

Looking Forward: The Role of Personal Responsibility in Healthcare Prioritization

by

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Introduction

According to the United Network for Organ Sharing, there are currently 75,899 active candidates who are waiting to receive an organ transplant.¹ Twenty-two people, on average, die each day waiting for a transplant. These statistics demonstrate the large discrepancy between the demand for organs transplants and the amount of organs available to meet those demands. Instances of scarcity, such as this, inhibit healthcare providers' ability to provide care to all of their patients. As a result, healthcare providers are forced to make decisions about patients' eligibility and priority for receiving organ transplants to try to accommodate for the fact that it is not feasible for all patients to receive the care they need. Healthcare providers generally focus on the urgency of treatment and likelihood of successful transplants when considering eligibility for receiving transplants². For example, the Lung Allocation Score Calculator, a tool utilized to “estimate each lung candidates’ urgency and expected post-transplant survival rate relative to other patients on the waiting list for a lung transplant”, considers two separate factors: “waitlist urgency” and “post-transplant survival.” Respectively, these two factors are estimates of “the number of days a candidate is expected to live... if he or she does not receive a transplant” and “the number of days a candidate is expected to live... after receiving a lung transplant.”³

While these two factors dominate the discussion about eligibility for organ transplants, the large number of waitlisted patients has begun to initiate considerations of other factors when

¹ The United Network for Organ Sharing website has an updating tracker of the number of individuals who are currently active waiting list candidates. As of 12:34am on April 18th, 2017, the total consisted of 75,899 individuals. The link to this site is: <https://www.unos.org/data/>.

² The U.S. Government Information on Organ Donation and Transplantation has comprehensive lists that are utilized for consideration in different organ transplants. This website can be accessed at the following link: <https://organdonor.gov/about/process/matching.html>.

³ A version of the LAS calculator, can be found on the U.S. Dept. of Health & Human Services site: <https://optn.transplant.hrsa.gov/resources/allocation-calculators/las-calculator/>.

determining the eligibility of transplant recipients⁴. One of these factors is the patient's lifestyle choices and how those choices can or will affect a patient's health outcomes. This method of healthcare allocation is referred to as *personal responsibility* throughout the paper, and its focus is to prioritize patients based on whether their health outcomes were or could be affected by their own lifestyle choices.

The focus on unhealthy lifestyle choices is of growing importance in the medical field. In 2014, the top-three causes of death in the United States were heart disease, cancer, and chronic lower respiratory diseases.⁵ The Centers for Disease Control and Prevention (CDC) estimates that 34%, 21%, and 39%, respectively, of the deaths from these causes were “potentially preventable” in nature.⁶ The preventable nature of these diseases is in large part due to people's decisions to engage in unhealthy lifestyle choices which directly increase the risk of contracting these type of conditions.

The impact of unhealthy lifestyle choices is also substantial in patients who are actively waiting for organ transplants. For example, some of the individuals currently on the waitlist for liver transplants suffer from alcoholic liver disease (ALD). In these cases, considerations of personal responsibility would allow healthcare providers to prioritize patients based on the fact that their past behaviors did not cause their current health condition. This example demonstrates

⁴ For an example of how these programs have been implemented in the United States, see: Steinbrook, R. (2006). Imposing Personal Responsibility for Health. *N Engl J Med*, 355, 753-756, doi:10.1056/NEJMp068141

⁵ See The Centers for Disease Control and Protection's *Health, United States, 2015* Table 19 p. 107. This data can be found online at the following website: <https://www.cdc.gov/nchs/data/hus/15.pdf#019>.

⁶ A summary of the percentages and the reasons behind the “preventable” nature of the deaths can be found on the archived CDC cite “Up to 40 percent of annual deaths from each of five leading US casualties are preventable”. The site can be found at: <https://www.cdc.gov/media/releases/2014/p0501-preventable-deaths.html>. Data collected between 2008 and 2010 in the United States.

how appealing to personal responsibility would empower healthcare providers to make distinctions between patients when considering eligibility for limited resources. I focus a large portion of this paper to determining whether these distinctions are beneficial to both healthcare providers and patients.

While appealing to personal responsibility to prioritize patients has the potential to produce beneficial outcomes, ultimately the implementation of personal responsibility ends up being quite complicated. Considerations about moral agency and the circumstances that affect behaviors can limit the ability of healthcare providers to convincingly argue that an individual is responsible for their lifestyle choices. These concerns significantly limit the ability of healthcare providers to justifiably distinguish cases based on different levels of personal responsibility.

