

Personal Responsibility and Health: A Public Health Perspective

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Abstract

Historically, many commentators and practitioners have seen bioethics as a field of study focused primarily on medical ethics; of practical moral questions that emerge in a health care context. However, both within and beyond a clinical setting, much is being learned from contemporary works within public health ethics. This presentation examines the ideas of responsibility and health, considering how these concepts might be differently understood in the context of public health, as contrasted with clinical, ethics. In particular, it explores what differences are found when we explain personal responsibility and health as features of theories of political morality, as opposed to theories of interpersonal ethics. It is argued that a public health perspective affords insights into ideas of rights and obligations that have direct pertinence in our claims about sound clinical ethics.

Overview

1. Medical Law and Ethics

- Individual Autonomy; 'Disabling Professions'/Empowering Patients

Phase 1. Bare liberties?

Phase 2. Making patients responsible too?

2. Public Health Ethics

- Social and Collective Goods; (De)Politicisation of Responsibility

Phase 1. Prioritising welfare?

Phase 2. Compulsion through 'non-coercive' means?

3. Political and Interpersonal Morality:

- **Consider the value in switching perspectives, and beyond that in expanding perspectives towards an overall political bioethics**

Central conceptions of responsibility

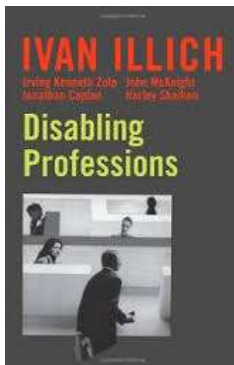
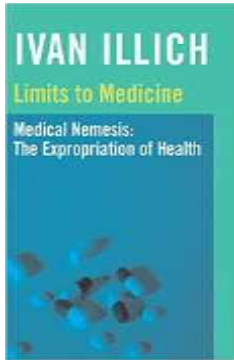
- 'Pure' moral responsibility:
 - More familiar within mainstream bioethical discourse
 - ➔ Relates to interpersonal obligations given particular moral theory
- Political responsibility
 - More overtly discussed in public health ethics
 - ➔ Relates to obligations owed:
 - By citizens and institutions
 - Enforced or encouraged through institutional mechanisms

Lessons to be learned from the relationships between, and tensions within, medical ethical- and public health ethics discourses

1: Medical Law and Ethics

'Disabling Professions' and Patient Empowerment

- Medical Law and Ethics as a response to:
 - Medicalisation
 - The 'expropriation of health'
 - Failure to recognise non-clinical components of medical decisions
 - Disempowerment of patients, disrespecting individual autonomy
- Philosophical argument having an impact on law and practice



Responsibility: Defending the Freedom to Fall

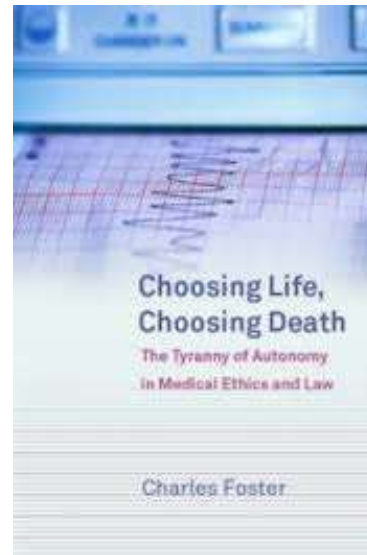
“One thing we can say with confidence is that ethical expertise is not ‘being better at being good’, rather it is being better at knowing the good and understanding what is likely to conduce to the good. The space between knowing the good and doing the good is a region entirely inhabited by freedom. Knowledge of the good is sufficiency to have stood, but freedom to fall, is all. **Without the freedom to fall, good cannot be a choice and freedom disappears and along with it virtue.** There is no virtue in doing what you must.”

- John Harris, *How to Be Good*, (OUP, 2016), p. 60.



Patient Autonomy: Freedom without Responsibility?

- Some arguments in health care law are argued to exhibit a near-absolute and unquestioning respect for individual autonomy



Cambridge Law Journal, 65(2), July 2006, pp. 397-422
Printed in Great Britain

DO NO HARM—DO PATIENTS HAVE RESPONSIBILITIES TOO?

