

Response to Commentaries on 'Responsibility in Healthcare Across Time and Agents'

Let us first thank the four commentators who have taken the time to read and thoughtfully reflect upon our paper. In that paper, we discuss how responsibility concepts must be sensitive to the temporal (*diachronic*) and social (*dyadic*) aspects of health-related behaviour, if responsibility is to play a role in health policy.

This 'if' is a big one, and Hanna Pickard rightly challenges our position of neutrality with regards to whether or not responsibility should be incorporated into health policy.⁽¹⁾ Pickard proposes that responsibility should play a forward-looking role in health policy – used as a tool to facilitate and encourage healthy behaviours where it is reasonable to expect people to adopt such behaviours. Whilst the conditions for such responsibility are similar to those involved in the backward-looking, desert-based responsibility we invoke, they do not warrant responses such as praise, blame, reward and punishment that may follow from desert-based responsibility. Pickard argues that even asking the question of 'what would desert-based responsibility look like in these health contexts' risks encouraging moralisation, stigma and blame, all of which have no place in healthcare.

We agree that forward-looking responsibility could be an important tool in healthcare. We have offered such an account as providing a Golden Opportunity to enable agents to take responsibility. Such an opportunity should be both socially constructed and diachronic. But it is hard to avoid the backward-looking implications of this: once agents have been provided with a genuine Golden Opportunity, a failure to capitalise on this would make it reasonable to consider them responsible in a backward-looking sense.

We take on board Pickard's concerns and would be deeply regretful if it turned out that our analysis encouraged stigmatisation and eroded compassion in healthcare. We think, however, that this is unlikely: our analysis aims to highlight the complexity of health-affecting behaviours such as smoking, over-eating and under-exercising, and to show how difficult it may be to establish that the conditions for responsibility are met with sufficient confidence to warrant any form of moral criticism. Indeed, Harold Schmidt, in his commentary, wonders if our analysis might be taken as a *reductio* of the use of personal responsibility in healthcare.⁽²⁾

To Schmidt's query we would say yes and no: yes to the extent that an accurate reflection of an individual's personal responsibility for her health is likely to be practically unachievable (aside from the discussion of the complicating diachronic and dyadic factors we discuss, there are numerous other hurdles such as establishing the causal contribution an agent made to her poor health). And no, to the extent that we recognise the powerful intuitive pull of notions of desert. Unlike Pickard, we are unwilling to abandon desert-based responsibility, and think it is unlikely that the majority of others (particularly non-philosophers) would be willing to do so as well. There appears no bright line that delineates health from other areas in life where desert-based responsibility is commonplace and is at least generally taken to be justified. What will ultimately matter is how powerful the intuition of desert is in the health context, since this will determine the value of making health policy sensitive to responsibility, the lengths we are willing to go to in order to establish (with some degree of confidence) who is responsible for what, and how responsibility-sensitivity should be traded off with other things we care about (efficiency in the system, compassion, addressing social inequality, etc.).

Per Algander highlights some ambiguities in how we identify the behaviours (or ‘acts’) for which people are considered to be (or not be) responsible.⁽³⁾ Algander questions the wisdom in looking at responsibility *for action* rather than responsibility *for outcome*. We think that it is likely to be important to consider both actions and outcomes: outcomes because (as Algander points out) this is what we are ultimately concerned about, and actions because responsibility for action will typically be a key part of the story of how we come to be responsible for outcomes. Our decision to discuss responsibility for complex behaviours – patterns of behaviour repeated over time – despite such behaviours not describable as a single action, is motivated by what we perceive as the significance of the complex behaviour (rather than, say, a single instance of that behaviour being performed) in the resulting consequences that we care about (i.e. health outcomes). How action should be individuated for the purposes of assessing responsibility here will not, we think, be guided by an underlying fact of the matter whereby one way of describing things is ‘right’ and all others are ‘wrong.’ Rather, there will be more or less useful ways of carving up the world for the purposes of understanding when the conditions of responsibility are fulfilled for behaviours we care about. Since there is reason to care about patterns of behaviour such as smoking, diet, and physical activity, we think it valuable to take these as the objects of consideration when assessing responsibility.

Finally, we welcome Neil Levy’s consideration of how the diachronic aspect of responsibility highlights the ways in which some people will have particularly limited responsibility due to frequent pressure on their capacities of self-control.⁽⁴⁾ We think this will be an important consideration of attempts to judge responsibility: different individuals are exposed to different levels of ‘risk’ of harmful behaviours, due to the kinds of environments they live in and the way those environments shape their opportunities and behaviour over time.

Due to limited space, we cannot address all the points raised by the commentators on this article, but thank them for their generosity in providing such considered responses, challenging our ideas and helpfully directing us towards areas for fruitful development of this research.

References

1. Hanna Pickard ‘Responsibility in Healthcare: What’s the Point?’ *JME*
2. Harold Schmidt ‘Personal responsibility for health: conceptual clarity, and fairness in policy and practice’ *JME*
3. Per Algander ‘Comment on Brown and Savulescu’ *JME*
4. Neil Levy ‘Applying Brown and Savulescu: The Diachronic Condition as Excuse’ *JME*