Ideology, not science

Public health academic Dr Michael Keane argues the Nanny State policy solutions designed by his colleagues have little sound basis in science.
The notion that freedom can be usurped under the guise of public health arouses great antipathy in many; often expressed as a frustration with the Nanny State. However, many also feel compelled to accept the advice of vocal public health advocates who assure us that these measures are necessary. Similarly, anyone who voices concerns about the Nanny State is ruthlessly labelled as an intellectual Neanderthal who can’t appreciate the supposedly impartial and ideologically-neutral ‘science’. However, those who warn against the Nanny State are, in effect, demonstrating a far more comprehensive and sophisticated understanding of all the relevant academic and scientific information than many public health campaigners whose simplistic pronouncements ignore established societal, historical, economic, biological, medical and ethical principles.

It is therefore relevant to review the dynamics of contemporary public health debates; to be on sure footing when critiquing and ultimately rejecting the more egregious public health measures.

Public health is the ‘science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention’, as defined by the United States Association of Schools of Public Health. Historically, public health measures often involved protecting third parties from hazardous environmental phenomena. For instance, people didn’t want faeces-flavoured drinking water. Disposal of sewage into a water system was convenient, but this had health consequences to third parties who could not avoid drinking cholera-causing excrement. No one wanted to inhale toxic fumes or actively want to, as one academic put it, drop their IQ due to lead exposure. These were the unwanted consequences of industrial processes that did otherwise bring utility.

In contrast, public health ‘2.0’ is now concerned with stopping people from consuming products and services that they actually want; on the basis that society should stop people from harming themselves.

But as well as a harmful side, alcohol, gambling, fast foods, soft drinks, retail shopping and, yes, cigarettes all have some degree of utility that people actively seek.

Oponents of the Nanny State show a more sophisticated understanding of the science than public health campaigners

Fundamentally, the decision to consume a product is a function of the perceived upside and downside; incorporating all the myriad of conscious and subconscious factors. Sometimes basic urges hold sway and sometimes the deliberate consideration of far off consequences prevails.

Modern health ethics determine that we defer to the principle of autonomy to answer the infinite possible ways that people can value harms and benefits. As public health initiatives are unambiguously couched in terms of health interventions they should adhere to established ethical principles. Don’t be fooled by arguments that people don’t make ‘informed’ choices, and therefore the public-health elite have to act in their best interests. Only a small fraction of the population would be judged not to have the capacity to make their own decision regarding even complex medical treatments. You don’t need to have the knowledge of a Professor of neurosurgery to make an autonomous decision about your brain operation; just a basic recognition of the adverse effects. It would be extraordinarily disingenuous to suggest that the vast majority of the population doesn’t know that smoking is bad for you and eating too much junk food makes you fat.

It is extremely frustrating when reports of harm are used to justify forcibly overriding autonomy, completely ignoring the other side to the equation. In this regard, ‘promoting healthy lifestyles’ is no longer enough; they are now being enforced whether you like it or not.

Internationally, the public health debate is somewhat more balanced than in Australia, as represented by Eli Feiring, an academic from the University of Oslo, Norway: ‘Given that respect for the autonomous choices of patients runs deep in modern healthcare, there are strong reasons to value the claim that competent and well-informed individuals are the best interpreters of their own interest and that they should be free to make choices others would regard as non-beneficial to them.’

Many academics demonstrate a fundamental misunderstanding of the importance of autonomy. This principle (in its wider form not merely limited to health ethics) has enabled Western Civilisation to flourish.

Admittedly, many public-health-inspired intrusions are minimal, such as the frequently used example of seat belts. However, the tolerability of occasional minimal intrusions doesn’t then justify extreme ‘mission creep’.

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Dr Michael Keane

Anaesthetist and lecturer in public health at Monash University. This is an extended version of an article that originally appeared in the Medical Journal of Australia.
One phenomenon that has enabled the rise of public health paternalism is that of the disease model. This is an especially insidious, superstitious phenomenon that is perpetuating what could be called an epidemic of lack of personal responsibility; ‘it’s not my fault it’s my disease!’ When working as a psychiatric registrar in the East End of London I saw firsthand how common this concept was among some of the most dysfunctional people we treated. It enabled frighteningly destructive behaviour.

Scepticism of the disease model is well grounded. Accepted tenets in the fields of neuroscience, ethics, psychology and philosophy make it unacceptable to conceptualise alcoholism, gambling, sex ‘addiction’ and so on as mere diseases no different from other medical conditions. In other words the ‘disease’ model is an expression of certain value judgments and is therefore representative of an ideology.

Fundamentally, people do have control over these activities, it is volitional behaviour. There are higher orders of control that we, as a society, must insist that adults use. For example, gambling ‘addicts’ can choose to seek help instead of gambling away their life savings. They are not automata who cannot resist their ‘disease’.

