a woman had died of Marburg after a Ugandan holiday during which she had visited a cave full of bats. Barnes spent the next 24 hours Googling every article on the case she could find. Early the following Monday morning, she was back at Dr Fujita's door. He agreed to test her a third time for Marburg. This time a lab technician crosschecked the third sample, and then the first sample. The new results went to Fujita, who called Barnes: "You're now an honorary infectious disease doctor. You've self-diagnosed, and the Marburg test came back positive." The Marburg virus had reappeared in Uganda in 2007. It was a small outbreak, affecting four miners, one of whom died, working at a site called Kitaka Cave. But Joosten's death, and Barnes's diagnosis, implied a change in the potential scope of the situation. That local Ugandans were dying of Marburg was a severe concern - sufficient to bring a response team of scientists in haste. But if tourists, too, were involved, tripping in and out of some python-infested Marburg repository, unprotected, and then boarding their return flights to other continents, the place was not just a peril for Ugandan miners and their families. It was also an international threat. The first team of scientists had collected about 800 bats from Kitaka Cave for dissecting and sampling, and marked and released more than 1,000, using beaded collars coded with a number. That team, including scientist Brian Amman, had found live Marburg virus in five bats. Entering Python Cave after Joosten's death, another team of scientists, again including Amman, came across one of the beaded collars they had placed on captured bats three months earlier and 30 miles away. "It confirmed my suspicions that these bats are moving," Amman said - and moving not only through the forest but from one roosting site to another. Travel of individual bats between far-flung roosts implied circumstances whereby Marburg virus might ultimately be transmitted all across Africa, from one bat encampment to another. It voided the comforting assumption that this virus is strictly localised. And it highlighted the complementary question: why don't outbreaks of Marburg virus disease happen more often? Marburg is only one instance to which that question applies. Why not more Ebola? Why not more Sars? In the case of Sars, the scenario could have been very much worse. Apart from the 2003 outbreak and the aftershock cases in early 2004, it hasn't recurred. . . so far. Eight thousand cases are relatively few for such an explosive infection; 774 people died, not 7 million. **Several factors contributed to limiting the scope and impact of** the **outbreak**, of which humanity's good luck was only one. Another was the speed and excellence of the laboratory diagnostics - finding the virus and identifying it. Still another was the brisk efficiency with which cases were isolated, contacts were traced and quarantine measures were instituted, first in southern China, then in Hong Kong, Singapore, Hanoi and Toronto. If the virus had arrived in a different sort of big city - more loosely governed, full of poor people, lacking first-rate medical institutions - it might have burned through a much larger segment of humanity. One further factor, possibly the most crucial, was inherent in the way Sars affects the human body: symptoms tend to appear in a person before, rather than after, that person becomes highly infectious. That allowed many Sars cases to be recognised, hospitalised and placed in isolation before they hit their peak of infectivity. With influenza and many other diseases, the order is reversed. That probably helped account for the scale of worldwide misery and death during the 1918-1919 influenza. And that infamous global pandemic occurred in the era before globalisation. **Everything nowadays moves around the planet faster, including viruses.** When the Next Big One comes, it will likely conform to the same perverse pattern as the 1918 influenza: high infectivity preceding notable symptoms. That will help it move through cities and airports like an angel of death. The Next Big One is a subject that disease scientists around the world often address. **The most recent big one is Aids**, of which the eventual total bigness cannot even be predicted - about 30 million deaths, 34 million living people infected, and with no end in sight. Fortunately, not every virus goes airborne from one host to another. If HIV-1 could, you and I might already be dead. If the rabies virus could, it would be the most horrific pathogen on the planet. The influenzas are well adapted for airborne transmission, which is why a new strain can circle the world within days. The Sars virus travels this route, too, or anyway by the respiratory droplets of sneezes and coughs - hanging in the air of a hotel corridor, moving through the cabin of an aeroplane - and that capacity, combined with its case fatality rate of almost 10%, is what made it so scary in 2003 to the people who understood it best. Human-to-human transmission is the crux. That capacity is what separates a bizarre, awful, localised, intermittent and mysterious disease (such as Ebola) from a global pandemic. Have you noticed the persistent, low-level buzz about avian influenza, the strain known as H5N1, among disease experts over the past 15 years? That's because avian flu worries them deeply, though it hasn't caused many human fatalities. Swine flu comes and goes periodically in the human population (as it came and went during 2009), sometimes causing a bad pandemic and sometimes (as in 2009) not so bad as expected; but avian flu resides in a different category of menacing possibility. It worries the flu scientists because they know that H5N1 influenza is extremely virulent in people, with a high lethality. As yet, there have been a relatively low number of cases, and it is poorly transmissible, so far, from human to human. It'll kill you if you catch it, very likely, but you're unlikely to catch it except by butchering an infected chicken. But if H5N1 mutates or reassembles itself in just the right way, if it adapts for human-to-human transmission, it could become the biggest and fastest killer disease since 1918. It got to Egypt in 2006 and has been especially problematic for that country. As of August 2011, there were 151 confirmed cases, of which 52 were fatal. That represents more than a quarter of all the world's known human cases of bird flu since H5N1 emerged in 1997. But here's a critical fact: those unfortunate Egyptian patients all seem to have acquired the virus directly from birds. This indicates that the virus hasn't yet found an efficient way to pass from one person to another. Two aspects of the situation are dangerous, according to biologist Robert Webster. The first is that Egypt, given its recent political upheavals, may be unable to staunch an outbreak of transmissible avian flu, if one occurs. His second concern is shared by influenza researchers and public health officials around the globe: with all that mutating, with all that contact between people and their infected birds, the virus could hit upon a genetic configuration making it highly transmissible among people. "**As long as [zoonoses]** H5N1 is [**are] out there in the world**," Webster told me, "**there is the possibility of disaster**. . . There is the theoretical possibility that it can acquire the ability to transmit human-to-human." He paused. "And then God help us." We're unique in the history of mammals. No other primate has ever weighed upon the planet to anything like the degree we do. In ecological terms, we are almost paradoxical: large-bodied and long-lived but grotesquely abundant. **We are an outbreak**. And here's the thing about **outbreaks**: they **end**. In some cases they end after many years, in others they end rather soon. In some cases they end gradually, in others **they end with a crash**. In certain cases, they end and recur and end again. Populations of tent caterpillars, for example, seem to rise steeply and fall sharply on a cycle of anywhere from five to 11 years. **The crash endings are dramatic**, and for a long while they seemed mysterious. **What could account for such** sudden and recurrent **collapse**s**?** One possible factor is **infectious disease**, and viruses in particular. SK