MARGARET BRAZIER*

I. INTRODUCTION

TOWARDS the end of his judgment in *R. v. Collins and Ashworth Hospital Authority ex p. Brady*,¹ Kay J. (as he then was) delivered the following homily:²

... it would seem to me a matter of deep regret if the law has developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing.

The context of his remark was his rejection of Ian Brady's application for judicial review of Ashworth Hospital's decision to force-feed him, and break his hunger strike. Brady contended that he was mentally competent and retained the right to refuse to eat. Prior case-law had confirmed that a mentally competent prisoner cannot lawfully be force fed.³ Moreover, patients, detained under the Mental Health Act 1983 as Brady was, can in theory, only be



- Charles Foster, *Choosing Life, Choosing Death, The Tyranny of Autonomy in Medical Ethics and Law*, (Oxford: Hart, 2009)
- Margaret Brazier, “Do no harm—Do patients have responsibilities too?” *Cambridge Law Journal* (2006) 65:2, 397-422

Medical Decision-Making: A Shared Endeavour



Three components to responsible medical decision-making

1. The patient's values, beliefs, wishes, and feelings
2. The clinician's professional judgment
3. Public interest assessment on provision

➔ In some ways, patients' autonomy is (formally) broad, but it is far from a laissez-faire/demand-and-get system...

- John Coggon, "Mental Capacity Law, Autonomy, and Best Interests: An Argument for Conceptual and Practical Clarity in the Court of Protection"

2: Public Health Ethics

Public Health Ethics and Activity

- Population focus, and social coordination

See Marcel Verweij and Angus Dawson, “The Meaning of ‘Public’ in ‘Public Health’,” in Angus Dawson and Marcel Verweij (eds.), *Ethics, Prevention and Public Health* (Oxford University Press, 2007)

- Social coordination requires concepts familiar in law and regulation
- ‘Public health law’, at least in England, cannot be limited to ‘hard laws’:
 - The Health and Social Care Act 2012 introduced reforms delegating public health responsibilities to local authorities, and affords a great deal of discretion about priorities
- Governmental agenda places governance roles in the hands of local authorities and industry – “responsibility deal”



Health and Social
Care Act 2012

CHAPTER 7



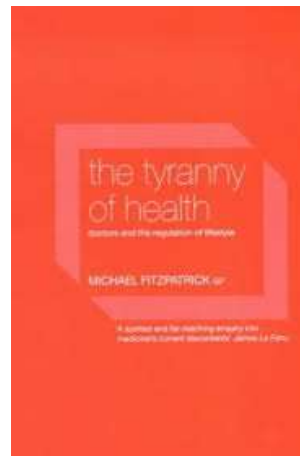
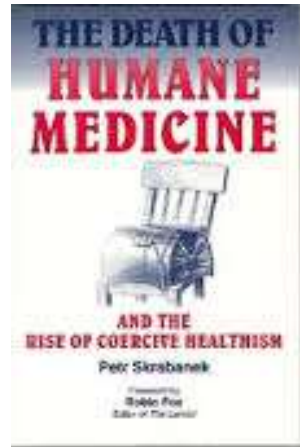
Public Health Ethics: Shared foundations with bioethics?

Contemporary public health ethics should not ignore historical debates in the field. See e.g. Petr Skrabanek

- Skrabanek discussed the phenomenon of ‘coercive healthism’ in a sustained critique of health promotion agendas, especially in the 1980s and early 1990s
- Building on Ivan Illich’s work, and leading into contemporary, ‘anti-health’ critiques – e.g. Michael Fitzpatrick

“The roads to unfreedom are many. Signposts on one of them bears the inscription HEALTH FOR ALL.”

- Petr Skrabanek, *The Death of Humane Medicine and the Rise of Coercive Healthism* (St Edmundsbury Press, 1994)



'Coercive Healthism'

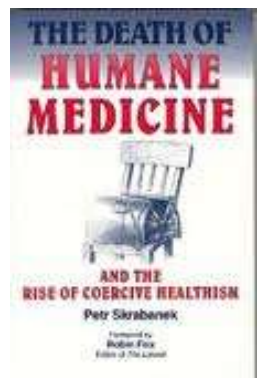
Petr Skrabanek:

- Not anti-medicine/anti-health care, but anti-health as a political goal:
- Health cannot be defined – and as a political value (right or left) is inherently dangerous

“Health, like love, beauty or happiness, is a metaphysical concept, which eludes all attempts at objectivisation. Healthy people do not think of health, unless they are hypochondriacs, which, strictly speaking, is not a sign of health. ... It is the absence of health that gives rise to dreaming about health, just as the real meaning of freedom is only experienced in prison.”