Proponents of the disease model often invoke neuroscience to justify Nanny State interventionism. For example, they point to areas of the brain ‘lighting up’ on various scans. Therefore, these ‘addictions’ are biological ‘brain disorders’ and therefore ‘diseases’. But this is a profoundly unsophisticated and simplistic conceptualisation and ignores what are ultimately philosophical questions about what it is to be human. Every single part of being human, every thought, behaviour and emotion is a function of the brain.

The neurosciences can demonstrate that many people are biologically predisposed to urges to indulge in various products and activities that may result in harm. Sometimes those urges can produce disabling emotional torment. In this regard, it is helpful to conceptualise these phenomena as diseases in order to offer help, which as a compassionate society we should. But what makes one person show the strength of character to seek help and not destroy their life and another person give in and recklessly and selfishly continue on their destructive path? Character and moral fibre are also encoded in the brain. So is compassion, altruism, the desire to help others too.

The burgeoning discipline of neuroethics is examining these and other existential questions. Indeed the most recent edition of The American Journal of Bioethics-Neuroscience was devoted to the question of free will and agency in neuroscience. From both an appreciation of how biological traits are distributed and specific neuroscientific research, it is accepted that many people are at a biological disadvantage in terms of impulse control and higher-order decision making skills. But we are nowhere near the stage where we should strike out our accumulated concepts of ethics, morality and freedom; something we logically must do under the disease model.

In this regard, it is misleading to describe dysfunctional behaviour in neutral terms. One example is the term ‘problem gambling’. Reckless gambling would be more accurate, as it encompasses a more comprehensive picture of what we know about the
phenomenon. It can't be emphasised enough that this doesn't mean we shouldn't be understanding and show compassion. But we should identify dysfunctional behaviour and show due prejudice against it. The epitome of nihilistically accepting even the most culpably anti-social behaviour as inevitable is the term ‘alcohol related harm.’ This does a terrible disservice to those who enjoy alcohol (even to the stage of severe intoxication) but who don’t engage in, for example, wanton acts of violence.

Perpetuating the disease model is one means to give cover to otherwise unpopular paternalism. The more enthusiastic public health interventionists also use somewhat cynical, ‘third-party’ arguments to wedge one group of society against others.

For example, a group of public health academics advocating mandatory pre-commitment technology for poker machines described some of the consequences of gambling: ‘Theft, fraud and other criminal offences associated with financial desperation are common problems.’ It is concerning that those pushing the third-party argument don’t acknowledge the logical consequences of their position—it is breathtaking in its expansive scope.

A recent article by Simon Chapman, a prominent public health campaigner, demonstrated further confusion in the concept of harm to self versus harm to third parties. Writing for the Sydney Morning Herald, Chapman argued ‘Occasionally, those who know how efficient regulation is get carried away with paternalist zeal. They want to restrict people when they are only harming themselves—like banning smoking in parks. A healthy dialogue within public health keeps most of this in check.’ So if someone only harms themselves we shouldn't intervene to stop them? But in the same article he sarcastically asked whether we deserved ‘The freedom to have your cocktail of carcinogens packed in attractive boxes?’ Smoking in a park may offend the sense of smell of a passerby, but how does the colour of a packet of cigarettes affect someone else?

This is logically incoherent unless you assume that the person buying the colourful packet of cigarettes is a victim; a third party being affected against their will by the tobacco company. In the same article Chapman draws a moral equivalence between those who want the freedom to deliberately consume a product and those who want the ‘The freedom to endanger others behind a car wheel with a lead foot or a skinful?’

Perhaps the most superficially appealing third-party argument is that which attempts to justify the usurpation of freedom and autonomy on the basis of healthcare costs.

This takes the form of ‘we have the right to control that group because they cost us money in the form of healthcare expenditure’. Consider a low-socioeconomic status individual who is smoking, drinking, gambling, eating junk, spending on frivolous retail purchases (a ‘shopping addict’) and having indiscriminate sex (‘sex addict’). Does she or he really employ sophisticated risk management equations and decide that the benefits outweigh the costs? Arousing public anger at those deemed unworthy of the privilege to make choices is a dangerous tactic. However, it is probable that many of the more vocal public health academics do genuinely believe that they, the elite, have a paternalistic duty to control the incapable masses.

As every dysfunctional behaviour can, without many inferential steps, be related to health expenditure, appeals to such imperative have few logical limits. The folly of enforcing interventions against peoples’ will on the basis of economic analyses of the cost to the state is obvious, and educated health professionals should know better than to use such divisive and emotive arguments.

If the growth of the Nanny State is to be curtailed, policy makers must have the confidence to stand firm against the mutton of opinion even when it is dressed up as the lamb of science.