Patients’ Responsibility for Their Health

Martin Langanke, Wenke Liedtke, and Alena Buyx

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© Springer Science+Business Media Dordrecht 2016
T. Schramme, S. Edwards (eds.), Handbook of the Philosophy of Medicine,
DOI 10.1007/978-94-017-8706-2_22-1
Abstract

Personal responsibility for health has been a topic of debate and analysis for decades. Most publications on the topic are devoted to the ethical and regulatory implications of holding individuals responsible for their own health status. This chapter introduces and discusses a philosophical definition of personal responsibility for health, as part of a logical and semantical analysis of the concept. Responsibility is defined as a relation among six variables U, V, W, X, Y, and Z: U is responsible to V for W to an extent of X and with regards to the time frame Y because of certain normative standards Z. Each of the variables is explained and discussed throughout the chapter. The chapter closes by drawing out the ethical and political implications of such a philosophical model of patients’ responsibility for their own health.

Introduction

Personal – or individual – responsibility for health has been a topic of debate and analysis for several decades now. Most of the publications on the topic are devoted to the ethical and regulatory approaches to, arguments for and against, and implications of, holding individuals, be they patients or healthy citizens, responsible for their own health status. At least since the later 1970s, influential authors from various fields, including practical medicine, health policy, philosophy, and epidemiology, have analyzed whether and how such responsibility could, and indeed should, be ascribed (see for example Wikler 1978a, b; Crawford 1977; Watkin 1978; Veatch 1980; Knowles 1977). Today, the literature analyzing and assessing the ethics and practice of personal responsibility for health is so wide-ranging that any attempt to select only a few citations for an introduction is nigh impossible.

By contrast, writings on individual or personal responsibility for health from a perspective of philosophy of medicine are few and far between. In most writings on philosophy of medicine, the term of responsibility does not play any role at all. And even volumes such as George Agich’s “Responsibility in Health Care” (1982), which came out in the Springer Series Philosophy and Medicine, is devoted mostly to the legal, political, ethical, social, and cultural aspects and implications of responsibility (Agich 1982, p. 5). Books specifically on the philosophy of medicine – itself arguably a small field dwarfed by the ever burgeoning area of biomedical ethics – rarely devote dedicated chapters to personal responsibility for health (see, however, Maier and Shibles 2010, Chap. 12; Engelhardt and Jotterand 2008, Chap. 10; Cherry 1999, Chap. 6), and it also does not play a significant role in published curricula of philosophy of medicine (e.g., Rudnick 2004).

This does not mean that philosophers of medicine have not written about personal responsibility of health; indeed, in this article, several such works are referenced. However, it does mean that overall, patients’ responsibility has, at least so far, not
been a topic of central or even sustained attention in the philosophy of medicine, unlike, as mentioned, in biomedical ethics. This chapter thus aims to summarize the work that has so far been done on patients’ responsibility for health. In addition to this, it also actively extends the discussions on personal responsibility by introducing, explicating, and ultimately applying a philosophical definition of personal responsibility for health. This is done as part of a logical and semantical analysis of the concept of responsibility (section “The Concept of Responsibility: Logical and Semantical Analysis”). Following this, a number of general considerations regarding personal responsibility for health are presented and discussed in section “Personal Responsibility for Health: General Considerations.” Co-responsibility for health is discussed in section “Co-Responsibility for Health.” The chapter closes by drawing out the ethical and political implications of such a philosophical model of patients’ responsibility for their own health in section “Ethical and Political Implications.”

“The Concept of Responsibility”: Logical and Semantical Analysis

A variety of meanings are associated with the term “responsibility” (cf. Werner 2011, 2013, 2016). Each depends on the context, for instance, “responsibility” as “causal responsibility” (for this concept cf. Feinberg 1977; Putnam 1982) or as a “normative relation.” Regarding the context of patients’ responsibility for their own health, the second usage of the term is of particular interest. In this usage, responsibility refers to the demand on a person or an institution to justify its action or actions towards another person or institution. Often, this happens because that person seeks to receive a service or financial compensation, or not to lose certain entitlements. It can also happen outside of any regulatory environments, for example, when individual responsibility is demanded by particular religious or moral teachings (for the general discussion of responsibility in biomedicine see, for example, Buyx 2008; Schicktanz and Schweda 2012; for legal aspects, for example, Krpic-Mocilar 2003; various ethical and political aspects and implications are discussed, e.g., by Minkler (1999), Steinbrook (2006), Brownell et al. (2010), Wikler (2002), Rohr and Schade (2000), Yoder (2002), Cappelen and Norheim (2005), Pearson and Lieber (2009), Schmidt (2008, 2009a, b), Buyx and Prainsack (2012), Eyal (2013), Brown (2013), Bæroede and Cappelen (2015), Resnik (2014), Nielsen and Andersen (2014), Wiley et al. (2013), Fleck (2012), Lewis and Rosenthal (2011), Yang and Nichols (2011), Bringedal and Feiring (2011)).

It is worth noting that this requirement for justification emerges only in settings where the compliance of the person or institution with certain rules or requirements is in question (for the philosophical discussion about the responsibility of supraindividual entities cf. French and Wettstein 2006); if a person is in compliance with a relevant normative setting and the setting itself is not in question, no need for justification arises.
Defining Responsibility

This general understanding of responsibility can be sharpened and specified by constructing a formula, according to which responsibility is a relation among six variables U, V, W, X, Y, and Z:

- U is responsible to V for W to an extent of X and with regards to the time frame Y because of certain normative standards Z.

