What Jurisdiction? Whose Justice? A Response to Eckenwiler

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In "Ethics and the Underpinnings of Policy in Biodefense and Emergency Preparedness," Lisa Eckenwiler advances discussion about emergency preparedness by exploring ethical commitments that shape healthcare and defense policy in an age of terrorism. Eckenwiler rightly discerns that policymakers' assumptions about controlling and containing hostile malefactors and (lack of) the need for public consent regarding security measures are part of an epistemic framework that orders the current response to terrorism. Again rightly, she suggests that (1) citizens ought to have a say in shaping and interpreting such fundamental assumptions, (2) a reductive medical model that focuses on mitigation and the management of casualties is insufficient for understanding and responding to the complex social, political, and economic factors that precipitate terrorist attacks, and (3) there is in emergency preparedness an ethically problematic disproportion between the demands society places on public health/medical professionals and the resources society provides for them to meet these demands. She is also probably correct in claiming that, properly understood, the ethical underpinnings of public health policy are teleological in nature (though her conception of the *telos* is suspect).

Unfortunately, Eckenwiler's project unravels due to several misapprehensions about the task of healthcare and public health, and due to her uncritical introduction of "social justice" as a guiding ethical framework. My aim in this essay is to analyze these difficulties and to suggest some characteristics of a more adequate ethical framework for public policy in disaster preparedness.

Fundamental to Eckenwiler's argument are assumptions that (1) the fields of healthcare and public health should not concern themselves merely with illness and disease and the biological agents that precipitate them, but also and more fundamentally with social, political, and economic factors that shape the understanding, experience, and prevalence of illness and disease; (2) as a facet of healthcare and public health, emergency preparedness should employ an ethical framework that systematically focuses on social, political, and economic factors, with the aim that actual preparedness measures faithfully embody a particular, comprehensive social vision or ecology; and (3) an egalitarian conception of justice, focused on the relative equalization of human capacities, provides the basis for such a comprehensive social ecology. Eckenwiler offers little justification for any of these assumptions (especially the first and third), which is a pity, because they are each highly contestable. I will argue that each is false. In the first section that follows, I address (1) and (2), holding

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that Eckenwiler has expanded the boundaries of medicine and public health too far by imposing an unlikely and unworkable moral mission. In the second section, I argue that Eckenwiler's egalitarian program, beyond being insufficient for her designs, is also weak in its own right.

What Jurisdiction?

In democratic societies, collective action requires a significant level of agreement on at least two levels. First, citizens and representatives in a democratic polis must be able to identify certain principles and procedures as fundamental, shared commitments. Second, at some point decisionmakers must agree about specific actions they will undertake together. At the first level, the kind of agreement involved can rightly be regarded as a species of moral consensus. For example, the authors of the United States' Declaration of Independence declared they found certain ethical principles "self-evident."[1] Later, these principles were fleshed out to some degree in a federal Constitution whose authority has been widely accepted for more than 200 years. Yet, as the history of political wrangling, disquisition, outrage, and exegesis in the United States abundantly illustrates, whatever consensus we enjoy about first principles of government does not translate into a consensus about the nature of moral goodness, rightness, or justice. At the second level, moral consensus rarely pertains at all. On the contrary, specific collective actions generally arise from compromise. One group may prefer Option A whereas another prefers Option B. In the end there is usually an agreement to undertake some option C, which seems better than B to the first group, better than A to the second, and better to each party than no action at all. Democratic government, then, seems to require a significant level of agreement about little things (such as what we will do together) and about a few middle-sized things (such as the principles and procedures to which we will appeal when we work out our disagreements). But there is no requirement, and no precedent, for agreement about big things like the good, the right, and the just.

The lack of agreement about the good, the right, and the just manifests itself in conflicting opinions about how to target the essential causes of poverty, hunger, disease, and violence. Though almost everyone in the higher echelons of international politics regards such human afflictions as genuine evils, diverging moral visions lead to strikingly incongruous accounts of where we should look for their sources. Hence, although most parties can agree that HIV/AIDS is a disease and (Thabo Mbeki notwithstanding) that it is caused by a virus, we cannot agree about how to describe the social, political, and economic malefactors that allow it to proliferate. This lack of accord reflects deeper disagreements about what constitutes a social, political, or economic malefactor. For instance, someone who views sexual promiscuity as a grave social problem might carve out a different narrative about the genesis of AIDS than someone who regards the failure to withhold moral judgments about sexual behavior as a grave social problem. It is not that thoughtful people fail to see the link between promiscuity and AIDS or between moralism and AIDS. It is rather that thoughtful people evaluate promiscuity and moralism differently. Those who abhor promiscuity will target promiscuity (usually without attending to the manner in which promiscuity arises from the same moral/cultural influences that condemn it). Those who abhor moralism will target moralism (usually without

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attending to the moralizing nature of their own arguments).