The goal of this paper will be to argue that prioritization based on personal responsibility ensures a more net-positive outcome than conceptions of prioritization that ignore personal responsibility entirely. This paper will focus on instances of scarcity in order to discuss situations where all patients cannot receive their required treatments. To achieve this goal, I will start by distinguishing between different components of personal responsibility and how those components can lead to more or less beneficial outcomes. Once I have sufficiently discussed these distinctions at length, I will move on to consider whether prioritizations that ignore personal responsibility are capable of producing more positive outcomes that result from prioritizations that consider personal responsibility and whether distinction based on responsibility are justified in healthcare. I will then shift my attention to dealing with complications of responsibility, especially environmental and genetic factors that impact people's ability to view someone as responsible for their actions. After coming to a conclusion about how to deal with these complications, I will offer recommendations

regarding how these theories of prioritization should be implemented in modern healthcare systems.

I: The Two Components of Personal Responsibility

A survey of adults in the United States measured people's preferences for allocating care in instances where patients are varying responsible for their poor health outcomes.⁷ One of the distributed survey questions involved two patients who were both in need of liver transplants; one of the individuals' liver disease was caused by years of drinking alcohol while the other had liver disease as a result of an inherited factor. For the purpose of our discussion, the individual whose liver disease was caused by drinking will be referred to as Patient X and the individual whose liver disease was the result of an inherited factor will be referred to as Patient Y. The results of this survey found that those who responded were 10 to 17 times more likely to allocate liver transplants to Patient Y than Patient X.⁸ Wittenberg concluded that the results of this survey demonstrated a preference among respondents to the survey to distinguish these cases based on whether a patient was personally responsible for their health conditions.

However, for the purpose of clarity, I wanted to determine whether people's justifications for prioritizing Patient Y was actually based on Patient X's blameworthiness for their illness.⁹ To do this, I created and distributed my own survey on a smaller scale that was focused on the prioritization of lung cancer treatments for patients with different smoking habits.¹⁰ As a way to

⁷ See Wittenberg, E., Goldie S. J., Fischhoff, B., Graham, J. D. (2003) Rationing Decisions and Individual Responsibility for Illness: Are All Lives Equal? *Medical Decision Making*, 23 (3), 194-211, doi:10.1177/0272989X03253647.

⁸ *Id.* 194

⁹ See *Id.* 200 for a list of respondents' given justifications for favoring the patient with the inherited disease. Of these responses, the three most common were "Alcoholism is voluntary", "Alcoholics are to blame/are responsible for their liver disease", and "Alcoholics will keep on drinking."

¹⁰ This survey was distributed to twenty-three individuals of varying ages, 16-70 years old, and varying education levels, current high school students to graduate degrees. Results were collected online using a Google Form. A copy of the distributed survey can be found in Appendix A.

control for other variables, I implemented specific guidelines on the patients' similarities and differences. Each question in the survey involved two patients who were identical twins that grow up in the same environment.¹¹ Each patient's ailment is said to be the same and the patient's time-frame for needing treatment is the same.¹² The only distinguishing factor in these cases is the patients' behaviors and how their actions or inactions have affected their health outcomes.¹³ Knowing this, the respondents had to determine how care should be allocated and how certain they were in their responses.¹⁴

Advocates of personal responsibility tend to focus on the fact that patients' past actions have impacted their health outcomes, which changes their priority of receiving care. However, I believe there is another component of personal responsibility: how future actions will impact health outcomes. Appealing to this component of personal responsibility, respondents could argue that Patient Y is also less likely to take up a future of excessive drinking. To test which component of personal responsibility is more influential on the prioritization of allocating care in these cases, I divided the negative behaviors associated with smoking into two distinct parts: the smoking that caused the lung cancer, and the likelihood that a patient will smoke after receiving treatment. The

¹¹ The reasoning behind this claim is that assuming similar genetic codes and environmental influences neutralizes the ability to distinguish the patients based on these factors that are known to have large impacts on behavior. (Hill 2005)

¹² The reasoning behind this claim is that it neutralizes the ability of the respondent to distinguish the patients based on the urgency or success rate of treating either patients' condition. This might have had an impact on the respondents' inclinations on allocating care based on the earlier discussion of eligibility for organ transplants.