This formula, further developed from earlier work in Langanke and Fischer (2012), Langanke et al. (2012, 2013), takes into account both the results of a predominately German, long-term discourse on the normative function of the relational concept of responsibility, as well as different contributions from Anglo-American philosophy that both have ancient roots in Aristotelian Ethics (Aristotle 2011). In 1919, Max Weber prominently introduced the concept of responsibility into academic and public debate (Weber 1919). After the Second World War, the German debate on responsibility as a relational normative category was mainly continued by contributions from the ethics of technology. The discussion then markedly changed its character following the widely received, but highly controversial, publication of an “ethics of responsibility” by Hans Jonas (1979). Influenced, among others, by the philosophy of language and the German tradition of Discourse Ethics, authors from the field of ethics of technology, such as Lenk and Maring (1991), Ropohl (1993), Ott (1997), and Grunwald (1999) argued for a relational, logically clarified understanding of “responsibility.” They proposed different relational logical formulas and schemata, akin to the formula presented above. Reconstructions of responsibility range from three-digit formulas to six-digit relations (e.g., Ropohl 1993). Most suggestions are based on four-digit formulas, covering the variables U, V, W, and Z of the formula above (e.g., Hillerbrandt 2006; Werner 2011, 2013, 2016). The introduction of a relational logical understanding into the discourse of medical ethics and its application to the problem of patients’ responsibility of health was prominently proposed, for example, by Marekmann et al. (2004).

The six-digit formula introduced here includes “extent” and “time frame” of responsibility as relevant relational aspects. In contrast to the six-dimensional concept published by Ropohl (1993), the aspect of time is not applied to a retrospective or prospective understanding of “responsibility” in the formula here, but instead to the temporal dimension of the preconditions of accountability (see below). Furthermore, Ropohl’s dimension of “results” or “consequences” of acts is covered in our formula by W, based on the decision to interpret acts and their results as one single aspect. Instead it includes the implementation of the “extent” of responsibility as a separate sixth dimension or relational aspect.

Within the equation proposed in this chapter, U and V are placeholders for single persons or institutions (for institutional responsibility cf. French and Wettstein 2006). W stands for certain results of an action or an omission, but often the respective action or omission itself is inserted into the position of W. X defines to
which extent a person or institution U is responsible for W, for example, whether U is partially or fully responsible for W. Y determines the period of time for or during which U is responsible to V. Z stands for particular norms, including rules, regulations, commandments, prohibitions, permissions, etc., or even larger normative systems (cf. Table 1).

### Intentionality

In this definition of responsibility, only results of actions or omissions may have to be justified (variable W in the formula). In line with broad intuitions, common sense, and indeed legal understandings of responsibility, it does not make sense to demand the assumption of responsibility for a state of affairs that cannot be influenced by a person or institution, e.g., because this state of affairs cannot be modified intentionally. The concept of responsibility is therefore strongly connected with the concepts of intentionality and susceptibility to intentional modifications, affecting the extent of responsibility (variable X in the formula). In this, the intention of an action or omission is to be understood as the actor’s objective or, more precisely, the purpose of her act. Because of this character of intentionality, actions and omissions differ from other human behaviors that are not subject to intentional and purposeful control by the actor. Such involuntary behaviors are, at least from a theory of action as well as an ethical perspective, no, or only marginal, cases of objects of responsibility (for the following cf. Fischer and Ravizza 1998).

Intentionality can only become effective if particular actions or omissions are connected with the purpose of the action in such a way that through them, the purpose can be achieved reliably. This means that it is likely, normal or even inevitable that it can be achieved in this way. This necessary connection between purpose and act can in turn be mediated by causal relations that are initiated by a person through certain actions or omissions, when the person is taking intentional advantage of them for her purpose. Hence, an intended result or state of affairs for which factors – including causal relations – guarantee or reliably allow for its achievement can be considered “intentionally modifiable.”

### Table 1

The relation of responsibility – variables, terms, and suitable insertions (Modified from Langanke and Fischer 2012; Langanke et al. 2012, 2013)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Term</th>
<th>Suitable insertions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 U</td>
<td>Subject of responsibility</td>
<td>Persons or institutions</td>
</tr>
<tr>
<td>2 V</td>
<td>Authority of responsibility</td>
<td>Persons or institutions</td>
</tr>
<tr>
<td>3 W</td>
<td>Object of responsibility</td>
<td>(Results of) actions or omissions</td>
</tr>
<tr>
<td>4 X</td>
<td>Extent of responsibility</td>
<td>Specifications like “fully” or “partially” or percentage</td>
</tr>
<tr>
<td>5 Y</td>
<td>Time frame</td>
<td>Time intervals</td>
</tr>
<tr>
<td>6 Z</td>
<td>Normative standard</td>
<td>Rules, regulations, prohibitions, permissions, or systems of those norms</td>
</tr>
</tbody>
</table>
For some intended states of affairs, none, or not all, factors are known that can contribute to bringing them about. Such states of affairs are under limited, or even no, control of an acting individual. Therefore, and this is a crucial point, they cannot be wittingly and willingly brought into existence. It follows from this that all states of affairs that cannot be intentionally modified in the sense described cannot correctly be criticized or sanctioned by referring to them in terms of responsibility (cf. critical Frankfurt 1969; in line with the concept presented here Fischer and Ravizza 1998). “Shall,” as it is said traditionally, implies “can.” In other words, intentionally not modifiable states are no candidates for the attribution of responsibility regarding an action or omission of an individual. The latter cannot be expected or requested, and no rule can be formulated that would classify a certain act or omission as violating some normative standard with regard to that state of affairs. Instead, in cases of this type, the circumstances responsible for the deviation from the desired target have to be considered – such as, for example, the genetic causes of a particular monogenetic disease, that, as a deviation from the desired state of health, simply befalls someone (for the discussion of the term “to befall” cf. Kamlah 1972; Marx 2010).