In proposing that they view illness and disease primarily as products of social, political, and economic processes, Eckenwiler invites healthcare and public health professionals to construct their own moral narratives. The problem with this approach is not that social, political, and economic processes aren't important or fundamental sources of illness and disease. Most certainly they are. Rather, the problem is that ethical pluralism precludes a single, authoritative narrative about the interplay of social, political, and economic factors in producing illness and disease. Positivist claims notwithstanding, social, political, and economic theories are imbued with ethical assumptions that are far more contentious than the ethical assumptions framing ordinary clinical medicine. If medical and public health professionals want to maintain their aura of relative ethical neutrality, and the professional authority that comes with it, then they should stick with ethical foundations that are widely shared (e.g., the claim that physical suffering and premature death are generally bad and that it is permissible to cure, ameliorate, or prevent them by taking medications, adjusting one's lifestyle, or joining cooperatively with like-minded allies).

Attempts at carving out and employing an ethical framework that systematically focuses on social, political, and economic factors will undermine the authority of the health professions and divide their ranks. It will undermine their authority because they will no longer be regarded as beneficent guardians by those with diverging moral visions. Instead, they will be regarded (rightly) as advocates for a social agenda that falls outside the domain of their professional training and expertise. It will divide their ranks because ethical pluralism is not confined to the uneducated masses—it afflicts health professionals as well.

If health really is a comprehensive, integrated state of physical, emotional, and social well-being, as the World Health Organization and other proponents of the sociopolitical model of health professions maintain, then health is the human *telos*—that is, the ultimate, comprehensive human ethical good. As such, it is as much (or more) a domain for theologians, philosophers, mystics, and moral communities as it is for physicians, nurses, and public health authorities. But WHO, Eckenwiler, and their many collaborators want to change the status quo. Health professionals, in their view, should be regarded as authoritative experts—about virtually everything.[2]

For critics as diverse as H. Tristram Englehardt, Jr. and Daniel Callahan, these pretensions bespeak a kind of globalizing secular priesthood or aristocracy. In clever subterfuge (or naive self-assertion?) these new priests offer an ostensibly neutral public vocabulary that canonizes their own moral commitments, yet allows them to claim that they are all good and tolerant pluralists. Eckenwiler wields the new lexicon in her approval of plans for "nurturing diversity" and in her suggestion that President Bush has undermined "thoughtful dialogue" and the separation of church and state by using a "religious concept"—"evil"—to describe the perpetrators of the World Trade Center attack. By "diversity" Eckenwiler denotes a plurality of customs and lifestyles, undisrupted by a plurality of conceptions about justice or basic ethical principles. Her account of "thoughtful dialogue" precludes any term that suggests a "particular religious commitment." One uninitiated to her underlying worldview might wonder how it is that Eckenwiler regards a widely employed term like "evil" to denote a particular religious

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commitment, or, if she grants that "evil" has any applications at all, why she thinks it should not be applied to those who employ beheadings and mass murder as their preferred medium of political speech. The answer, it seems, is that there is a moral ideology that repudiates the concept of evil (except, perhaps, in describing the Bush administration) and that regards any metaphysical belief that does not square with their own canon (no matter how widely shared between the religions of the world) to be a "particular religious commitment."

Secular humanism—or whatever we choose to call the nexus of cosmological, ethical, and sociopolitical assumptions that bind individuals who hope for the eventual eradication of religious concepts and nonliberal premises from public discourse—is, at its best, a thoughtful and coherent system (or collection of related systems) of belief. Perhaps it will indeed prevail in some form over the long run. But its ascent to prominence should not and cannot be achieved simply by declaring jurisdiction over world affairs. There are currently other thoughtful and attractive alternatives with which it will need to contend. World governance, for now, is at best a *modus vivendi* between nations and other parties that nurture radically diverging visions of how the world should look.

Whose Justice?

One of the most problematic aspects of Eckenwiler's particular healthcare reform program is its self-referential inconsistency. In response to government supporters who suppress dissent, Eckenwiler writes: "The willingness to stifle debate and defer to 'experts' in authority also shows disdain for entertaining alternative positions that could help generate knowledge that contributes to policy." This insightful criticism captures the importance of dissent and debate, not merely as first principles of democratic procedure, but also as tools for the accumulation of knowledge. Eckenwiler holds that citizens should have the prerogative of giving "explicit consent to the emphasis on security or to any measures deemed necessary by those who provide protection in exchange." Yet she never addresses or even acknowledges dissent or debate, or the prerogative for consent, when it comes to her favorite security measure—an operational concept of social justice.

In a key passage, Eckenwiler writes of "the link" between her proposed epistemology and "a model of social cooperation." This model incorporates two facets. First, it "sees people as situated or embedded in relationships of various kinds and centers around cultivating and nurturing these." On its face this claim seems noncontroversial or even tautological, because it holds for virtually everyone (including those whom Eckenwiler criticizes) and it is hard to imagine a model of social cooperation that didn't try to cultivate relationships. Placed in the context of her other comments, however, Eckenwiler's point seems to be more controversial; it is the twofold claim that (1) persons should be held relatively blameless for their actions because their situations and relationships—not moral character or any stubborn personal properties—are the true sources of these actions, and (2) we should respond to ostensibly blameworthy actions of others primarily by examining ourselves and amending any of our own actions that might be precipitating the ostensibly blameworthy behavior. Second, Eckenwiler says that the "end of social organization and cooperative efforts in this scheme [i.e., according to her model of social cooperation] is enhancing the capacities of people everywhere—above all the least

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advantaged—to determine their actions and the conditions of their actions and to flourish in conditions of relative equality." She equates her model with "the promotion of social justice," which in her view constitutes "the proper role of public and other health professionals in resisting terrorism and protecting and promoting health more generally." In other words, the "model of social cooperation" that should guide healthcare is really an ideology of social cooperation, based on a particular account of social justice that reflects the assertions of capacity-egalitarians such as Amartya Sen (whom she does not mention explicitly).

