MEDICAL HUMANITIES REPORT

Personal Responsibility for Health: Discovery or Decision?

by Scot Yoder, PhD

As a runner I read the Spring 1998 issue of the *Healthy U Health Letter* with both interest and amusement. Included in the issue was a table listing the number of minutes you'd have to walk or jog in order to burn off the calories ingested in common treats. I'm sure the information was meant to be empowering, but from my perspective the news was both good and bad. My dislike of Big Macs (66 minutes of jogging[1]) can now be reinforced with moral smugness, but I'll probably never be able to enjoy another serving of pecan pie (73 minutes) without an annoying pang of guilt. Fueled by increasing knowledge of the relationship between lifestyle choices and health, our interest in personal responsibility for health is escalating, almost to the point of obsession. We know that smoking, excessive drinking, indulging in a high-fat diet, and failing to exercise or wear seat-belts are behaviors which put our health at risk. And almost daily, news reports tell us how to reduce our risk of illness by eating properly, exercising, or taking an aspirin a day. These messages lead us to believe that we can, *and imply that we should*, protect and enhance our health by controlling our behavior.

But attention is not limited to our personal well-being. The controversy surrounding Mickey Mantle's liver transplant and the popularity of proposals to fund health care through additional taxes on tobacco are evidence of concern regarding the impact lifestyle choices make on others. When the concern moves from improving our own health to the behavior of others, the practical question becomes what "lifestyle proposals" — i.e., public or private policies designed to influence or make people bear the burden for personal health-related behavior — should be implemented in a liberal society? Because lifestyle interventions almost inevitably infringe on individual autonomy, it is important that decisions regarding them not be arbitrary or discriminatory.

Unfortunately, the substantive question of when and how we should hold people accountable for lifestyles which pose health risks cannot be answered entirely objectively or specifically through either philosophical or empirical analysis. Empirical evidence connecting lifestyle decisions and health is important, but it is not sufficient to support decisions regarding lifestyle proposals. Such decisions require both the balancing of competing moral values and agreement on several conceptual issues which only admit of pragmatic resolutions – that is, resolutions which dependent on our values, goals, and interests. However, I believe, we can both avoid discriminatory decisions and protect autonomy if we make such decisions through a process of public deliberation in which these values, goals, and interests are exposed to public scrutiny and discussion. That is, we must reframe the substantive question as a procedural one, *"How can we determine, fairly and rationally, when and how to hold people accountable for lifestyles which pose risks to their health?"*

In this paper I examine the moral and conceptual issues involved in lifestyle proposal debates in order to demonstrate why the substantive approach is inadequate. While I believe that a

particular procedural approach — i.e., the process of rational democratic deliberation — is superior, in the interest of brevity I will not argue for it here.

Lifestyle Proposals and Moral Values

In a liberal society any restraints placed on the exercise of individual autonomy, such as those entailed by coercive lifestyle proposals, require substantial moral justification. Generally, three types of justification have been given, paternalistic justifications which appeal to the welfare of the individual, justifications which appeal to the welfare of society, and justifications which appeal to fairness.

The paternalistic justification for lifestyle proposals maintains that for their own good some people need an external authority to impose healthy habits on them. The extent to which lifestyle proposals justified in this way actually conflict with autonomy is not altogether clear since most are based on "soft", as opposed to "hard", paternalism. A hard paternalist would allow a person's fully voluntary choices to be overruled for his or her benefit, whereas, a soft paternalist assumes that the choice to be overruled must be involuntary to some extent. So the soft paternalist might be able to justify age restrictions on tobacco or alcohol by reasoning that people under age 18 or 21 are not yet able to make fully-informed, voluntary choices regarding use of these products.

Another possible justification for lifestyle interventions is that they serve to protect the health or the public or the common good, that is, to promote social welfare. Though the appeal is to social welfare, this need not be a straightforward utilitarian justification. Dan Beauchamp has argued that there is a constitutional basis for the protection of the public health found in the government's responsibility to protect and promote both private and group interests (29). At this time the need to control rising health care costs represents at least one compelling social interest which might be addressed through lifestyle proposals.