It also follows from this how to consider states of affairs that might be partially modifiable: The smaller the degree of intentional modification possible, and the bigger the uncertainty and/or lack of knowledge regarding causal factors, the less it is correct to discuss a relevant act or omission in terms of (lacking) responsibility.

**Implications**

The terminological decisions described so far have several consequences that are pertinent to the discussion about patients’ responsibility for their health (for the following Fischer and Ravizza 1998; Marckmann et al. 2004; Werner 2011, 2013, 2016):

(a) An individual or institution is only responsible for an action or omission with respect to the results of that action or omission. This is the case if an event or situation can be understood as being caused or generated by the action or omission and if the event or situation can be judged to be desirable or undesirable by virtue of applying the rules, regulations, values, etc., governing in a particular setting.

(b) If it is uncertain which of two or more potential acts causes a desirable or undesirable situation, it will necessarily be problematic to claim or attribute any responsibility regarding either act.

(c) Responsibility concerning a certain action can be understood prospectively as well as retroactively (cf. Zimmerman 2001). Therefore, it is possible to distinguish between “responsibility of competence” and “responsibility of accountability”:

– Responsibility of competence (prospective): An individual or an institution bears responsibility for something which must be executed in the future (for problems of prospective responsibility cf. Hart 1949).
Responsibility of accountability (retrospective): An individual or institution is held responsible for the results or consequences that have occurred as a result of an action or omission of that individual or institution in the past.

In light of this distinction, we can specify the logical relationship between responsibility of competence and of accountability as follows:

Only if someone, on the basis of normative standards, bears prospective responsibility for a situation this person can be held retrospectively accountable. (Marckmann et al. 2004, p. 716)

**Preconditions**

From these terminological considerations it further follows that there are certain requirements that have to be fulfilled when claiming responsibility or attributing it to a particular person or institution (for the following cf. Fischer and Ravizza 1998; Langanke and Fischer 2012; Langanke et al. 2012, 2013):

1. Voluntariness: Pressure and coercion decrease the degree to which a person can intentionally modify a particular state of affairs. An action by a person or institution needs to be performed with no coercion and at most minimum external pressure in order for responsibility to be attributed both prospectively and retrospectively to this person. In cases of undue pressure or coercion, depending on its degree, responsibility is shifted fully or partially from the coerced person towards the coercing individual or institution (this criterion was already presented and discussed in Aristotle’s Nicomachean Ethics, Book III, cf. Aristotle 2011).

2. Availability of alternative options: If someone is to be held accountable for an action, a feasible alternative action needs to have been available at the time of acting. Responsibility reaches its logical limit if the possibility to act otherwise neither existed, nor exists, and it is diminished in proportion with decreasing options to act.

3. Level of information: To hold an agent accountable for an action or actions, prospectively as well as retrospectively, that agent needs to have had reasonable knowledge regarding possible results of both the action and the alternative options or at least needs to have been in a position to have this knowledge in principle (cf. Marckmann et al. 2004). This would be the case if the knowledge that a certain action or omission leads to an undesirable result can be reasonably regarded as part of common knowledge (obviously, some pragmatic difficulties can arise from exactly determining “common knowledge” and “reasonable” itself).

4. Self-determination and accountability: The ability of persons to be self-determining – that is, to be autonomous – when considering and performing certain actions or omissions is a transcendental precondition of responsibility.
This simply follows from the terminological decision that persons can be, at most, responsible for their actions – or, more precisely, for the results of their actions (cf. Fischer and Ravizza 1998). As suggested above, states of affairs or situations that cannot be brought about or at least modified intentionally are not potential objects of responsibility. In legal and other practical contexts, the possibility that human beings can lose and regain their ability for self-determination regarding certain actions or omissions is taken into account. Consequently, the responsibility of a person for certain states of affairs can be limited (always, or temporarily) in a fundamental sense.

**Limitations of Responsibility**

It is indeed important to note that responsibility can be full or limited. In view of the thematic focus of this chapter, two types of limitations in particular require a more detailed investigation:

1. **Extent of responsibility**: Limitations with respect to the extent of responsibility can result in at least two different cases:
   - A particular state of affairs or situation cannot be understood as the result of a single person’s or institution’s actions or omissions, but as the result of the cooperation or at least coinfluence of multiple agents. In this case, the responsibility for the respective state or situation is typically distributed among the different persons or institutions involved and depends on the extent of their respective involvement(s).
   - If a state of affairs or situation is only partially modifiable through intentional acts, a person or institution can, at most, be held co-responsible for it.