Ironically, Eckenwiler tells us that the epistemology underlying our current approach to terrorism (and other public health problems) is bad on its face because it is linked, without public consent, to a particular morality (i.e., the morality that believes in evil and uses force to resist it); then she holds forth that epistemology properly understood should be linked, without public consent, to another particular morality (i.e., the morality that believes in equal capacities and uses force to achieve them). From here she opines that, contrary to the popular morality, the ethical dimension of medicine and public health centers not on the commitment to ameliorate illness, suffering, and disease, but rather on the commitment to promote an ideology of egalitarian social justice.

From a practical standpoint, Eckenwiler's proposal will fail because she and her fellow capacity-egalitarians have not yet garnered enough political power to silence the legions of Americans who disagree about the meaning of "social justice" and who reject the notion that healthcare should be, first and foremost, a political movement designed to effect the egalitarian agenda.

From a theoretical standpoint, Eckenwiler's proposal fails not merely because of the inconsistencies noted above, but also because, in failing to have her cake and eat it too, she eventually settles for having her cake (keeping her egalitarian ideology despite its repudiation of consent) rather than eating it (bagging her egalitarian ideology in order to honor the principle of democratic consent that she wielded against her political opponents). She should take the latter approach for just the reasons she enumerated (rightly) in decrying the attitude of government officials toward healthcare workers and institutions who disagreed with their smallpox immunization program. Debate on important ethical and political issues should not be stifled in deference to "experts"—not even to expert bioethicists, clinicians, and public health authorities. Experts, like the unwashed masses, are susceptible to error, bias, prejudice, and overgeneralization from limited experience. By inviting representatives of as many moral outlooks or ideologies as possible to the arena of deliberation, and by allowing them to express their ideas in their own words, we can, as Eckenwiler suggests, enhance the likelihood of moral and epistemic progress—through suasion, conversion, influence, or the subtle osmosis of sympathies. Consent or permission for intrusive measures such as disease surveillance, military action, taxation, and so forth should be sought on as wide a basis as practicable, for nothing vitiates deliberation like coercion.

Capacity-egalitarians will respond, predictably, that divergent moral communities cannot deliberate effectively with one another unless we even the playing field—a task they propose to accomplish by censorship (in service of a common vocabulary) and force (in service of equalizing capacities). No doubt they are correct that people with loaded bank accounts, nice clothes, and vacation homes will be able to

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talk more loudly and direct more publicity to themselves and their own views than people without these things. Yet, as my cousin Annabelle proved in the 1960s, even naked beach bums can garner attention. In their attempts to even the playing field, capacity-egalitarians seek independent control of political inquiry's primary dependent variables—the capacities to generate goods, services, wealth, and contentment. Deprived of these markers, there is no way for any particular moral community (even the egalitarian one) to demonstrate or realize its advantages and disadvantages. Constructive competition between moral visions is quelled—as are the ambitions of those who seek to exceed the collective standard.

Ultimately, the easiest way to equalize capacities is to sketch a pallid caricature and then resist every effort to inject color and energy. In such a radically equalized world, the only rewarding orientation would be an otherworldly one. And that is decidedly *not* what Eckenwiler and the secular humanists want. Perhaps they should eat cake.

Notes

1. As Michael Zuckert points out, these principles were not regarded by the authors of the Declaration to be self-evident in the usual philosophical sense, but rather self-evident in the sense that Americans of the day accepted them without the need for argument. That is, they were regarded as objects of deep consensus. Zuckert writes: "The language, the logic, and the historic connections of the Declaration all point to the same conclusion: the truths announced in the Declaration are not self-evident, nor are they pronounced to be. They are rather to be held as if self-evident within the political community dedicated to making them effective. The truths must serve as the bedrock or first principles of all political reasoning in that regime." See Zuckert M. *The Natural Rights Republic* Notre Dame, Ind.: University of Notre Dame Press, 1996:49.
2. The Shakespearean grandiosity of this vision of health professionalism is well reflected in the words of Dr. Brock Chisholm, the first director of WHO: "The world is sick and the ills are due to the perversion of man: his inability to live with himself. The microbe is not the enemy: science is sufficiently advanced to cope with it were it not for the barriers of superstition . . . *The scope of the task before the Committee knows no bounds*" (italics mine). See Callahan D. *What Kind of Life: The Limits of Medical Progress* New York: Simon and Schuster, 1990:35.

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