And health as a political ideology is “a symptom of political sickness.”

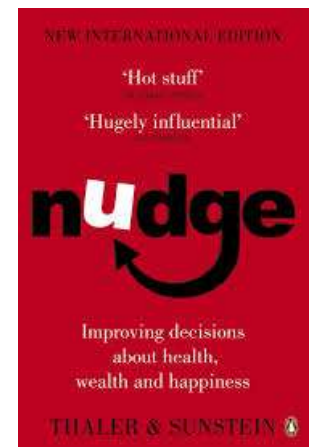
Skrabanek, *The Death of Humane Medicine*, p. 15



Coercion, Responsibility, and the Current Public Health Ethics

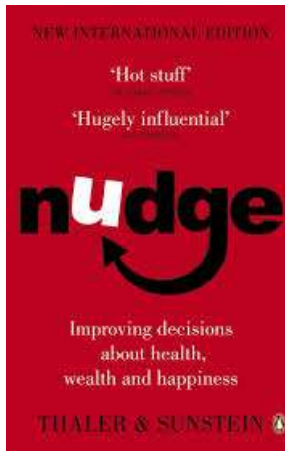
Nancy Kass, “Public Health Ethics: From Foundations and Frameworks to Justice and Global Public Health,” *Journal of Law, Medicine and Ethics* (2004) 32:2, 232-242

- Three phases
- Leading to a politicisation of responsibility?
 - Macro-level focus
 - Attention to ‘the population as patient’ (*cf* Gostin)
- Instructive to consider the vogue for *Nudge* in light of contemporary conceptual debates in legal philosophy regarding coercive measures and individual liberty



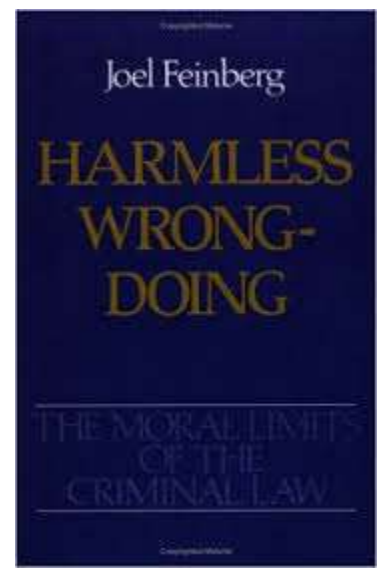
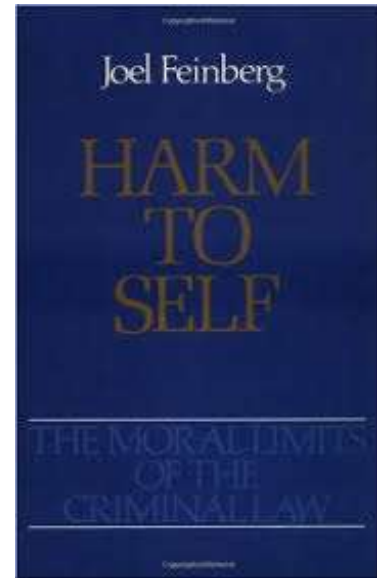
Does the Dominant Approach Make Public Health Responsibilities Just *Personal* Morality?

- Analytical distinction:
 - ethics *qua* interpersonal morality; ethics *qua* political morality
- The latter requires theories that accommodate State and other institutional actors
- Through ‘nudges’, including from private sector, any coordination—and associated responsibility—is not a moral concern because people remain free not to participate (?)



Legal Paternalism and Legal Moralism Debates: Highly influential on bioethics

- We are concerned with 'standard' questions regarding paternalism
- We are also concerned with legal moralism: the State promoting health *and* well-being
- How do we respond to the idea that the State should not be defining 'good' behaviour? (*cf* Feinberg, and bioethics broadly)
- In the 1980s (and to an extent now), legal and political theorists distinguish coercive measures (classically a rule/command backed by a sanction) and other modes of State control (with some even suggesting that only criminal coercion is a real moral concern)



So No (Moral) Political Responsibility?

