Personal Health Responsibility: Blaming Victims or Empowering Nations?

Nicholas VALELA* [1]

[1] Student, University of Ottawa, Canada

* *Auteur(e) correspondant* | *Corresponding author*: N/A

Abstract:

The place for personal responsibility within healthcare has been highly contested within academic debate. Meanwhile, leading causes of death within the United States have shifted to chronic disease as a result of lifestyle behaviours suggesting the need for health promotion to take action. In this position paper, I will argue that the less punitive element of personal responsibility implied by health promotion is both ethically justifiable and beneficial as a means of empowering the individual, population and healthcare system as a whole. Several counter-arguments are presented and subsequently refuted: health responsibility unduly places blame upon vulnerable populations; administration of negative sanctions based on health responsibility is difficult; and actions detrimentally affecting health are not certain to be autonomously undertaken by the individual. Arguments in favour are then presented: a dependence of the population upon the healthcare system has been created; empowerment is effective as the central guiding principle of health promotion; and sensible care for oneself should be a duty of citizens, which they are required to fulfill as the healthcare system is not in a position to act as an unlimited resource. As such, health promotion must continue to emphasize the importance of sensible health behaviour as a means of empowering individuals through self responsibility.

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Introduction

When debating criteria for rationing within healthcare systems, personal responsibility seldom receives good press (Buyx, 2008). Holding individuals personally responsible has often been perceived as a way of 'blaming the victim,' which is contrary to the aims of contemporary medicine (Buyx, 2008). However, at present in the United States, it has been estimated that approximately forty percent of premature deaths in the population are attributable to personal health and lifestyle behaviours (Adler & Stewart, 2009). In essence, this is indicative of a high degree of dependency by citizens on their healthcare system as a result of the overly medicalized society in which we live. And the outcomes are clear. Within the past fifty years, the life expectancy of the United States population at birth has increased steadily. During the same time, the leading causes of death have shifted from infectious to chronic diseases resulting from 'lifestyle' behaviours, which include smoking, diet, exercise, and sexual practices (Adler & Stewart, 2009). Such a changeover within a relatively brief period of time has led to widespread calls for people to review their behaviour (Schmidt, 2009). Preventative medicine and health promotion, two components of contemporary medicine, implicitly involve the use of personal responsibility as means of empowering populations to better their health themselves. Rather than punishing or withholding treatment from individuals who choose otherwise, the element of self-responsibility encourages autonomy and aids the individual in making beneficial lifestyle choices. In this position paper, I will argue that the less punitive element of personal responsibility implied by behaviourally focused health promotion is not only ethically justifiable, but also beneficial as a means of empowering the individual, population and healthcare system as a whole.

Cross Arguments and Refutes

The central focus of the recent health responsibility debate has been centered on the justification or criticism of responsibility as a sufficient criterion to impose controversial negative sanctions, primarily the denial of healthcare treatment (Schmidt, 2009). I am suggesting that a more nuanced and less punitive model of self-responsibility, rather than the outright denial of services, is the most efficacious mode of implementing health responsibility to yield positive behavioural changes. However, not all are in agreement.

Health responsibility is still viewed by many as unduly placing blame on the victims, as well as adding further pressure on vulnerable groups within the population (Buyx, 2008). In addition, identifying a direct causal link between behaviour and resulting conditions is nearly impossible as the causes of conditions most often cited as preventable through healthy behavioural choices are multifactorial (Buyx, 2008). It may be possible to clearly identify responsibility for an injury as a result of skiing, whereas it is impossible to unambiguously say whether lung cancer was the result of choosing to smoke (Denier, 2005). However, if we acknowledge that it is unjust to hold individuals responsible for conditions over which they do not have control, it follows that they will only be held responsible for partaking in healthy behaviours when they have full access to the resources that enable those behaviours (Adler & Stewart, 2009). Therefore this places a primary moral responsibility on society, rather than the individual, to provide equal opportunities and resources for all people to be able to make healthier choices (Adler & Stewart, 2009). That said, it would be nearly impossible for one to be able to gain access to healthcare by primarily relying upon one's own possessions (Denier, 2005). Healthcare resources are unequally distributed, needs are highly unpredictable, and healthcare often can be very costly (Denier, 2005). This furthers the importance of society's provision of equal opportunities for all, rather than blaming the unfortunate.

Practically speaking, the notion of implementing negative sanctions based on health responsibility is administratively arduous (Schmidt, 2009). Location of voluntary risk takers would involve, at minimum, the regular and routine breach of individual privacy and confidentiality by government officials to investigate potential health abuses (Denier, 2005). However, I am not advocating for the punishment of irresponsible health behaviours. This practice would be without a doubt demeaning, costly and intrusive (Schmidt, 2009). Instead health responsibility needs to be viewed as a tool used to direct the health behaviours towards a positive route, rather than for the purposes of removing a fundamental human right.