### Contention 3 is FGM

#### Adolescent girls are forced into FGM without being given a choice.

Bloom ’14, [Female genital mutilation: teenage girl’s campaign takes off, Adi Bloom, 7th February 2014 at 15:40. SK]

**The W**orld **H**ealth **O**rganisation **estimates that 100-140 million girls and women around the world have undergone FGM. The practice has been recorded in 28 African countries, as well as some countries in Asia, the Middle East and South America. FGM is traditionally carried out by a woman with no medical training.** She uses a knife, scissors, or even a razor blade or piece of glass to remove part or all of a girl’s clitoris. Some types of FGM include the removal of the labia that surround the vagina, or the narrowing or sealing of the vaginal opening. **The procedure is usually carried out on girls under the age of 15, many of whom have to be forcibly restrained while it is taking place. Anaesthetics and antiseptics are rarely used. “There are no health benefits to FGM**,” the UK’s National Health Service states.

#### The root cause is a lack of choice – giving them this choice solves.

Althaus, [International Family Planning Perspectives Volume 23, Number 3, September 1997 SPECIAL REPORT Female Circumcision: Rite of Passage Or Violation of Rights? By Frances A. Althaus. SK]

Indeed, **girls have very little choice**. **Given their age** and their lack of education and resources, **they are dependent on their parents**, and later on their husband, for the basic necessities of life. **Those who resist may be cut by force**. **If they remain uncircumcised** and their families are therefore unable to arrange a marriage, **they may be cast out** without any means of subsistence. **Because of their lack of choice** and the powerful influence of tradition, **many girls accept circumcision** as a necessary, and even natural, part of life, **and adopt the rationales given** for its existence. Of the five countries for which DHS data are available on women's opinions toward excision, the Central African Republic is the only one in which the majority favor discontinuation.18 A variety of justifications are given by DHS respondents who favor continuation of the practice, including preservation of virginity before marriage, fidelity after marriage, enhancement of the husband's sexual pleasure, enhancement of fertility, prevention of infant and child mortality, cleanliness and religious requirements, but tradition is by far the most commonly mentioned reason.SK