A third justification for lifestyle proposals appeals to the value of fairness. Fairness, it is argued, "demands that those whose choices involve risks to health be made to suffer the consequences, including the costs of medical care, and that these not be imposed on others who take better care of themselves" (Wikler, 1987, 336). In contrast to the previous two approaches, the fairness justification emphasizes holding people accountable for lifestyles choices rather than reforming or influencing them. While some interventions have the welcome side-effect of curbing the behavior which imposes burdens, the real aim is to make the person shoulder the burden or pay her own way so that others are not burdened. Examples include excise taxes, making persons pay for their own health care, forfeiting claims to resources, or being placed at the end of the line for scarce resources. The fairness justification currently has significant appeal in light of both the relative and absolute scarcity of health care resources.

Though I cannot, in the scope of this paper critically assess each of these justifications for lifestyle proposals I want to venture two observations. First, while none of the justifications are entirely conclusive, each serves to highlight at least one moral value in addition to autonomy which deserves attention when we consider coercive lifestyle proposals. Individual health and welfare, the common good, and fairness all merit legitimate moral consideration. In a liberal society there is a strong prima facie presumption in favor of autonomy, but other values are nevertheless relevant. Second, these additional values can compete not only with autonomy, but also with one another and with other moral values as well. A lifestyle proposal justifiable in terms of one value may not be justifiable in terms of another. Consider, for instance, the prevention paradox (Wikler and Beauchamp, 1995b, 1368). The paradox is that many prevention policies, such as mandatory seat-belt laws, may produce large aggregate savings in terms of lives and money, but little benefit to the individual. For the individual the slight reduction in risk may not be worth the loss of liberty. Moreover, the values used to justify a lifestyle proposal may

conflict with other socially important moral values. For instance, the fairness justification which seeks to place the burden of health care on the person responsible for the illness may conflict with the principle of distributing medical care according to medical need (Wikler, 1987, 337). Or to use a more concrete example, AIDS prevention through needle exchange programs and the promotion of safe sex may put the values of individual and social welfare in conflict with other social values regarding the acceptability of drug use and extramarital sex (Wikler and Beauchamp, 1995a, 1128).

Conceptual Problems

In many cases the moral justifications discussed above rely on problematic conceptual and empirical assumptions regarding the nature of responsibility and the selection of risks. How can we say that a behavior is responsible for a particular illness or that a person is responsible for her behavior? What constitutes a significant health risk? Of those lifestyle choices and behaviors which do entail a risk to health, which are appropriate, both morally and practically, for intervention? In this section I will argue that there are not clearly objective, uniquely correct answers to these questions. While both philosophical analysis and empirical research undoubtedly make important contributions to resolving the quandaries, they can neither individually, nor together provide conclusive answers.

1. Responsibility for Health — Questions of responsibility have a direct impact on both the paternalistic and fairness justifications of lifestyle proposals, but in starkly different ways. The soft paternalist's argument relies on the behavior which we seek to limit, the use of illicit drugs for instance, being involuntary. If the drug use is, in some sense, involuntary, then we may not be overriding the drug user's autonomous choice if we use coercion in order to regulate his behavior. In fact, an intervention such as forcing him into a drug treatment program, may be justified on the grounds that it is intended to restore his autonomy as well as his health. Just the opposite type of argument is used to limit a person's liberty in the name of fairness. In order for the fairness argument to work, it must be the case that the person is responsible for his own illness. If the person is not responsible for his illness, then it is not fair to make him bear the burden for it. If the drug user's addiction can be shown to stem from social, psychological, or physical factors which are beyond his control, then it would not be fair to make him bear both the burden of the addiction and the financial burdens incurred as a result of it.