2. **Temporal limitations**: A person’s or institution’s responsibility for a certain state of affairs or situation can be temporally restricted. All four aspects mentioned in the section *Preconditions* – that is, voluntariness, availability of alternatives, level of information, and self-determination – as well as the extent of responsibility have, or can have, a temporal dimension. It follows that a person or institution can be retrospectively held (co-)responsible for a certain situation with respect to the time interval \([t_1; t_2]\) in which, e.g., the condition of voluntariness was fulfilled, but not for a later interval \([t_3; t_4]\), in which relevant circumstances changed fundamentally and she was, e.g., under duress.

Having defined responsibility in this way, it can be assessed how responsibility and, more specifically, individual or personal responsibility should be defined within the general context of medical care. In this chapter, personal responsibility for health is taken to mean that *one’s health is the object of one’s own responsibility*. Alternatively, individual responsibility could be interpreted as a responsibility in which *the subject and the authority of responsibility are the same*. In the following paragraphs, this alternative interpretation will not be the prominent one. The debates about personal responsibility for health are mostly framed in the way that a person, e.g.,
practices an unhealthy lifestyle and is therefore responsible to others for her diminished health, or, broader, for her way of life. The alternative interpretation of personal responsibility as mentioned above does not fit such a concept. (It will be shown below that subject and authority of responsibility can indeed coincide.)

Personal Responsibility for Health: General Considerations

The results of the logical and semantical analysis in the preceding section can be applied to the context of both healthy individuals and patients. This section discusses three major premises that often underlie the assumptions that individuals themselves are the subjects of responsibility in the way introduced above. These are not always made explicit, although they are very pertinent to the debate. All three have already been mentioned above, as part of the formula: (1) the susceptibility of health to intentional influences, such as health behavior including eating, exercise, etc. (affecting extent of responsibility, X in the formula), (2) the existence of a normative standard, such as regulatory demands, that allow for the attribution of responsibility in the first place (Y in the formula), and (3) the existence of an authority of responsibility (Z in the formula), which decides on assertions of responsibility. In other words, for a person to be responsible for her state of health that state had to have been intentionally modifiable; there had to have been a clear normative standard in place that expected or demanded responsibility for health, or certain behaviors regarded as responsible health behaviors; and there had to have been a person or, more likely, an institution the person was responsible to. The first premise – intentional modifiability – has already been unpacked regarding responsibility in general in section “The Concept of Responsibility: Logical and Semantical Analysis.” In the following, it will be analyzed in the particular context of health, as will the other two. Even if the three premises are fulfilled, questions of the extent of responsibility and temporal limitations remain to be answered; they will be examined in section “Co-Responsibility for Health.”

Diseases as Potential Objects of Responsibility

Following the logical and semantical analysis on the links between action and responsibility, the personal health status of an individual may be an object of responsibility if, and only if, it can be modified through actions or omissions of patients or healthy individuals (cf. Rohr and Schade 2000; Yoder 2002; Schmidt 2008, 2009a; Pearson and Lieber 2009). However, it has already been described that in many cases, a state of affair cannot be clearly or fully ascribed to the person in question in this way, for several reasons. In such cases, the person would be at most co-responsible for them. In the context of illness and disease, therefore, we can specify that some conditions are potential candidates for being objects of responsibility or co-responsibility (for the definition of the term “co-responsibility” cf. Schmidt 2008, 2009a), because their emergence, development, or course is
considered to be susceptible to personal choices and individual actions (cf. Langanke and Fischer; 2012; Langanke et al. 2012, 2013) (Note that this does not mean that in each case, the person would be responsible for that health status. In order to come to that conclusion, other elements — such as the relevant normative standard — have to be considered as well, see below):

(a) This includes diseases that can be prevented, entirely, largely, or to some degree, through protective or health-promoting behaviors such as appropriate physical activity or healthy nutrition.

(b) Furthermore, diseases which are directly related to chosen risky behaviors are potential objects of (co-)responsibility.

(c) Under the additional premise that the respective agents have access to healthcare services, diseases which can be avoided by making use of preventive medical interventions like vaccinations or preventive surgery could be discussed as potential objects of persons’ (co-)responsibility for their own health.

(d) Assuming the same premise of access to relevant healthcare resources, diseases that can be modified in their course and severity by screenings and preventive health assessments could also be regarded as objects of patients’ (co-)responsibility, even though they are not affected by lifestyle, health behaviors, or preventive medical interventions (cf. Dabrock 2006).

In general, individual responsibility for health could be construed prospectively and retrospectively (cf. Marckmann et al. 2004). If, and only if, all premises discussed above are met, a patient who has developed, e.g., a disease as a direct result of unhealthy behaviors could be held responsible retrospectively, once treatment for that disease required medical resources. Real-world examples of being held responsible retrospectively would be paying higher premiums for insurance, higher co-payments, or exclusion from some services (cf. Pearson and Lieber 2009). (Note that this does not include a judgment whether holding the person responsible would be ethically and/or politically appropriate.) Likewise, if, and only if, premises were met, an individual could be held responsible prospectively for a particular behavior, if that behavior lead to the development of diseases that would require treatments. Real-world examples would be sanctions if a person did not keep up with certain prospective requirements of health promotion (e.g., regular visits to the gym, keeping to a certain weight, etc.) or for being noncompliant in other ways.