#### This has lasting physical harm such as HIV – we need to discuss this in school systems

Bloom 2, [Female genital mutilation: teenage girl’s campaign takes off, Adi Bloom, 7th February 2014 at 15:40. SK]

**Women whose genitals have been mutilated often find it difficult to urinate. Sex is usually painful, and pregnancy can be dangerous. There is also risk of the wound becoming infected, and of girls being exposed to HIV.** The practice has been illegal in the UK since 1985. However, the NHS estimates that more than 20,000 girls under the age of 15 are at risk of FGM each year. Shortly after Fahma’s campaign was publicised in The Guardian newspaper, Liberal Democrat MPs tabled an early day motion declaring their support. They called on Mr Gove to take action “before the ‘cutting season’ begins once more, during the 2014 school summer holidays”. So far, **ministers have said that they will redraft safeguarding guidance for schools to include advice on dealing with FGM. But John Cameron of children’s charity the NSPCC told TES that the topic should be addressed during** **health education lessons at primary school.** Meanwhile, the first UK prosecution for FGM is expected to take place within a few weeks. Ten additional cases are being investigated in London.

HIV leads to extinction – cross apply Karesh and Quammen.

### Underview (1:45)

**One,**

**A.** Interpretation: Neg must not run theory on the aff being allowed to have theoretical interps or the formatting, length or number of the paragraph shells in the 1AC.

**B.** You will violate if you do all of the things that the interp says that you “must not” do.

**C.** Key to debatability: I cannot debate through any method if the negative can initate and run theory on me every round – I need theory in the 1AC to counter any 1NR shells against the aff otherwise the time skew destroys any chance for me to win the round as well. Key because people have to be able to debate in order to reach the ballot. Crossapply time skew. Also, you can keep changing your interp to add more ways in which the formatting can be changed (number 12 font, different colors) which skews norm creation.

**D.** The voter is for fairness as this is the only reason debaters participate because it is competitive and education because schools fund debate for this reason and it’s the long term benefit of debate. Crossapply this to every other paragraph shell in the AC. Prefer competing interps on aff interps to reasonability because of (a) time skew and (b) the fact that this is the only way to set norms and reasonability is (a) infinitely regressive and (b) incites judge intervention. Drop the argument on this shell.

**Two,** Neg must only gain offense from one piece of unconditional offense on a single layer, as otherwise it would be skewing my time in the round, as they can just spread out the aff in the 1N, which is structurally unfair. This is also is independently key to education as there is no educational benefit for me from the neg running multiple conditional arguments and then dropping them in the next speech.

**Three,** Aff must get all theoretical ground because of reciprocity – the aff does not have prefiat k ground while the neg does – if you give neg theory as well the skew will be 2-1 on the prefiat layer because I only have theoretical ground in the 1AC – otherwise you’d read T meaning no T against the aff as its irreciprocal. To clarify, the negative many not get offense on theory or read counter standards, and I cannot get offense on kritiks so its reciprocal. The negative can read a K on any interp in the aff which solves back any abuse. Reciprocity key because it controls equal access to the ballot.

**Four,** Allow the aff to reevaluate its advocacy in the 1AR – key to real world – we create exceptions to policies if there are negatives – this leads to a greater chance of norm setting as well – I can change my advocacy to comply with neg norms. Absent this interp norm setting fails because theres no guarantee as to what ill do after the round. My advocacy includes any part of the AC, including both prefiat and postfiat arguments.

**Five,** If both debaters have offense in the round, automatically vote aff because I do not have enough time to make new weighing, it’s a 13-4 skew in terms of new arguments.

**Six,** Allow new 2AR responses to the 1NC – the neg has 7 minutes to respond to AC whereas I only have 4 to respond to the NC – I need the extra 3 minutes.

**Seven,** Conceded aff arguments outweigh any neg argument – they knowingly violate an interp or conceded offense off of the AC versus me not knowing what their arguments are before my first speech – the interps in the aff serve to deter abuse whereas 1NR interps serve to punish abush.