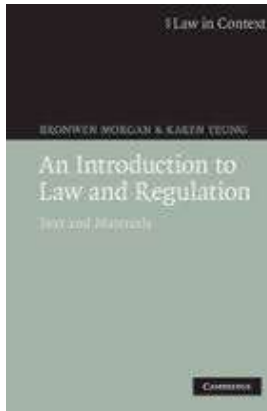
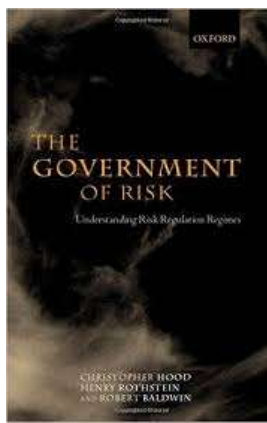
Consider defining features of *regulation* more widely conceived:

- Hood *et al.*: three components are common to regulatory systems:
 - they *set standards*;
 - they *gather information or monitor* the system;
 - and they have a role in *modifying behaviour*.

Christopher Hood, Henry Rothstein and Robert Baldwin, *The Government of Risk—Understanding risk regulation regimes* (Oxford: Oxford University Press 2001) 23

- “At their narrowest, definitions of regulation tend to centre on deliberate attempts by the state to influence socially valuable behaviour which may have adverse side-effects by establishing, monitoring and enforcing legal rules. At its broadest, regulation is seen as encompassing all forms of social control, whether intentional or not, and whether imposed by the state or other social institutions.”

Bronwen Morgan and Karen Yeung, *An Introduction to Law and Regulation: Text and Materials* (Cambridge: Cambridge University Press 2003), 3-4



Deeper Conceptual Insight on Coercion

And against questions of what coercion anyway is, consider Grant Lamond's analysis:

1. "coercive laws" = "parts of 'the law' [that] provide for the use of coercion"
2. "coercive institutions" = "agencies or officials charged with giving coercive effect to the law"

Each applies pressure to act in a particular way, but differently: one is "rational compulsion", the other "physical compulsion"

Grant Lamond, "The Coerciveness of Law," *Oxford Journal of Legal Studies* (2000) 20:1, 39-62

- Taking this forward → we are interested in the morality of the use of pressure (or **degrees** of compulsion) in modifying people's behaviour, and the legitimacy of that



3: Concluding Reflections on Responsibility in Clinical- and Public Health Ethics

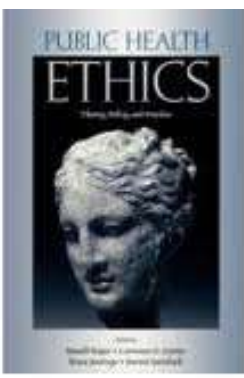
Clinical- and Public Health Ethics: Different Forms of Responsibility?

Learning from Public Health Ethics and Responsibility:

- On its face, in 'patient ethics', there is limited political responsibility imposed on patients
- Contrast patients' obligations in the NHS Constitution with the obligations of professionals and government
- Plus e.g. freedom to make 'irrational' and 'unreasoned' decisions
- But, moral relevance e.g. in:
 - Nudge-type mechanisms to meet obligations
 - Wider-constraints on decision-making (esp. clinical judgments and resource considerations)



Clinical- and Public Health Ethics: Different Forms of Responsibility?



But: Learning too in Public Health from Clinical Ethics and Responsibility:

- Fluidity of the concepts of public and governance/regulation?
 - Especially so when the government formally uses professionals and private actors as regulators
 - Nudge etc. agendas are not neutral; not apolitical/politically amoral (and are maybe not terribly effective!)
- Distinctions between (State) coercion *versus* allowing/encouraging?
- Overemphasis on health as a value?
- The idea of exceptionalising law (either positively, thinking it's 'special', or negatively, thinking 'it's not relevant to public health ethics') does not stand

Clinical- and Public Health Ethics: Different Forms of Responsibility?

- Conceptually, responsibility within clinical ethics and public health ethics may be seen as deriving from the same source
- Different practical emphases can allow an illusion of radical philosophical difference between clinical- and public health ethics
- Clinical ethics is strengthened when it is seen as part of **political bioethics**
 - A public health perspective can help...
 - ... but also needs to recognise the lessons learned in clinical ethics

I.e.: both Clinical- and Public Health Ethics do well to look at political morality more widely