This line of reasoning is used by Eike-Henner Kluge, Alvin Moss, and Mark Siegler to argue that lifestyle choices are a morally legitimate consideration in making choices about the allocation of organs for transplantation. Kluge argues that the right to equal access to health care (Kluge writes for a Canadian audience) is premised on the presupposition that no one is responsible for their health care needs. However, this is not always the case; as a result of lifestyle choices some people are responsible for their illnesses. In the name of fairness they should not be entitled to the same benefits as those who are not. "To smoke" she writes, "is to create an artificial and preventable health need. That is irresponsible, and to insist that smokers be treated like nonsmokers is to unjustly treat irresponsible people the same as responsible people" (746). In a similar vein Moss and Siegler argue that patients with alcohol-related end stage liver disease should be given lower priority as candidates for liver transplants than patients who are not responsible for their liver disease. They point out that it is not the alcoholism per se for which the patients are responsible, but the failure to seek effective treatment. Alcoholism, as a disease, is not chosen, but the decision to seek or not seek treatment is one over which people do have control (1295-1297).

These arguments are suspect for several reasons, not the least of which are the seemingly unproblematic assumptions made concerning responsibility for illness. Not only does Kluge assume that smoking is a voluntary behavior, she also assumes that we can determine when smoking was the actual or primary cause of the illness. Moss and Siegler seem to make similar assumptions regarding alcoholism and liver disease. Surely there are reasons to question both assumptions. Many people are influenced by advertising and peer pressure to start smoking or drinking at a very young age, and are addicted by the time they are old enough to thoroughly process the information needed to make a well-reasoned choice. Does this not diminish their responsibility? Furthermore, while many people are able to quit smoking or drinking, many others, try as they might, are not. Is the person who has tried to quit five times and failed each time just as responsible as the person who has tried only once, or who has not tried at all? And how do we know that the person's illness can be attributed to his smoking or drinking? We know, for instance, that there is a correlation between cigarette smoking and heart disease. However, we also know that there are other factors, including genetic factors, which contribute to heart disease as well. How are we to sort out, in any particular case, which factor is responsible for the illness?

My intention is not to argue that smokers or drinkers should bear no responsibility for either their behavior or their illnesses, but simply to point out that the assignment of responsibility for both behaviors and illness is highly problematic. Determining whether a behavior is voluntary or involuntary, both philosophically and in everyday life, can be quite difficult, in part because we can provide different types (e.g., medical, psychological, or sociological) of causal explanations.[2]

My point is that responsibility is a social, as well as metaphysical or empirical concept. There are *reasons* why we assign responsibility, reasons which depend largely on our goals and interests. Why is it, for instance, that we assign different ages at which individuals are responsible enough to drive, to vote, and to purchase alcoholic beverages? "Responsible" is not an adjective which, by itself, identifies a property or characteristic of a person. Alone and in the abstract it has no meaning. It has meaning only relative to a certain context. One can be both responsible with respect to holding down a job and irresponsible with respect to parenting or managing money. It is also relative to our motivations or goals for assigning responsibility. Why are we willing to try juveniles as adults for certain types of criminal offenses, but not for others? Whether or not we hold someone responsible, and how we hold them responsible depends not only on the attributes of the person, but on what is at stake in the decision.

This is not to say that empirical data is irrelevant, but only that it is insufficient to determine responsibility. To see this more clearly consider a question raised by Norman Daniels in relation to the human genome project. Daniels asks how new genetic information will affect our assumptions about responsibility for heart disease. Will greater acceptance of genetic determinism resulting from new knowledge of genetic predisposition to certain diseases, lessen or increase our emphasis on personal responsibility for health? (111-112). Suppose, for instance that you find out I am genetically predisposed for heart disease. Should you overlook my fatty diet on the grounds that I am likely to have heart problems regardless of what I eat? Or should you hold me to an even higher standard of responsibility since my fatty diet places me at greater risk than it would someone without the genetic predisposition? The plausibility of both responses suggests that greater empirical data about the causation of illness will not conclusively settle questions of responsibility.

But if philosophical and empirical analysis will not tell us when to hold a person responsible for his health how do we go about deciding? Given the different causal explanations we can give for behavior, the significant role our goals and interests play in assigning responsibility, and the inconclusiveness of empirical data, we should be wary of any claims which suggest that there is

a "fact of the matter" about responsibility. The assignment of responsibility is not a fact we discover, it is a *decision* we make.