¹³ While this is not explicitly explained in the survey, all those who responded have been exposed to the scientific studies that have demonstrated a causal linkage between smoking and an increased risk of lung cancer. For an example of this study, see
Khang, Y-H. (2015) The causality between smoking and lung cancer among groups and individuals: addressing issues in tobacco litigation in South Korea. *Epidemiology and Health*, 37, doi:10.4178/epih/e2015026

¹⁴ One of the options for determining allocation of care was "No preference (i.e. flip a coin to determine who gets treatment)". This option was meant to measure if the respondent felt both patients were equally deserving, or undeserving, of receiving care.

backward-looking component of personal responsibility is a patients' *blameworthiness for their illnesses*. In contrast, the forward-looking component of personal responsibility is a patients' *accountability for having healthy behaviors in the future*.¹⁵ Using these distinctions, I developed three examples that would attempt to identify the respondents' justification for prioritization: The Smoker vs. The Non-Smoker, The Smoker vs. The Smoker Who Quit, and The Smoker vs. The Changed Non-Smoker. I will elaborate on the results and conclusions of these examples in the following sections.

1. Healthcare Allocation Survey

1.1 Question 1: Smoker vs. Non-Smoker

In this first example, Patient A's lifetime smoking habits have caused their lung cancer. Patient B has lung cancer from an uncontrollable cause and has never smoked before. Of the twenty-three respondents, 52% strongly preferred giving care to Patient B while 35% hesitantly preferred giving care to Patient B.¹⁶ 13% said they had no preference in who received care, while none of the respondents felt Patient A should have their treatment prioritized.

The purpose of this example was to determine if prioritization of lung cancer treatments based on patients' smoking habits would reflect the findings of Wittenberg's survey. In this example, I make no stipulations about the patients' future smoking habits.¹⁷ This was purposefully done so that respondents could potentially argue for prioritization from either a forward-looking

¹⁵ These accounts correspond to the "Alcoholics are to blame/are responsible for their liver disease" and "Alcoholics will keep on drinking" justifications in Wittenberg et al.'s survey, respectively. (See Note 9).

¹⁶ For convenience, percentages were rounded to the nearest whole percent. A summary of all results are included in Appendix B.

¹⁷ The explicit wording of this question can be found in Appendix A.

or backward-looking conception of personal responsibility.¹⁸ Determining what aspect was more important for respondents was the purpose of the next two examples.

1.2 Question 2: Smoker vs. Smoker Who Quit

In this example, Patient A's lifetime smoking habits has caused their lung cancer, and it was clearly stated that Patient A never quit smoking and will continue to smoke even after they receive treatments. Patient B's lifetime smoking habits have also caused their lung cancer. However, Patient B quit smoking last year and will never smoke again. Of the twenty-three respondents, everyone felt that Patient B should be prioritized for treatments in this case, with 61% of respondents being strongly certain and 39% being hesitantly certain.

In the context of our accounts of backward-looking and forward-looking personal responsibility, this case is an example where the two patients are equally blameworthy for their lung cancer but have demonstrated different levels of accountability with regards to their post-treatment behaviors. Therefore, the distinguishing factor between the two patients, and thus the factor that all respondents used as the basis for determining which patient should receive treatment, is accountability, or forward-looking personal responsibility. We can therefore conclude that everyone who responded to the survey viewed accountability for future actions as a justifiable way to prioritize Patient B.

1.3 Question 3: Smoker vs. Changed Non-Smoker

In the final example, Patient A's lifetime smoking habits has caused their lung cancer, and it was clearly stated that Patient A never quit smoking and will continue to smoke even after they receive treatments. However, Patient B has never smoked and has developed lung cancer from

¹⁸ To argue that the life-long smoker was justifiably prioritized lower than the non-smoker from a forward-looking account of personal responsibility, the respondents would have to appeal to a justification, similar to what is seen in Wittenberg's survey, that life long smokers are more likely to keep smoking.

uncontrollable causes. However, the stress of developing lung cancer will cause Patient B to start smoking after and during their lung cancer treatments. Of the twenty-three respondents, 26% were hesitantly certain that Patient B should be prioritized while 9% of those who responded felt hesitantly certain that Patient A should be prioritized. Meanwhile, 65.0% of respondents had no preference in determining which patient received care.

In the context of the accounts of backward-looking and forward-looking personal responsibility, this case is an example where the two patients are demonstrating an equal disregard for their accountability to engage in healthy post-treatment behaviors but have different levels of blameworthiness for their illnesses. Therefore, the distinguishing factor that is the basis for determining which patient should be prioritized is blameworthiness, or backward-looking responsibility.

The mixed results of the respondents for this example seem to demonstrate that blameworthiness might not be as appealing as Wittenberg concluded. In this example, if blameworthiness was the primary consideration, respondents would have prioritized Patient B since their lung cancer was not the result of their own actions. However, the fact that the majority of respondents felt that Patient B should not be prioritized demonstrates that blameworthiness is not a compelling reason to prioritize Patient B over Patient A when blameworthiness isolated from considerations of accountability.