Furthermore, we must be certain that the personal activities in question were autonomously undertaken by the individual, as a lack of autonomy is frequently mentioned as a counterargument. (Denier, 2005). It should be noted that most health behaviours are not impulsively undertaken, but rather are subject to the process of conscious choice (Schmidt, 2009). Yet this process is influenced by numerous factors including socioeconomic status, socialization

and education, family influence, social and peer values, advertisement, addictions and so forth (Schmidt, 2009). A denial of treatment, placement of blame, or emphasis on health responsibility would be considered unjust if the person could not have acted otherwise, or could have only acted otherwise with great difficulty (Denier, 2005). This was emphasized in Norman Daniels' 1985 *Just healthcare and just health: meeting health needs fairly* (Schmidt, 2009).

> *"Too much emphasis on [personal responsibility] ignores egalitarian considerations central to democratic equality. Our health needs, however they arise, interfere with our ability to function as free and equal citizens. [We] must meet the[se] needs however they have arisen, since capabilities can be undermined by bad luck" (p. 69, cf p. 68).*

However, Daniels further noted that even if an emphasis is not placed upon responsibility in assigning obligations of justice, we can still apply this concept through the use of education and incentive strategies (Schmidt, 2009). Urging and directing the population toward the adoption of beneficial health behaviours is not contradictory to this approach (Schmidt, 2009). In fact, present day health promotion strategies makes use of health responsibility as a tool of empowering people through the provision of education and resources rather than punishment and the denial of services.

Arguments

The immense progress of medicalization throughout society has been heavily criticized in recent years as more and more of peoples' behaviour has become subject to medical intervention (Clark, p. 32, 2008). Ivan Illich, in *Limits to Medicine* (1976), offered an influential critique of medicalization. According to Illich, contemporary medicine is *iatrogenic*, that is, it creates disease and illness even as it provides medical assistance (Clark, p. 32, 2008). Illich further proposes structural iatrogenesis, in which the responsibility of good health and self-autonomy has been removed from the individual as a result of the imposition of the medical model (Clark, p. 33, 2008). What has resulted is a dependency on the healthcare system that in turn diminishes any remaining sense of self-empowerment or proactivity within the respective population.

The basic human right to healthcare is not being called into question, however citizens need not only act as passive recipients (Denier, 2005). As the costs of healthcare progressively rise, individuals should feel compelled to aid where possible. Contemporary healthcare has been described by Denier as being built upon an elaborate and diverse framework of institutions, services, and policies that aim at the prevention, restoration, and support for those in need. Rather than simply treating and curing as proscribed in the medical model, behaviourally focused health promotion is mandated to prevent foreseeable conditions and strive for a high quality of life for all.

Health promotion initially gained popularity in the United States during the 1980s as, "wellness programs" (Galloway, 2003). Corporations eagerly adopted these programs in response to the desire to establish healthy habits within the workplace and consequently increase productivity (Galloway, 2003). Since then, community empowerment has acted as a guiding principle for both theory and practice in health promotion (Braunack-Mayer & Louise, 2008). "At the heart of this process is the empowerment of communities, their ownership and control of their endeavours and destinies," (Braunack-Mayer & Louise, 2008). Each empowered community thus is composed of empowered individuals with the responsibility and capability to go about their lives in prescribed ways which are beneficial to their health.

Responsibility is an important value as people's behaviour undoubtedly impacts their health (Denier, 2005). Often, it is the unfortunate reality that the truth regarding lifestyle behaviours is not considered convenient or favourable in the eyes of individuals (Guiet, 2008). Humans on the whole do not react well to forced change and will only do so when a considerable level of suffering has been reached (Guiet, 2008). Thus, it is the work of health promotion to act in the best ways possible to prevent this from happening. Framing health damaging behaviours in terms of choice generates appeal and this way of framing causality can give people a greater sense of control over and responsibility for their own health (Galloway, 2003). Moreover, health promotion should not hesitate to emphasize the importance of sensible health behaviour by generating awareness of the influence that behaviours have on health needs (Denier, 2005).