2. The Definition of Risk — There are many behaviors which have a potentially negative impact on health, but advocates of lifestyle proposals generally focus on only a very small number. There are risks which we pose to ourselves and to others that we do not, as a society, seem inclined to regulate. For instance, bearing children, fighting fires, and farming all entail significant risks to health, but we do not consider coercive restrictions on them due to health concerns. Driving automobiles presents not only risk to ourselves, but the emissions, noise and potential for accidents also pose risks to others. We place some restrictions on emissions, but the fact that we allow any emissions at all suggests that we are willing to allow others to place us at a certain amount of risk. How do we determine what risks to consider if we do not base our decisions on a simple correlation between behavior and health?

One possible response, and one that lies behind the fairness and social welfare justifications, is that cost should be considered as well. Both justifications are premised on the claim that certain behaviors or lifestyles should be restricted because of the external cost they impose. This response, however, is inadequate. For those advocating lifestyle interventions based on these justifications it is not enough to show that the behavior is voluntary and that it imposes external costs. It is also necessary to show that these costs are imposed *unfairly* or that risk is one which is *not worthy* of public subsidy. These are normative, not empirical, judgments. Furthermore, until we have gone through the process of calculating the cost of all lifestyles and behaviors which pose a risk to health we are not in a position to argue persuasively on grounds of fairness or social welfare that only certain types of behaviors and lifestyles should be restricted.

The apparent selectivity of target behaviors has led some critics to charge advocates of lifestyle proposals with being arbitrary and discriminatory, or even with pushing a covertly moralistic agenda. The term "sin taxes" is not just coincidental. Since there does not seem to be any consistently applied criterion for distinguishing risky behaviors which we want to penalize or discourage from those which we want to leave entirely to the discretion of the individual, there is reason to suspect that such decisions are based not on principle, but on convention and quite possibly prejudice. The fairness and social welfare arguments only serve to hide this tendency under a veil of seemingly objective economic analysis.

Conclusion

As we gain more knowledge about the relationship between health and lifestyle, and as the competition for limited health care resources intensifies, questions about lifestyle policy will emerge more frequently. What policies designed to influence or make people bear the burden for personal health-related behavior should be implemented in a liberal society? Which lifestyle interventions represent justified infringements on individual autonomy? I have tried to show that attempts to provide substantive answers to these questions will likely yield decisions which are arbitrary and potentially discriminatory. Any answer will be pragmatic, relative to our values, goals, and interests. For this reason, we should shift our attention from substantive to procedural solutions. Only by using a decision making process in which our values, goals, and interests are exposed to public scrutiny and discussion can we both avoid arbitrary and discriminatory decisions and protect autonomy. Even if cannot, as I have argued, determine with certainty when a person is responsible either for their behavior or their health, we should still aim to decide together in a fair and impartial manner when we should hold them responsible.

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NOTES

1. The minutes are estimated for a 150-pound person jogging 11- minute miles.
2. See Veatch for discussion of the voluntary, medical, psychological, and social structural models of causation and their relation to health risks (51-53).

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Adjunct Corner

The last issue of the *MHR* listed the Center's adjunct faculty. However, the list did not indicate the many ways these faculty contribute to the Center and to their respective fields. Thus, in this issue we would like to begin a practice of identifying some of the projects in which these faculty are involved. What follows is a **small** sampling.

Elizabeth Price has two articles which are forthcoming. "The Evolution of Health Care Decision Making: The Political Paradigm and Beyond" will appear in the *Tennessee Law Review*, and "Does the FDA Have Authority to Regulate Human Cloning?" will be published in the *Harvard Journal of Law & Technology*. She will serve as speaker on panel discussion on the ability of public schools to teach creationism. The panel discussion will follow showing of the play, "Inherit the Wind," Wharton Center, Sunday, April 19th.

Keith Applegren and **Carol Slomski** have submitted an abstract regarding the case report "Issues About Operations in Elderly Patients: Futility, Informed Consent, Legal Fears" for the meeting of the American Society for Bioethics and Humanities.

Barb Supanich has co-authored two book chapters: Supanich B, Brody H, and Ogle K., "Palliative Care and Physician-assisted Death." in *Principles and Practice of Supportive Oncology* edited by Berger (1997); and Supanich B, Brody H. "Ethical Issues in Physician-assisted Suicide" in *Healthcare Ethics: Critical Issues for the 21st Century*, edited by Thomasma and Monagle (1997). An article, "Rural and Urban Michigan Primary Care Physicians Attitudes and Values Related to Physician-assisted Death" co-authored with D. Doukas and D. Gorenflo is in publication.