**Eight,** Potential abuse is not a voter because it allows debaters to be punished for abuse that hasn’t occurred which destroys fairness. All negative abuse stories are potential abuse because they do not know how I will extend my arguments in the 1AR and 2AR. You violate aff shells in the 1NC before you extend arguments.

## Extensions – FW

### 1AR FW Expansion

#### Life has intrinsic value – preservation is an a priori goal

Amien Kacou 8 WHY EVEN MIND? On The A Priori Value Of “Life”, Cosmos and History: The Journal of Natural and Social Philosophy, Vol 4, No 1-2 (2008) cosmosandhistory.org/index.php/journal/article/view/92/184

Furthermore, **that manner of finding things good that is in pleasure can certainly not exist in any world without consciousness (i.e., without “life,” as we now understand the word**)—slight analogies put aside. In fact, we can begin to develop a more sophisticated definition of the concept of “**pleasure**,” in the broadest possible sense of the word, as follows: it **is the common psychological element in all psychological experience of goodness** (be it in joy, admiration, or whatever else). In this sense, pleasure can always be pictured to “mediate” all awareness or perception or judgment of goodness: **there is pleasure in all consciousness of things good; pleasure is the common element of all conscious satisfaction**. In short, **it is simply the very experience of liking things**, or the liking of experience, in general. In this sense, **pleasure is,** not only uniquely characteristic of life but also, **the core expression of goodness in life—the most general sign or phenomenon for favorable conscious valuation, in other words. This does not mean that “good” is absolutely synonymous with “pleasant”—what we value may well go beyond pleasure**. (The fact that we value things needs not be reduced to the experience of liking things.) **However, what we value beyond pleasure remains a matter of speculation or theory**. Moreover, we note that a variety of things that may seem otherwise unrelated are correlated with pleasure—some more strongly than others. In other words, **there are many things the experience of which we like**. For example: **the admiration of others; sex; or rock-paper-scissors**. But, again, what they are is irrelevant **in an inquiry on** a priori value—what gives us pleasure is a matter for empirical investigation. **Thus, we can see now that**, in general, **something primitively valuable is attainable in living—that is, pleasure itself. And it seems equally clear that we have a priori logical reason to pay attention to the world in any world where pleasure exists. Moreover, we can now also articulate a foundation for a security interest in our life: since the good of pleasure can be found in living** (to the extent pleasure remains attainable),[17] **and** only in living, **therefore**, a priori, **life ought to be** continuously (and indefinitely) pursued **at least for the sake of preserving the possibility of finding that good**.However, this platitude about the value that can be found in life turns out to be, at this point, insufficient for our purposes. It seems to amount to very little more than recognizing that our subjective desire for life in and of itself shows that **life has some** objective value**. For what difference is there between saying, “living is unique in benefiting something I value (namely, my pleasure); therefore, I should desire to go on living,” and saying, “I have a unique desire to go on living; therefore I should have a desire to go on living**,” whereas the latter proposition immediately seems senseless? In other words, “life gives me pleasure,” says little more than, “I like life.” Thus, **we seem to have arrived at the conclusion that the fact that we already have** **some** (subjective) desire for life **shows life to have some** (objective) value. But, if that is the most we can say, then it seems our enterprise of justification was quite superficial, and the subjective/objective distinction was useless—for all we have really done is highlight the correspondence between value and desire. Perhaps, our inquiry should be a bit more complex.

#### Change and survival are key to avoid passivity and ressentiment

May 5 (Todd, Professor of Philosophy at Clemson University, September 2005, “To change the world, to celebrate life,” Philosophy & Social Criticism, Vol. 31, No. 5-6)