Taken one step further, personal responsibility should be seen as a practice that can be expected, to a degree, from individuals. In the literature, personal responsibility is found to be an underlying thread to a quasi form of Liberal

-egalitarianism with an added element of solidarity (Buyx, 2008). Liberal egalitarians most certainly call attention to the importance of individual freedoms within society, yet they are also committed to equality of opportunity - the founding justification of healthcare for all (Buyx, 2008). From this, the idea of solidarity reflects the high degree of interdependencies within societies (Buyx, 2008). It is important to ensure that this is not mistaken for the idea of charity or welfare in which only a special group is supported (Buyx, 2008). Rather personal responsibility reflects a dual-sided system that implicates reciprocity, ensuring at least a rudimentary level of assistance and support for all (Buyx, 2008). As said in the outset, people cannot only act as passive recipients. This theory promotes that one should take an active role in trying to avoid damaging effects toward the system (Buyx, 2008). Furthermore, according to Buyx, "[individuals] should act responsibly when it comes to their health and that it is justified to expect this to a reasonable degree." Such efforts will likely lead to the more effective use of healthcare resources, a better quality of life for the individual and the preservation of the system for the long run.

In December of 2001, Winnipeg family physician Frederick Ross took a stand against self-destructive vices and delivered an ultimatum to his patients which attracted the attention of international media (Segal, 2005). Ross' patients were warned that if they were not able to quit smoking within the following three month period, then they would be dropped from his roster. Ross notably stated, "I got fed up with wasting my time treating people with smoking-related diseases. People who continue to smoke are obviously not interested in maintaining their health" (Segal, p. 149, 2005). Although the latter may not necessarily be the case, Ross' strong-willed approach and high expectations of the behaviour of his patients delivered decisive results. Fewer than one dozen patients chose to quit seeing Dr. Ross, while many others found this to be incentive to quit smoking altogether (Segal, 2005). This suggests that further research into the effects of patient responsibility and resulting compliance with prescribed treatment is fully warranted. If in fact responsibility is found to secure compliance, this method could be implemented into mainstream society to significantly reduce the prevalence of "smoking-related diseases" and the like as well as the financial burden on the healthcare system.

Funding is key to a well functioning healthcare system. In recent years, the United States' system in particular has been criticized for the high level of costs associated with the provision of care and delivery of healthcare services. Healthcare expenditures in the United States have risen dramatically from roughly $73 billion in 1970 to an estimated $1,600 billion in 2003 as Americans continue to look to the government for solutions to their health dilemmas (Galloway, 2003). With such a substantial financial commitment, society has the right to expect a return on the investments it has made in the health of individuals through the expenditure of the system's resources (Denier, 2005). That being said, citizens have a basic human right to healthcare services but associated with that right are obligations and duties (Denier, 2005). Sensible care for oneself should be seen as a citizen's duty as required in maintaining one's membership in society (Denier, 2005). One mechanism to address this theoretical duty is to reduce financial stress on the healthcare system through implementation of treatments for preventable clinical conditions.

Within the North American culture, there has been longstanding tension between empowering those who are obese to manage their weight and in contrast, blaming them for failing to do so successfully (Adler & Stewart, 2009). In 2009, Nancy Adler and Judith Stewart at the University of California published work specifically addressing attempts to reduce obesity through empowerment without blaming the individuals. Their findings coincide well with what is being argued here within. Adler and Stewart propose that the obese members of society are already a stigmatized group. It is also felt that their situation will likely worsen unless the general public becomes educated. There needs to be greater awareness with regards to the dire need of people who are obese for resources to enable them to engage in health-promoting activities, thus reducing the harmful placement of blame. Adler and Stewart are not suggesting the complete absolution of blame, but rather highlight the need to provide resources to enable free choice and equality of opportunity. Ultimately, the best way to achieve o this would be to maintain both individuals' autonomy and responsibility for lifestyle behaviours as well as society's responsibility to provide proper health-promoting surroundings (Adler & Stewart, 2009).

Conclusion

According to Illich, the most onerous example of medicalization in present day society is the ever growing dependence of the population upon its healthcare system (Clark,

2008). The vast surge of spending by governments on medical treatment, on hospitalization and on pharmaceuticals is highly indicative of this approach to healthcare (Clark, 2008). But with increasing rates of chronic disease associated with lifestyle behaviours rather than infectious disease, the need for intervention strategies within primary care could be greater than ever before. A more nuanced and less punitive version of health responsibility should be both ethically justifiable and practical in its implementation. The outright denial of healthcare services based upon the concept of personal responsibility is not acceptable as the healthcare system is in no position to place judgement on its patients and may be viewed as victim-blaming. Health promoters have the responsibility to continue to educate the public and facilitate the positive direction of health behaviours without passing judgement. In return, society can expect individuals, as members of a cooperative healthcare system, to make a conscious effort to avoid damaging the system by acting responsibly towards their personal health. Such efforts will likely lead

to the more effective use of healthcare resources, a better quality of life for the individual, and the preservation of the healthcare system for future generations. Thus, health promotion must continue to emphasize the importance of sensible health behaviour as a means of empowering individuals through self responsibility.

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