Responsibility for health

John McMillan

doi:10.1136/medethics-2019-105830

The question of whether any of us can truly be held responsible for what we do is an issue that occupied the ancient Greeks and continues to entertain our leading thinkers. Whether we can be held responsible for our health, or lack thereof, has additional layers of complexity because of the way in which what we do over time impacts our health. Those of us who have ever self-deceptively wondered about the apparent shrinking of our belt or at the fact that the stairs seem to have multiplied are familiar with the idea that our health can change gradually over time as a result of successive choices that we have made. While there are one-off behaviours that can have an impact on health, for example, a single exposure to a very high level of radiation, in general, ill health develops over time, within an environment and complex set of interactions with other people.

The implications of that complexity are central to this issue's Feature Article by Brown and Savulescu.¹ They note that there is debate over whether responsibility should play a role in the allocation of healthcare, and, rather than taking a view on that issue, make a number of suggestions about how the concept of responsibility used in healthcare can be enriched by attending to the complex relationship between behaviour and health.

In an area where many claims are controversial, Brown and Savulescu build upon two of the less arguable claims about responsibility that were first expressed by Aristotle in the *Nicomachean Ethics*.² At 3.12, Aristotle observes 'What comes about by force or because of ignorance seems to be involuntary'. These are recast by Brown and Savulescu as the 'epistemic' and 'control' preconditions for responsibility: in the absence of any knowledge about a link between behaviour and ill health or control over the behaviour that leads to ill health, a person should not be held responsible for that ill health.

They point out that a meaningful concept of responsibility for health should be able to accommodate two sources of complexity that typify health and behaviour. First, health is often the result of behaviour over time: an idea that they describe as the diachronic nature of health. The second source of complexity is the dyadic nature of health, meaning that

it often involves the behaviour of other people.

Algander's commentary puzzles over why the diachronic condition is added to the two standard preconditions for responsibility.³ Levy agrees that our account of responsibility for health must be diachronic and that Brown and Savulescu are correct to emphasise this.⁴ They claim that attention to the diachronic condition is our best way of scrutinising health outcomes and behaviour with a view to assessing responsibility. For example, if we look at obesogenic environments and factor that in to the choices that people make over time, that is likely to imply (presumably by mitigating) something informative about responsibility for obesity.

That point is picked up by Schmidt and Pickard in their commentaries. Schmidt notes that it might often be inappropriate to blame or praise for failure or success at changing health behaviour.⁵ So, it might follow from paying closer attention to the diachronic and dyadic nature of health that it is inappropriate or unfair to attribute responsibility for health.

Pickard emphasises a distinction that she has previously drawn in the context of therapy for personality disorders between forward-looking and backward-looking responsibility. While it will often be therapeutically helpful to look forward in time with a view to developing agency about the future, looking back in time is potentially harmful. She says '...allowing a backward-looking concept of responsibility to seep into healthcare and therefore inevitably into clinical relationships and treatment decisions cannot but undermine the fundamental clinical aim, namely, to care for people. It is only human for attributions of backward-looking responsibility to bleed into blame – the antithesis of care'.⁶

Pickard's objection is not so much to the possibility of holding some people responsible for their health, but to this being an account of responsibility that we should want.

Brown and Savulescu discuss the improbability of our successfully banishing responsibility entirely from healthcare. In support of this they note Peter Strawson's 'commitment' theory of reactive attitudes and claim that it is 'difficult to see how we could, and why we should, do away

with them altogether'. In *Freedom and Resentment*, Peter Strawson argues that we are committed to taking reactive attitudes towards other persons, by which he means attitudes such as praise and blame that imply persons are responsible for what they do.⁷ Peter Strawson claims that for us to cease taking attitudes of praise and blame to each other would be to radically revise the way in which we understand the world, hence the idea that we are 'committed' to responsibility.

This point can be expressed as follows:

1. While the role of responsibility for health is debated, responsibility is a pervasive and commonly used concept in health.
2. The all-pervasive nature of responsibility for health means that we are committed to it and could not readily abolish it.
3. Therefore, we should adopt a diachronic and dyadic account of responsibility for health that is fit for purpose.

While many find a commitment theory of responsibility attractive, it is worth mentioning that not everyone agrees that we could not nor should not try to rid ourselves of reactive attitudes such as praise and blame. In 'On "Freedom and Resentment"', Galen Strawson argues that we could rid ourselves of responsibility and the world might be a better place if we did.⁸ This is a radical reimagining of our world in which we no longer attribute praise and blame to each other, and is perhaps not something that we should expect any time soon. However, while Peter Strawson seems correct that ridding ourselves of reactive attitudes and responsibility would be a radical change that is not obviously the case with health. What would be so hard about eliminating the use of all reactive attitudes and talk of responsibility from health?

In their response, Brown and Savulescu resist the implication that paying attention to the diachronic and dyadic nature of responsibility in health might in effect be a *reductio* of responsibility in health.⁹ In any case, what they have done is demonstrate how those debating the role of responsibility for health should adopt an enriched version of the concept that can accommodate the complex relationship between behaviour and health.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

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