The undeserving sick? An evaluation of patients' responsibility for their health condition

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Christine Clavien
christine.clavien@unige.ch

Samia Hurst
samia.hurst@unige.ch

	Risk factor	Deaths (millions)	Percentage of total
	Low-income countries[a]		
1	Childhood underweight	2.0	7.8
2	High blood pressure	2.0	7.5
3	Unsafe sex	1.7	6.6
4	Unsafe water, sanitation, hygiene	1.6	6.1
5	High blood glucose	1.3	4.9
6	Indoor smoke from solid fuels	1.3	4.8
7	Tobacco use	1.0	3.9
8	Physical inactivity	1.0	3.8
9	Suboptimal breastfeeding	1.0	3.7
10	High cholesterol	0.9	3.4
	High-income countries[a]		
1	Tobacco use	1.5	17.9
2	High blood pressure	1.4	16.8
3	Overweight and obesity	0.7	8.4
4	Physical inactivity	0.6	7.7
5	High blood glucose	0.6	7.0
6	High cholesterol	0.5	5.8
7	Low fruit and vegetable intake	0.2	2.5
8	Urban outdoor air pollution	0.2	2.5
9	Alcohol use	0.1	1.6
10	Occupational risks	0.1	1.1

In contemporary wealthy societies, thanks to better nutrition and medical progress, we live longer

Implications:

- more chronic illnesses and multi-morbidity in old age
- diseases associated with scarcity (malnutrition, infectious diseases, etc.) progressively replaced by diseases related to unhealthy lifestyles (tobacco use, physical inactivity, unhealthy nutrition, etc.)

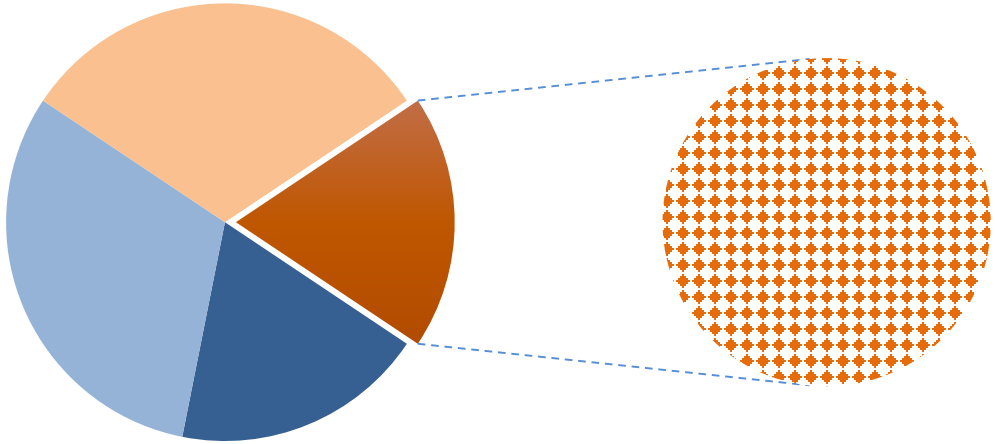
These trends challenge the traditional foundations of social health insurance systems

Principles underlying social health insurance	Lifestyle related diseases seem to clash against these principles
Risk management: collectivity contributes to the costs of non-predictable diseases of individuals	Do predictable and avoidable diseases count as risks?
Solidarity: common effort to preserve the health of all members of society	Had sick patients conducted a healthier lifestyle, they would have spared health costs to the collectivity
Selective Altruism : wealthy members of the society provide assistance to vulnerable groups who deserve to be helped	Do these patients deserve to count among the vulnerable individuals deserving altruistic help?

To what extent is it warranted to hold these patients *responsible* for their disease and sanction them accordingly (less access to healthcare resources) ?

Minimal conditions for attributing practical responsibility	
Condition 1	Actors are responsible for actions and lifestyle choices, rather than states of affairs (e.g. illness)
Condition 2	Responsibility depends on the existence of minimally valuable choice options
Condition 3	Responsibility requires some prior knowledge of existing options, their causal effect, and their fair value
Condition 4	Responsibility depends on actors' minimal *level of control** over their choices
Additional condition for attributing moral responsibility	
Condition 5	Moral responsibility depends on actors' level of practical responsibility and on their understanding and endorsing that some choices are 'wrong'

** Level of control:*
a) Capacity to identify deep preferences and form coherent evaluations
b) Matching between deep preferences & action choices



known factors unrelated to lifestyle choices

unknown factors unrelated to lifestyle choices

unknown factors related to lifestyle choices

known factors unrelated to lifestyle choices

How can we attribute responsibility to a typical patient suffering from a lifestyle related disease?

Criterion 1: explained variance of known factors related to unhealthy lifestyle, compared to causal precursors over which patients have no grasp (unknown factors, genetic and environmental background).