For those among us who seek in philosophy a way to grapple with our lives rather than to solve logical puzzles; for those whose reading and whose writing are not merely appropriate steps toward academic advancement but a struggle to see ourselves and our world in a fresher, clearer light; for those who find nourishment among impassioned ideas and go hungry among empty truths: there is a struggle that is often waged within us. It is a struggle that will be familiar to anyone who has heard in Foucault’s sentences the stammering of a fellow human being struggling to speak in words worth hearing. Why else would we read Foucault? We seek to conceive what is wrong in the world, to grasp it in a way that offers us the possibility for change. We know that there is much that is, to use Foucault’s word, ‘intolerable’. There is much that binds us to social and political arrangements that are oppressive, domineering, patronizing, and exploitative. We would like to understand why this is and how it happens, in order that we may prevent its continuance. In short, we want our theories to be tools for changing the world, for offering it a new face, or at least a new expression. There is struggle in this, struggle against ideas and ways of thinking that present themselves to us as inescapable. We know this struggle from Foucault’s writings. It is not clear that he ever wrote about anything else. But this is not the struggle I want to address here. For there is, on the other hand, another search and another goal. They lie not so much in the revisioning of this world as in the embrace of it. There is much to be celebrated in the lives we lead, or in those led by others, or in the unfolding of the world as it is, a world resonant with the rhythms of our voices and our movements. We would like to understand this, too, to grasp in thought the elusive beauty of our world. There is, after all, no other world, except, as Nietzsche taught, for those who would have created another one with which to denigrate our own. In short, we would like our thought to celebrate our lives. To change the world and to celebrate life. This, as the theologian Harvey Cox saw, is the struggle within us.1 It is a struggle in which one cannot choose sides; or better, a struggle in which one must choose both sides. The abandonment of one for the sake of the other can lead only to disaster or callousness. Forsaking the celebration of life for the sake of changing the world is the path of the sad revolutionary. In his preface to Anti-Oedipus, Foucault writes that one does not have to be sad in order to be revolutionary. The matter is more urgent than that, however. One cannot be both sad and revolutionary. Lacking a sense of the wondrous that is already here, among us, one who is bent upon changing the world can only become solemn or bitter. He or she is focused only on the future; the present is what is to be overcome. The vision of what is not but must come to be overwhelms all else, and the point of change itself becomes lost. The history of the left in the 20th century offers numerous examples of this, and the disaster that attends to it should be evident to all of us by now. The alternative is surely not to shift one’s allegiance to the pure celebration of life, although there are many who have chosen this path. It is at best blindness not to see the misery that envelops so many of our fellow humans, to say nothing of what happens to sentient nonhuman creatures. The attempt to jettison world-changing for an uncritical assent to the world as it is requires a self-deception that I assume would be anathema for those of us who have studied Foucault. Indeed, it is anathema for all of us who awaken each day to an America whose expansive boldness is matched only by an equally expansive disregard for those we place in harm’s way. This is the struggle, then. The one between the desire for life-celebration and the desire for world-changing. The struggle between reveling in the contingent and fragile joys that constitute our world and wresting it from its intolerability. I am sure it is a struggle that is not foreign to anyone who is reading this. I am sure as well that the stakes for choosing one side over another that I have recalled here are obvious to everyone. The question then becomes one of how to choose both sides at once.

## Frontlines – Spikes

### Frontlines – Spike 1

AT: “Must be reciprocal”

My argument just justifies that the aff gets an RVI, not that you cannot get one – you have to provide your own justification for one and we can debate that out if you want.

### Frontlines – Spike 2

AT: “CX Checks bad”

## Frontlines – FW

### Frontlines – General

#### AT: FOD

Extend Estlund – ok I link into fear of death, but the only way the alt can solve is through some political action – Estlund says that political action can only be undertaken due to some underlying fear of death. This is terminal defense on the alt because it cannot solve.

Extend Paterson – death is the worst ontological evil because it destroys the subject which outweighs any neg argument. This means that the AC outweighs the K.

#### AT: Cannot weigh

You cannot weigh maximizing life? Any weighing mechanism could work under this standard.

### Frontlines – AFC

#### AT: Clash

This is the best way to clash because then we can do actual weighing under the standard. None of this unverifiable “strength of link” nonsense

## Frontlines – Underview

### Frontlines – General

#### AT: All this time you read theory

I literally read substance for 2/3 (the majority) of the affirmative – you have no abuse story.

### Frontlines – Underview 1

#### AT Flowability:

1. time skew outweighs because time is the binding factor for us to be able to flow in the first place – also time skew is the reason why we have to go through arguments fast.