In February **Michael Fetters** and M. Danis presented "We Live Too Short, and Die Too Long--On Japanese and U.S. Physicians' Caregiving Practices and Approaches to Withholding Life Sustaining Treatments" in Zushi, Japan. Fetters is co-author of "Cancer Disclosure in Japan: Historical Comparisons, Current Practices" (forthcoming in the *Social Science and Medicine*), and author of "The Family in Medical Decision Making in Japan" (forthcoming in the *Journal of Clinical Ethics*).

Karen S. Ogle has recently developed a CD-ROM program, "Easing Cancer Pain." The software features stories of people being treated for cancer pain, and offers information on the assessment of pain, barriers to treatment, and approaches to treatment. Plans are to distribute the program through the state health departments, medical societies, nursing homes, hospitals, and cancer centers as well as by the American Cancer Society. For more information visit the Easing Cancer Pain web site at http://commtechlab.msu.edu/sites/cancerpain.

Lou Snow's book, *Walkin' over Medicine*, has just been reprinted by Wayne State University Press in its Africana series.

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Center News and Announcements

Len Fleck contributed a chapter titled "Multi-Organ Procurement for Transplantation: Ethical and Religious Issues" to *The Multi-organ Donor: Selection and Management* (Blackwell Science, 1997).

Len Fleck did a day-long workshop, "Shades of Gray: Ethical Issues in Providing Services to Older Persons with Mental Illness and Persons with Dementia," for the Gerontology Network in Grand Rapids.

Judith Andre conducted a workshop on ethical practice in managed care for the conference "Union Solutions to Managed Care," put on by MSU and the University of Illinois.

Judith Andre spoke on ethical issues in managed care to the Sigma XI chapter at General Motor's Research and Development site in Warren.

At the Association for Practical and Professional Ethics, **Judith Andre** presented "The Language of bioethics as a Pidgin" and chaired a panel discussion on ethics in the academy, "When Collegiality Fails."

Len Fleck gave the keynote address, "Genethics: The Moral and Political Challenges of Genetic Responsibility in a Discriminatory World," at the 14th Annual Conference on Developmental Disabilities at the Kellogg Center on April 7.

Leonard Fleck is chairing the special session of the American Philosophical Association Committee on Philosophy and Medicine at the Central Division Meeting on May 7. The topic of that session is "Priority-setting in Health Care Today: From Managed Care to Moral Mayhem."

Libby Bogdan-Lovis will present "Coming Up for Air: Midwifery Meets Managed Care" at the Michigan Women's Studies Association Conference at Saginaw Valley State University on April 14.

Leonard Fleck will be doing a day-long workshop for the Advocate Health Care System in Chicago on ethical issues in managed care on April 24.

Scot Yoder will present, "Can a Pragmatist Teach Philosophy? Some Problems with Problems," at the Central Division Meeting of the American Philosophical Association in May.

Leonard Fleck will give several presentations at the conference "Genome Horizons: Public Deliberations and Policy Pathways" on May 15 and 16 in Washington D.C. This conference marks the conclusion of the three-year NIH ELSI grant project "Genome Technology and

Reproduction: Values and Public Policy," carried out jointly by Michigan State University and the University of Michigan.

Leonard Fleck will be doing a workshop for the Wayne State University Institute of Gerontology on May 20 in Troy, MI under the title "Just Caring: Health Care Rationing and End-of-Life Decisionmaking for the Elderly."

Leonard Fleck will present "Ethics, Genetics and Reproductive Decisionmaking: Emerging Challenges" for the Maternal and Child Health Conference sponsored by the Michigan State Medical Society on May 28.

Libby Bogdan-Lovis will present "The Midwifery Model of Care: An Examination of Available Models for Improving Maternal and Child Health" at the Michigan Healthy Mothers, Healthy Babies conference at MSU's Kellogg Center, June 11-12.