1.4 Results of the Survey

The purpose behind these thought experiments was to isolate the different justifications that people have for prioritizing who gets healthcare in instances of limited resources. In questions 2 and 3 of the survey, both patients engaged in the same behaviors with regards to either forward or backward-looking personal responsibility. For The Smoker vs. The Smoker Who Quit, both

patients engaged in unhealthy behaviors that made them blameworthy for their lung cancer, but the patients demonstrated different levels of accountability for their post-treatment behaviors. For The Smoker vs. The Changed Non-Smoker, both patients would have engaged in the same unhealthy post-treatment behaviors, but the patients had different levels of blameworthiness for their health outcomes. By holding different variables constant in these examples, I was able to isolate the stronger justification for prioritizing care: forward-looking personal responsibility.

In Wittenberg et al.'s survey, the blameworthiness justification for prioritizing Patient Y ("Alcoholics are to blame/are responsible for their liver disease") was more common than the accountability justification ("Alcoholics will keep drinking").¹⁹ This seems to contradict the results of the smoking thought experiments, which found that the accountability distinction led to a stronger preference for valuing healthy behaviors when determining healthcare prioritization. I believe that the disconnect between these surveys' results is caused by a misconception people have about their justifications for prioritizing personal responsibility. The first example, The Smoker vs. The Non-Smoker, is intended to demonstrate how we prioritize healthcare allocation to patients based on their personal responsibility for poor health outcomes. The justification for making this distinction in prioritization of receiving care seems intuitively based on the blameworthiness aspect of these two individuals' past decisions.²⁰ However, the fact that the respondents' opinions of this case more closely match the results of the accountability case, The Smoker vs. The Smoker Who Quit, and not the blameworthiness case, The Smoker vs. The Changed Non-Smoker, demonstrates that justifications are more likely based on an intrinsic, psychological connection that respondents make between blameworthiness for past actions and the

¹⁹ See Wittenberg et al., 200 for a list of given justifications for favoring patient with inherited disease.

²⁰ This was the conclusion of Wittenberg et al.'s article as well as the most common response for justifying this distinction from respondents to Wittenberg et al.'s survey.

likelihood of a lack of accountability for future actions. Once these two different forms of personal responsibility were separated from one another, it became clear that accountability was a stronger justification for prioritizing the non-smoker in the first example.

2. Justifications for Favoring Accountability Over Blameworthiness

While the results of these experiments demonstrate a tendency of the respondents to favor accountability, these results are not sufficient to convince someone that accountability is a better account than blameworthiness for prioritizing healthcare allocation. In this section, I will argue for the superiority of accountability based on three factors: patient motivation, the physician-patient relationship, and increased likelihood of successful health outcomes. Each will attempt to demonstrate why accountability-based prioritization leads to a more positive outcome than a blameworthiness-based method, and why the resulting positive outcomes are valuable for both healthcare providers and patients.

2.1 Patient Motivation

One of the potential benefits of personal responsibility in general is that it will dissuade individuals from engaging in unhealthy behaviors. Personal responsibility involves punishing individuals whose behaviors negatively impact their health, and enforcing this type of punishment could instill a societal wide incentive to engage in healthier behaviors. However, the ways in which backward-looking and forward-looking personal responsibility successfully motivate patients to engage in healthier behaviors is quite different. By distinguishing the results of these two models, I will attempt to demonstrate why the motivation to be accountable for future behaviors leads to healthier patients than the motivation to not be blameworthy.

When considering the impacts of a backward-looking personal responsibility based prioritization model on patients' behaviors, it is fairly straightforward to infer how prioritizing

patients based on blameworthiness would motivate people to engage in healthier behaviors. By implementing regulations that allowed healthcare providers to prioritize patients who are less blameworthy for their behavior, patients would be further incentivized to engage in behaviors that ensured they were not blameworthy for their poor health outcomes. For example, if healthcare providers in the United States implemented a rule that all liver transplant recipients could not have drunk alcohol at any point in their life, the intuition is that less people would drink alcohol to ensure that they are eligible for a potential liver transplant if they need one in the long-run. As a result, advocates for blameworthiness in personal responsibility could argue that such regulations would motivate people to engage in healthier behavior.

However, a problem that arises from this depiction of personal responsibility as blameworthiness is that such regulations offer no method of motivation for individuals who have already engaged in unhealthy behaviors.²¹ Consider *The Smoker vs. The Smoker Who Quit* example. Implementing regulations that focus on blameworthiness cannot motivate the life-long smoker, Patient A, to quit smoking. This conception of personal responsibility has already determined that Patient A is blameworthy for their lung cancer, and as a result, it offers no way for Patient A to redeem his lost priority for receiving lung cancer treatments.