2. passing pages solves – you can flow off of the pages I pass to you

3. this is not different than any other analytic argument – there is no unique difference between flowing these and flowing normal args

#### AT Time skew:

Really? I read about 2:15 of theoretical arguments in the 1AC – if you cannot beat that back, read an NC, and respond to the aff, you do not deserve to win the round so might as well concede

Time skew for the aff outweighs – I have to extend these argumetns in the 1AR so theres no way I can go for all of them – if you put minimal defense on all of them then you can still win the round

Turn – if there aren’t that many easy responses to the shell that probably means that the shell is more likely true.

#### AT Clash:

Its not my fault you didn’t respond to the arguments, its yours, so you actually kill clash

### Frontlines – Underview 2

### Frontlines – Underview 3

#### AT: No way to respond:

We still can get out of kritikal and theoretical arguments – you can make I meets and I can make no-link arguments. Similarly, we can both make permutations on each of these arguments.

Also, because the negative has K ground it solves back because then they can read a K on any theoretical interpretation that they believe is illegitimate.

#### AT: You can read a C/K

Counter-Ks don’t solve because they don’t prove the aff is legitimate and thus once the NC reads a K we can never revert back to the 1AC, whereas a counterinterp would allow the negative to revert back to the 1NC.

Also **Time Skew** – reading a critique in the 1AR is so much harder because then you have many more ways out in the 2NR – also skews the time I could spend on substance or actually responding to your critique.

Also **Research Burdens** – its much easier to extemp a counterinterp but not as easy to read a counter k because I have to find evidence which criticizes you criticism so it’s a meta level analysis – if you get theory ground I will always be behind no matter what.

#### AT: You can read prefiat critique:

Even if I could it would be really easy for you to read T or another critique so the round is still skewed against me if I go for that strategy. My arg is not that its impossible, just that I’d have a lot of skews working against me which is not fair as you have an easier path to the ballot.

Also, it makes no sense for me to derive prefiat offense off of a postfiat defense of the resolution – affirming the resolution is not a viable solution to a prefiat critique because it does nothing for us in the debate space.

#### AT: No offense means its not reciprocal:

No my interp already solve back for that. Extend the fact that you can read a K on any interp that’s in the aff. You don’t need a counterinterp. You have offense on the same layer just not offense on the same argument.

#### AT: I’m not a K debater:

Ive literally conceded that I cant get offense on the K debate if you give me 100% offense on the theory debate – its not that hard for you to win a K

Also, if the goal of education is to learn new things, then my interp fosters that for you because you don’t stick to your old practices of whatever and attempt new strategies so its net beneficial

Also, im not a theory debater, but im running theory. No way to classify what a debater is.

Also, I don’t care what “type” of debater you are because you could also run different strategies if I don’t run this interp which skews my strat and functions as a double bind for me before I walk into the round.

#### AT: I don’t have K evidence for your theoretical interp:

You don’t need evidence – you can just criticize the interp analytically

Ok then you can just meet the interp in the 1NC which is good for both of us then.

#### AT: Your interp constrains my strat too much

Double bind: either (a) the constraint is legitimate meaning that your strategy should be constrained (this is hypercharged by the fact that my interp still stands) or (b) the constraint is really illegitimate so its easy for you to win terminal defense to it.

#### AT: You don’t allow me to contest your interp

No, I don’t let you get offense under my interp but terminal defense would still work.

My interp clarification only says you cant read counter-standards but you can read your own C/I and then defense to my standards.

### Frontlines – Underview 4

### Frontlines – Underview 5

#### AT: “No way to win”

You can just read defensive responses to the AC – this makes it easier for you to win, not harder

### Frontlines – Underview 6

### Frontlines – Underview 7

### Frontlines – Underview 8

## Frontlines – CX Questions

### AT: Possible Strat

Q: *What is a possible strategy for me to run in the 1NC that would meet all of the theoretical specifications in the aff?*

A: Well, my dear opponent. You could run a disad and put terminal defense on the aff. That would not violate any of the shells in the affirmative.

Q: *What about another one?*

A: You could read a CP and put defense on the aff or explain

*Q: Why do I need to put defense on the aff?*

A: I mean, you don’t have to, but then you would lose because my arguments outweigh

Q: *What about another strat?*

A: You could read a kritik that is extrinsic to my advocacy