Criterion 2: patients' responsibility for their lifestyle choice (i.e. their capacity to fulfil the conditions for practical responsibility) → their responsibility can be constrained by various 'limiting factors' (e.g. biased available information, framing of choice options, automatic psychological mechanisms)

Explained variance: how much the factor accounts for the expression of the disease, assuming that the sum of the explained variances of all causal factors equals 1

Limiting factor	Condition 2: Existence of minimally valuable choice options	Condition 3: Patients' knowledge about existing options, their causal effect, and their fair value	Condition 4: Actors' minimal level of control: a) Capacity to identify deep preferences and form coherent evaluations / b) Matching between deep preferences & action choices
Low socio-economic status	Patients have fewer choice options (e.g., cannot afford healthy food)	Where access to health education is based on ability to pay, patients have less knowledge	With fewer options, mismatch between deep preferences and action choices is more likely
Biased information or framing of choice options		lack of information about the negative impact of some lifestyle on health. Or biased perception of the value of adopting a lifestyle.	
Mental disorders	Patients' status in the society closes many choices options	Patients' disorder may cloud their understanding that some lifestyles are unhealthy	Patients' disorder may compromise their competencies (a) and (b)
Addiction	Patients socially identified as addicted may lose choice options (e.g., not be allowed to drive, or work)	Addiction clouds the fair evaluation of lifestyles and possible action pathways	Addiction usually impairs individual's competency (b), and possibly competency (a) as well

Intermediate conclusions

- **Patients are responsible for a health-risky lifestyle choice rather than for their actual sickness** (condition 1)

  → *I am not responsible for my lung cancer but for deciding to smoke (there is no perfect correlation between the two)*

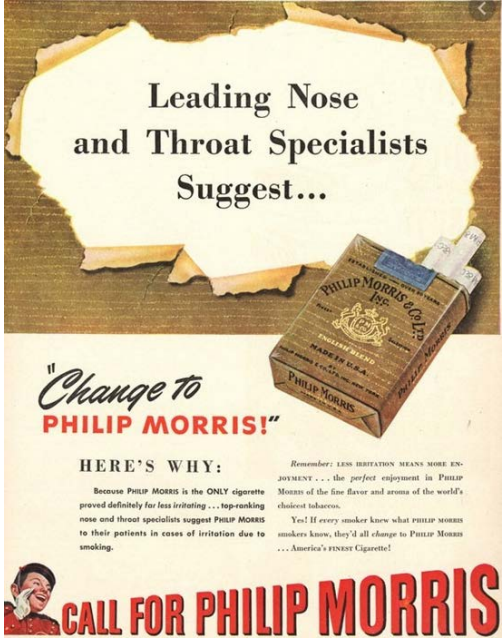
- **Practical responsibility is a matter of degree** (conditions 2–4 can be more or less fulfilled)
  - while assessing the extent of individual responsibility, it is important to consider all context-relevant limiting factors
  - the degree of practical responsibility may change during patients' life histories (e.g. before and after the installation of an addiction)
  - third parties' activities may decrease individual practical responsibility (e.g. advertising generating wrong beliefs)

Third parties' responsibilities

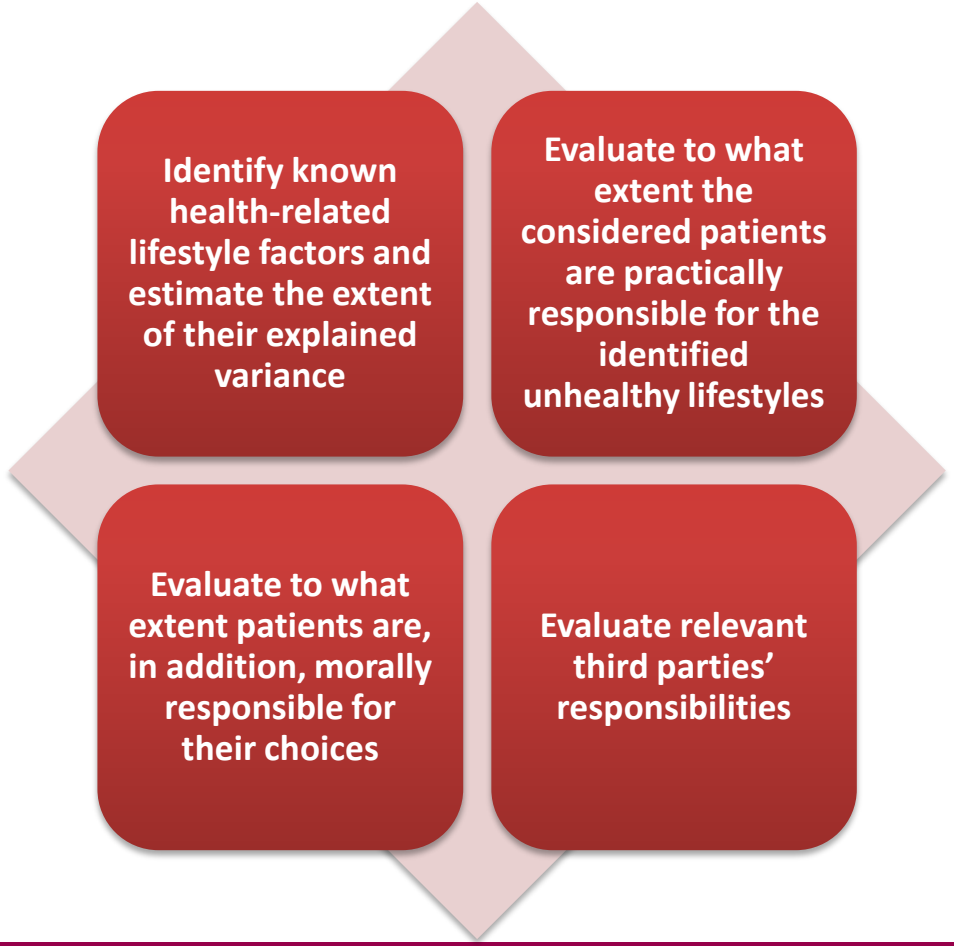
Third parties (e.g. individuals, private companies, public administration) that induce patients to opt for health-related lifestyles…