Since, as explained in section “The Concept of Responsibility: Logical and Semantical Analysis,” persons can be held responsible only if they could have chosen otherwise, prospective responsibility is indelibly linked to the access to relevant information — in the healthcare context, as well as in general. Only a person who is informed about and aware of health risks that result from a certain behavior, or from refusing healthcare interventions, can choose not to engage in the relevant behavior, or decide differently. In other words: Only if patients or healthy individuals have access to adequate information about a health risk can they become subjects of responsibility regarding that health risk, in the sense that they are accountable for failing to avoid risky behavior or take relevant preventive measures if these, indeed,
exist (cf. Paul 2010). In the context of this section, the criterion of a sufficient level of information can be reconstructed as a premise under which diseases that belong to one of the categories, (a) to (d), are candidates for being objects of responsibility.

It is obvious from the analysis so far that the potential for assigning personal responsibility for health does not include all diseases (cf. Düngen 2009; Resnik 2014). Since some diseases cannot, according to current knowledge, be modified through actions or omissions of the individual, they must be treated as unfortunate situations that occur through no action or omission of persons, i.e., which befall individuals (cf. Kamlah 1972; Marx 2010). Here are a few clear-cut cases:

(a) Conditions of this type include those with unknown etiology. In cases in which it is unknown which out of two potential acts causes a desirable or undesirable situation, it is problematic to claim or attribute responsibility with respect to either act. All diseases with unknown or partially known etiology are therefore excluded from being the object of responsibility. It is important to stress that this holds even where most – or even all – etiological factors of a multifactorial condition have been described, but it is unclear which factors have contributed to the illness in each individual case. If it cannot be determined clearly what the etiology in an individual case has been, retrospective responsibility cannot be attributed for the reasons mentioned. This is the case in many chronic, so-called “lifestyle-related” illnesses, including diabetes, coronary heart disease, back pain, and depression.

(b) Diseases that are determined entirely through genetic causes are no potential objects of patients’ responsibility. This includes genetic disorders (cf. Düngen 2009; Resnik 2014) such as single-gene disorders, autosomal and x-linked illnesses, as well as forms of trisomy, etc.

(c) It also seems to be illegitimate to attribute responsibility for diseases that are caused by living conditions, such as environmental or working conditions which cannot be directly and/or immediately influenced or changed by the concerned people. Illnesses of this kind include, e.g., lead poisoning from drinking contaminated tap water or occupational illnesses such as hearing loss in certain professions.

These diseases clearly do not fit into the category of illnesses that can be objects of individual responsibility for health, because they cannot be intentionally modified. Another group of illnesses are difficult to assess because they are caused partially or entirely by behaviors and actions that are, at the same time, risky and health-promoting. Many forms of sports and exercise belong into this group of ambivalent behaviors. Skiing, for example, is an outdoor activity that may have positive effects on the physical and psychological health of an individual. On the other hand, every winter season many skiing accidents happen which often require surgery. Do individuals who practice skiing as a winter sport behave responsibly regarding their health, by being athletic and active outside, training their muscles, and improving their cardiovascular fitness? Or are they responsible for their broken bones, because they have engaged in behaviors that put them in harm’s way?
Summing up the observations in this section, it becomes apparent that a significant number of disease entities are not suitable as potential objects of responsibility. In addition, there are also lifestyle and behavioral factors, such as having certain professions or choosing certain forms of exercise that can contribute to illnesses, because they have positive as well as negative influences on health. Many of these, in turn, are affected by social determinants such as education and income, which makes the attribution of individual responsibility for related illnesses even more complicated. (Note that the debate around the social determinant of health is very extensive and cannot be summarized here; a good overview can be found in, e.g., Venkatapuram (2011).

**Normative Standards**

Another component of the attribution of responsibility must be discussed. According to the understanding of responsibility presented in section “The Concept of Responsibility: Logical and Semantical Analysis,” responsibility cannot be attributed if there is no relevant normative standard; that is, a particular set of values within a particular context, providing the normative background for assessment (cf. Ott 1997; Grunwald 1999; Werner 2011, 2013, 2016). This standard allows classifying certain acts or omissions as desirable or undesirable. Only on the basis of its rules, regulations, prohibitions, commandments, permissions, etc., do certain behaviors become objects of judgments. Hence, if we attribute responsibility to a person in the full sense of the formula introduced in section “The Concept of Responsibility: Logical and Semantical Analysis,” we render a value judgment on this person’s actions or omissions in accordance with the normative standard.

In the discourse on patients’ responsibility for their own health, this connection between normative standards and judgment is regularly ignored or not made explicit enough. In consequence, the normative standard for sanctioning certain health-related behaviors is often not made transparent.

However, the normative standard is of significant importance for any discussion of responsibility for health. For example, national health care systems vary greatly. In countries with full, or partial, publicly funded health care systems, the question of the relevant normative standard can have a regulatory or quasi-regulatory dimension. There are various terms in use to denote that a health care system is paid for from common resources, such as tax, income, or insurance contributions, instead of private out-of-pocket payments, and administered through state-controlled or even state-run actors, instead of industry and private enterprises. This article follows established usage in that “publicly funded health care system” (and short, “public health care system”) is used to describe a system of the first kind. Obviously, systems vary in many details that cannot be discussed here.

