Responsibility in healthcare: what's the point?

Hanna Pickard

In a welcome broadening of the discussion surrounding responsibility in healthcare, Rebecca Brown and Julian Savulescu propose that standard philosophical accounts of responsibility are too narrow to be useful. Although these accounts of course differ with respect to the exact conditions they posit as necessary and sufficient for responsibility, they are nonetheless relatively united in their focus on a single individual at a single moment in time. Suppose a subject S performs an action *a* at a time *t* that has harmful consequences for their health. Is S responsible for *a* and derivatively their condition? Brown and Savulescu argue that answers to this question that fail to consider both what S was or was not doing at times other than *t* and what people other than S were doing to encourage or discourage S from performing *a* cannot do justice to actions which are habitual and socially influenced—such as unhealthy patterns of eating, exercise and substance use. Given that it is precisely these kinds of patterns of behaviour that typically inflame the discussion of responsibility in healthcare, Brown and Savulescu's insistence on the need for a diachronic and socially contextualised account of responsibility is essential—*if* we are to consider the issue of responsibility in healthcare at all.

But should we and, if so, why? With respect to this question, Brown and Savulescu hope to sit on the fence. This is both because they recognise the complexity and balance of arguments for and against the view that responsibility ought to have a role in healthcare, and because they hold that, whatever the answer in theory, in practice people will always raise the spectre of responsibility and shape their response to others in light of it. But this resigned neutrality is not without consequence. Although they criticise standard philosophical accounts of responsibility, Brown and Savulescu nonetheless appear to endorse a standard view of what the point or purpose of the concept is, namely, to deliver onto people their *just deserts*—at least in a minimal sense of what this might mean. They hold that, with respect to actions that are morally neutral as well as actions that are morally wrong, if there are negative consequences that ensue from the action, prima facie these ought to be borne by the person whose action it is: the responsible agent, no one else. Although this intuition is certainly common and can appear innocent, in fact it expresses a concept of responsibility which is *backward-looking*: responsibility, thus justified, is related to the aim of distributing benefits as well as burdens on the basis of a person's past actions.

I do not sit on the fence: I believe responsibility has a place in healthcare contexts. But my view is that the concept of responsibility that is of value to healthcare ought to be resolutely *forward-looking*.

Broadly speaking, I agree with Brown and Savulescu about the correct *conditions* of responsibility. Responsibility is attributed when a person knows what they are doing and has choice and sufficient control over their actions—both at a time and over time, and when embedded within a social and material context that provides them with the fair opportunity to do otherwise. This inevitably requires support from others. But responsibility, thus understood, matters not because it pinpoints who deserves what even in a minimal sense, thereby enabling us to appropriately deliver benefits as well as burdens. Responsibility, thus understood, matters because it pinpoints where healthcare interventions aimed at altering unhealthy patterns of behaviour are most likely to be *effective*. This is why we should consider the issue of responsibility in healthcare: not as a means to deliver benefits and burdens in relation to past actions, but as an indication of the potential for positive change in future.

The reason for this is simple. Responsibility tracks agency. And, as Brown and Savulescu also note, it is *agents*—those who have knowledge, choice and a degree of control—who can be supported to make different choices going forward, no matter the actions they have exhibited in the past. Agents can 'take responsibility' (as we often put it) and learn to do things differently. This is so whether the agent in question is the patient, a person who is close to the patient and so well placed to help and encourage them in making behavioural changes, or—an agent strikingly neglected by Brown and Savulescu but surely essential to any discussion of responsibility in healthcare—the state. Arguably, many of the causes of unhealthy patterns of behaviour such as eating, exercise and substance use lie not simply with individuals and their friends and family, but with the social and material contexts within which their agential possibilities are both imaginatively and actually defined. No doubt we all have some power to reshape aspects of our society—such as disparities in wealth, education and employment opportunities, alongside the suffering and hopelessness these cause—that contribute to the adoption and entrenchment of unhealthy behavioural patterns. But the state is surely unique both in its capacity and in its obligation to address the life circumstances of its residents that push them towards ill health.

I wrote above that my own view is that the concept of responsibility useful in healthcare contexts is *forward-looking*. One reason is that it is often straightforward to determine whether or not a person is responsible in the sense that interventions that engage their agency stand some real chance of making a difference in future. In contrast, as Brown and Savulescu note, determinations of desert in contemporary healthcare contexts are near impossible—even on the thin interpretation of the concept they favour. This is both because we lack a good theory of how to apportion costs and burdens in principle, and because, even if we had it, the relevant facts pertaining to individual ascriptions of backwards-looking responsibility—especially when temporally and socially contextualised in the way Brown and Savulescu rightly advocate—are unlikely to be fully available in practice to those who would be making the ascriptions, such as clinicians. But I also believe that 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. This is especially so when the patterns of action

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in question involve eating, exercise and substance use or other behaviours that we are far too ready to moralise in our society.

Brown and Savulescu acknowledge the possibility I have advocated of *responsibility without blame* in healthcare (Pickard 2013[1]; see resources at: https://www.hannapickard.com/responsibility-without-blame.html) and suggest it is consistent with their position. Meanwhile, their argument to broaden the conditions and subjects of attributions of responsibility is an essential and important contribution. But their desire for neutrality stands to undermine the value of this contribution. We must distinguish backward-looking and forward-looking conceptions of responsibility in order to interrogate what the point of deploying the concept in healthcare contexts ought to be. For only then can we fashion and put into practice a concept that is genuinely fit for purpose.

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