- **affect (decrease/increase) patients' responsibility**
- **generates new shared responsibilities**
  - This does not happen through a transfer of practical responsibility. When applied to multiple parties, practical responsibility is not zero-sum (as opposed to purely causal responsibility)
  - The impact of a third party's actions on patients' degree of responsibility and on its own degree of responsibility should be examined separately

Scientific knowledge about the effects of these limiting factors generates shared responsibilities



To sum up, objective individual responsibility attribution for one's disease involves a step procedure



From practical responsibility to punishement (decreased access to healthcare resources)

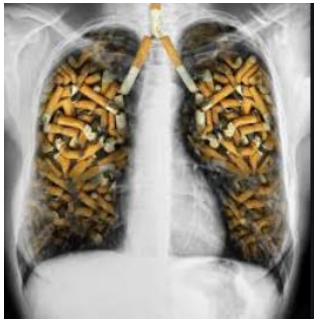
The responsibility attribution procedure may help in the task of evaluating roughly the degree of responsibility of a patient or group of patients.

However,

- **it does not help to decide the threshold above which one can confidently declare patients as 'significantly' or 'sufficiently' responsible**
- **it does not resolves the question of why undeserving sick patients should be punished in contrast to other lifestyle related illnesses** (physicians who catch infectious diseases, pregnancy, hockey playing, climbing, horse-riding)

→ what types of unhealthy lifestyles are blameworthy (and punishment-worthy)? Those that are socially condemned? But then, practical responsibility plays little role

The wrong logic



- people focus on the salient features of the unwanted situation: patients suffering from a socially stigmatized disease (e.g., alcoholism, compulsive eating behavior, smoking, addiction).

- By some sort of contagion mechanism, people attribute the stigma of immorality to the patients themselves.

- They then post-rationalize this evaluation by wrongly attributing to the patients the responsibility for their health condition (simply because they don't like these individuals).

- But since responsibility is attributed post-hoc as a means of justifying the punishment of already incriminated patients, it is done in an all-or-nothing manner which does not reflect the reality of partial and shared responsibilities.

Further difficulties

Suppose that it is possible to convincingly categorize an unhealthy behavior as morally blameworthy and to describe with some precision a class of undeserving sick patients who ‘sufficiently’ fulfil conditions 1-5.

lung cancer + regular smokers for at least 10 years + knew all along about the unhealthy character of smoking + made the decision to smoke as lucid adults + do not carry a genetic predisposition for cancer + have not yet shown clear signs of addiction (e.g., no previous failed attempts to quit smoking).

Further difficulties

- Who would determine whether an individual patient qualifies as an ‘undeserving sick,’?
  - Such an activity goes against medical deontology
  - Would hospital administrators, insurers, or other structures have (and interpret correctly) the most relevant information?

- How can we obtain relevant individual information for the evaluation?

- If a health-related risky behavior is deemed to be blameworthy, why should only those who become ill be sanctioned, as opposed to all those who engage in this behavior?

- Denying or constraining access to treatment would negatively impact the socio-economic status of the targeted patients.

Conclusions

- Patients suffering from stigmatized lifestyle related diseases are at risk of being disproportionately held responsible and sanctioned for their health conditions.
- Patient empowerment health policies targeting unhealthy lifestyles can increase unequal treatment of already vulnerable groups.
- Focusing on patients' responsibility make us overlook the importance of the shared responsibility of third parties including private companies and those determining policies that impact health