Responsibility may be ascribed, e.g., against the background of a particular legal framework that includes rules and regulations on responsibility and health behaviors. In countries without a publicly funded health care system, the ascription of responsibility will vary greatly, depending on the relevant normative standard, e.g.,
as stated in private health insurance policies (cf. Pearson and Lieber 2009). Where all health care is organized privately, individuals’ responsibility for their health will, at least in practice, be delineated to a significant degree by their ability to pay.

It is important to note that in addition to regulatory normative standards, relevant normative standards can also be part of the private morality of a person. Given, e.g., a family depending on one family member’s working and earning abilities, this person can attribute to herself the responsibility for her own health, because all other family members may depend on her. Irrespective of any regulatory frameworks, in this scenario, the normative standard is a more or less private principle of family care, which generates a purely moral obligation. Accordingly, in such a scenario, the subject and the authority of responsibility can (but obviously do not have to) coincide.

Such purely moral obligations and private principles are also relevant in countries with a fully or partially publicly funded health care system. In such countries, however, private moral principles are not the sole normative standards that can be applied to a person’s health related behavior. Germany, for example, with its mixed public/private health care system, is an illustrative example of this. In Germany, there is a legal obligation for almost every resident to have health insurance. Only civil servants, those who are self-employed, or earn above a certain threshold, can choose to have private insurance; everyone else is automatically part of public statutory insurance, with a (limited) choice among various sickness funds. This includes the unemployed, retired, or those not able to work. Statutory insurance is explicitly based on the principle of solidarity (cf. German Social Security Code [Sozialgesetzbuch] V, § 1). The contribution every member of a statutory sickness funds has to pay does not depend on individual risks, but typically on the level of income, and is subtracted directly from each person’s pay. Family members such as children and spouses that do not work are automatically insured in the earning person’s sickness fund. For those who cannot contribute, insurance is covered by social care.

In a system of this type, the overall community of members of statutory sickness funds shares an interest in ensuring that the fund exercises thrift in the use of available resources and that preventable costs are avoided (for the following cf. Werner 2006). Indeed, this is explicitly part of the legal framework regulating statutory insurance and applies not only to the administration of the fund itself, but also to the reimbursement of expenses.

The German normative standard appears to include, at least in principle, the option that, e.g., the costs of treatments originating from illnesses that are considered avoidable are regarded as the personal responsibility of the individual who did not avoid them. Note, however, that the criteria developed above regarding modifiability, alternative options, knowledge of causality, etc., all apply; that is, the question would arise whether the respective diseases are fully or partially individually caused and/or modifiable, and whether the individual actually had the option to avoid them. If these criteria were fulfilled, it would be appropriate to discuss whether the reimbursement of costs resulting from such diseases could be withheld or only
partial reimbursement provided, etc. (Potential practical, ethical, and political implications are discussed further below).

In the German case, the relevant normative standard could be reconstructed as the abovementioned aim to avoid the misuse of resources – if resources are understood as misused, when they are spent on treatments for avoidable, individually caused diseases. This can be rephrased in the following rule (cf. Langanke and Fischer 2012; Langanke et al. 2012, 2013):

All members of a public health-care system that carries costs for all its members are obliged to prevent costs of treatment for avoidable illnesses, in order to use resources as effectively as possible and to avoid misuse.

In Germany, a normative standard of thriftiness has indeed quasi-regulatory power. It is tied very directly to personal responsibility; the fifth book of the German Social Security Code claims in its preamble explicitly that all members of the statutory health insurance are co-responsible for their own health and that they are therefore obliged to strive towards preventing illness (cf. German Social Security Code V, § 1).

The example shows that responsibility for health cannot be attributed to an individual person without revealing the relevant normative standards. These standards have to be made explicit. If they are not clearly defined and/or made explicit, the concept of individuals’ responsibility for their own health can easily be manipulated for political or other goals in public debates. Obviously, the justifications of the relevant normative standards can be questioned. The outcomes of such debates will in turn alter whether personal responsibility can (still) be attributed within a given system or context (see below).

**Authority of Responsibility**

As noted above, responsibility depends on some authority (V in the formula). Without authority, it would be difficult to ensure individuals behaved in line with their responsibilities. But what kind of authority applies to the context of health care? To answer this question, it is helpful to return to the distinction between countries with a publicly funded, or partially publicly funded, health care system, and those without such a system.

Where there is no public system, or no obligation at all to participate in the public elements of a mixed system, a wide range of authorities may come into play, from individual conscience to societal institutions like churches, from private insurance companies to metaphysical entities like a god or gods. But in these cases, the binding power of these authorities results from the individual decision to acknowledge or join them.

In cases where a public system does exist, the question of the authority of responsibility has a public, or even political, dimension, particularly if individual responsibility is codified in regulation, such as, e.g., in Germany. Nevertheless,
which institution wields this authority is often not clearly addressed in relevant official statements even where explicit normative standards of personal (co-) responsibility exist. For instance, the fifth book of the German Social Security Code does only provide an implicit answer to this question (cf. German Social Security Code V, § 1): The publicly funded statutory health insurance (through sickness funds), which is representing the community of those insured, is functioning as the relevant authority of responsibility.

At this point, the value of a relational logical reconstruction of the concept of “responsibility” becomes clearly apparent (for the following cf. Werner 2006). The reconstruction, as developed in the formula introduced in section “The Concept of Responsibility: Logical and Semantical Analysis,” allows for the examination of the authority of responsibility, and this in turn can lead to follow-up questions of significant ethical and political importance at least in countries where the concept of individuals’ responsibility for their own health is charged with regulatory or quasi-regulatory power. Whenever personal responsibility for health plays a role within a health care system, the question of the authority for responsibility becomes highly pertinent, both for ethical and political reasons.

Co-Responsibility for Health

It follows from the discussion in the preceding sections that in most cases, individuals’ responsibility for their own health can at best be conceptualized as joint or co-responsibility.

Most health risks are the result of combinations of factors that can be controlled by individuals, such as health behaviors and the utilization of preventive measures on the one hand, and those that are beyond the control of individuals, such as genetic and environmental factors on the other. There are very few phenomena in human health and illness that can be attributed in a straightforward way to a single and, moreover, intentionally modifiable cause and only a few more that can be attributed to multiple factors that can all be controlled intentionally. Hence, it is only possible to connect patients’ responsibility for their health to those elements of risk that are regarded to be susceptible to personal choices.

The situation gets even more complex because most preventive strategies or healthy behaviors only have a statistically speaking, limited or even minimal influence on the prevalence and/or course of those diseases that are considered to be modifiable by prevention or healthy behaviors. It was argued above that when it is uncertain which out of two potential acts causes a desirable or undesirable situation, it is problematic to attribute responsibility for either act. In such cases, even a co-responsibility of individuals for their health can be doubted, regarding the compliance or noncompliance with preventive strategies or lifestyle-related suggestions (cf. Schmidt 2008, 2009a).

Other problems with the concept of responsibility for health arise from the fact that accountability of persons can be narrowed by biological and therefore medically relevant reasons. The phenomenon of addiction is a good example to
demonstrate how a disease can reduce someone’s accountability to the extent that it diminishes the possibility to attribute responsibility to that person. In cases of addiction, a person’s ability for self-determination is lost or at least temporally limited. For example, while a person might be held responsible for her alcohol consumption at nontoxic, nonaddictive levels, once alcohol consumption tips into addictive behavior, her control is significantly diminished. Therefore, it has to be doubted whether this person is responsible for her actions, or the results of her actions, at least in times when her alcohol consumption corresponds with addictive behavior patterns. At this point, the advantage of the integration of the time frame Y into the relational-logical formula of responsibility in paragraph 2 becomes obvious: Addiction is generally seen as a medical condition, which has as one important feature that someone’s co-responsibility for his or her health can be temporally, or permanently, limited. It should be noted that addictions are conditions with very complex etiology and progression. Behavior that would qualify as full blown addiction in one person might yet be under full voluntary control in another; and depending on family history, genetics, environment, and a host of other factors, some people might find it easier than others to retain or regain control over their substance abuse. This obviously does not make the ascription of responsibility any easier – on the contrary.

The dimension of time also plays an important limiting role within the context of pediatrics. Depending on their age, children are not or not yet fully accountable for their health-related behaviors. In consequence, the concept of individuals’ responsibility for their health has logical limits in pediatrics. Age-related limits to responsibility for health are particularly important, because much of health-related behavior, including eating behavior, level of physical activity, psychological coping mechanisms, level of impulse control, and many others, are learned – some would say ingrained – in early (and later) childhood (e.g., Brown and Roberts 2011). This in turn affects the level of accountability for such behaviors in adulthood.

Another complicating factor needs to be exemplified: it was established above that responsibility is diminished in proportion with decreasing options to act. In other words, a person who has many unconstrained options can, all things being equal, be held responsible or co-responsible, as opposed to a person who does not have these choices open to her. This condition of alternative options for action is very relevant to the prominent debates concerning the social determinants of health (cf. Venkatapuram 2011; and many others). If individuals live in so-called “obesogenic environments” of the kind that do not allow for a consistently healthy lifestyle (Egger and Swinburn 1997) – for example, if individuals do not have reasonably easy access to healthy food options and/or their built or work environments preclude physical activity – then an attribution of responsibility becomes less appropriate. Indeed, it becomes less appropriate the fewer alternative options individuals in such environments have to make healthy choices.
Finally, personal responsibility for health can be constrained through the influence of other agents, such as healthcare providers, for example, regarding the recovery from illnesses. It is necessary for a layperson to trust that whatever measures chosen and executed by their healthcare providers will contribute to a return to health with, ideally, minimal adverse effects. In such cases, the patient is only responsible for those adverse effects of medical treatment that he or she could have deliberately modified or avoided. In such a scenario, the individual and medical staff share co-responsibility for the patient’s health, again without clarity on how much each contributed to a given health status.

In sum, based on a consideration of these factors alone, it is very difficult to assign responsibility – even co-responsibility – to patients for their own health in a justified way, if all conditions of the definition introduced in section “The Concept of Responsibility: Logical and Semantical Analysis” are taken into account. The final section of this article will draw out a few additional problems and challenges of an ethical and political nature.

**Ethical and Political Implications**

In this chapter, through the philosophical analysis and discussion in the previous sections, it has become obvious that there is very limited scope to assign personal responsibility for health to individuals in a legitimate way. Moreover, even if there were cases that corresponded with all conditions set out above, other considerations come into play. If the ascription of personal responsibility for health has any practical consequences, for example, by being sanctioned via malus systems in health insurance; higher co-payments; or the exclusion from certain treatments or by being incentivized, for example, through bonus systems, etc., these consequences can be analyzed for their ethical and political implications (cf. Apel 1988; Bayertz 1995; Lenk and Maring 2003). (It is often difficult to clearly distinguish between ethical and political implications in this context, since they are regularly intertwined, see below). The literature on this analysis is, as mentioned in the introduction, significant (see references in the section “Introduction”). This being a chapter on the philosophy of medicine approach to examining personal responsibility for health, the following is but a very short summary of the most important ethical and political issues.

Firstly, and following on directly from the formula introduced in section “The Concept of Responsibility: Logical and Semantical Analysis,” both the authority of responsibility (V in the formula) and the normative standard applies (Z in the formula) can be controversial (if, as mentioned above, the subject of responsibility and the authority are not one and the same). The political legitimacy of a given authority of responsibility – which, in real life and as mentioned, sometimes is not even clearly specified – can be contested, particularly if it is empowered to sanction
undesired and incentivize desired health behavior. The same holds for the normative standard, if not more so. A normative standard has to be justified, and recent cases have shown that where new normative standards regarding personal responsibility for health have been introduced, these have often lacked sufficient justification (Steinbrook 2006; Bishop and Brodkey 2006; Prainsack and Buyx 2011, 2012). To return to the example from section “Personal Responsibility for Health: General Considerations”: While the German Social Security Code that requires co-responsibility from all members of statutory insurance has legitimacy by law, it could be challenged on ethical grounds. For example, it could be argued that if it was applied in a strict interpretation (which it currently is not), it could lead to the exclusion of individuals from care who could face stigmatization as a consequence. An (currently hypothetical) example would be the “reckless,” fully informed, unconstrained in her decision-making, skier, who suffered a complicated hip fracture in a skiing accident and could not fund optimal care for the fracture resulting in a highly visible gait defect. Others would describe this as an unethical example of “victim blaming” (Crawford 1977) or as an example of state actors evading their duties of care towards their citizens (Minkler 1999; Schmidt 2009b). Some would argue that any exclusion from medical treatment, or any financial penalty in health care based on behavior instead of need, even if fully responsible according to the conditions set out above, was unethical, based on the wrong values and principles (Wikler 2002). Finally, even those who would argue that the normative standard demanding responsibility for health in the German case was based on the value of solidarity have been challenged. The understanding of solidarity as reciprocity, as enshrined in the Social Security Code (cf. Buyx 2008), has been shown to be at least controversial (cf. Buyx and Prainsack 2012; Prainsack and Buyx 2016).

In addition to challenges to the authority and normative standard of personal responsibility for health, it could also be argued that personal responsibility for health contradicts values that are relevant in other spheres of life. For example, while thriftiness might be a key value in statutory health insurance, in other areas of life, abundance, joy, indulgence, etc., are important values, and these could come into conflict with thriftiness. Most obviously, the value of freedom and the related principle of personal autonomy over one’s private actions and behaviors, supremely important in modern pluralistic societies, are seen to conflict with incentivizing and sanctioning personal responsibility for health (Wiley et al. 2013; for many others).

And finally, even if all these implications are not deemed relevant, complex problems regarding the practical implication of incentives and sanctions remain: for example, which behaviors exactly would be incentivized/sanctions, and based on which criteria, how behaviors would be monitored, and what kind of investigative powers authorities would have. (Langanke and Fischer 2012; Langanke et al. 2012, 2013; for many others). Again, these issues highlight that an ascription of personal responsibility, if it becomes actionable, may conflict very directly with personal rights and liberties usually regarded as fundamental, both from an ethical as well as a political perspective.
Definitions of Key Terms

Responsibility

Responsibility is defined as a relation among six variables U, V, W, X, Y, and Z: U is responsible to V for W to an extent of X and with regards to the time frame Y because of certain normative standards Z.

Personal responsibility for health

Personal responsibility for health is taken mainly to mean that one’s health is the object of one’s own responsibility.

Summary Points

Personal responsibility for health has been a topic of debate and analysis for decades. Most publications on the topic are devoted to the ethical and regulatory implications of holding individuals responsible for their own health status.

This chapter introduces and discusses a philosophical definition of personal responsibility for health, as part of a logical and semantical analysis of the concept.

Responsibility is defined as a relation among six variables U, V, W, X, Y, and Z: U is responsible to V for W to an extent of X and with regards to the time frame Y because of certain normative standards Z.

Each of the variables is explained and discussed throughout the chapter.

If all conditions of the definition are taken into account, there is very limited scope to assign personal responsibility for health to individuals in a legitimate way. Both the authority of responsibility and the normative standard applies can be controversial, for a number of reasons.

There are also a number of important ethical and political issues to be considered. The ascription of personal responsibility may also conflict very directly with personal rights and liberties usually regarded as fundamental from an ethical as well as a political perspective.

Acknowledgments

This chapter is partially based on considerations, which appeared elsewhere (Langanke and Fischer 2012, Langanke et al. 2012, Langanke et al. 2013).

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