This is where accountability demonstrates its superiority to blameworthiness as a method of motivation. If we continue focusing on *The Smoker vs. The Smoker Who Quit*, accountability based personal responsibility prioritizes patients based on the likelihood that they will engage in unhealthy behaviors in the future. This offers an incentive for Patient A to quit smoking in the hopes that healthcare providers would be assured that their behaviors will not remain unhealthy after receiving treatments. This emphasis on future actions instills a constant motivating factor

²¹ Engaging in unhealthy behaviors can stem from both past indifferences to the backward-looking regulations or engaging in these behaviors prior to the implementation of such guidelines.

that engaging in healthy behaviors will result in higher prioritization of healthcare resources, even if past unhealthy lifestyle choices have led to poor health outcomes.

A potential objection to accountability based prioritizations is that its forgivingness toward individuals who engage in unhealthy behaviors would sufficiently dissuade people from engaging in such behaviors. However, this objection can be refuted by considering how forward-looking personal responsibility would calculate the likelihood that an individual will engage in healthy behaviors in the future. In a model based on accountability, the primary concern for healthcare providers would be the likelihood that a patient engages in healthy behaviors post-treatment. For example, if a patient with a history of smoking needs lung cancer treatments, the healthcare provider can prioritize the eligibility of this patient based on how likely it is that the patient changes their behavior and quits smoking. However, the fact that the patient is currently smoking increases the expected likelihood that the patient will continue smoking in the future. In this way, accountability motivates unhealthy patients to engage in healthier behaviors. It also motivates healthy individuals to maintain their habits so that healthcare providers are less inclined to doubt that the patient will engage in healthy post-treatment behaviors. Therefore, accountability can motivate both individuals who have never smoked and life-time smokers to not smoke, a feature that makes it distinct from the methods of motivation gained by pursuing blameworthiness.

Implementing accountability based healthcare prioritization results in encouraging patients to engage in healthier behavior and rewarding them for their healthy behavior through a higher prioritization of healthcare allocation. This will improve the overall health of society, which would

be an intrinsically and instrumentally beneficial outcome.²² For healthcare providers, the increased capacity to motivate healthy behaviors would lead to higher rates of compliance among patients.

2.2 Physician-Patient Relationship

Another potential impact of personal responsibility based prioritization is that it can have an effect on the relationship between healthcare providers (especially physicians and nurses) and patients. Research shows that when physicians and patients have a trusting relationship, healthcare costs are lowered and patient satisfaction is increased.²³ (Rosser 2001) The trust between patients and healthcare providers can deteriorate if the patient feels the need to lie to their healthcare provider about their own behaviors. This is a potential consequence of personal responsibility. If patients know that physicians consider blameworthiness when prioritizing treatments, the patient could be motivated to lie to the physician to receive higher levels of prioritization. As a result of patients lying, physicians will receive inaccurate accounts of their patients' medical information. This will make prescribing correct treatments more difficult, resulting in worse outcomes for the patient.

Another aspect of this break in trust between physicians and patients is that patients' sense of self-worth can be diminished. In Jacobson's *Dignity & Health*, there are testimonies of patients feeling "diminished" when they cannot be themselves and must lie to physicians in order to get their desired treatments.²⁴ If patients know that physicians are prioritizing them based on unhealthy behaviors, interactions with doctors could begin to feel like interrogations. When patients are

²² An example of these benefits could be described by the increased quality of life by being healthier (intrinsic) and the increased opportunities to pursue other interests as a result of not having to deal with as many crippling conditions (instrumental).

²³ See Rosser, W. W. (2001) The Benefits of a Trusting Physician-Patient Relationship, *J Fam Pract.*, 50 (4), 329-330.

²⁴ Jacobson, N. (2012) *Dignity and Health*. Nashville, Tennessee: *Vanderbilt University Press*.

forced to lie to physicians about their health behaviors, they are reminded of their inability to quit their unhealthy behaviors, reinforcing feelings of despair and helplessness.²⁵ These interactions can increase stress levels, which can correlate to a stronger tendency to indulge unhealthy habits. In this way, backward-looking personal responsibility can put unhealthy, counterproductive levels of stress on patients while also damaging a physician's ability to have a trusting relationship with patients.

However, accountability methods of prioritization do a much better job of empowering patients to be open about their behaviors. As described in the prior section, forward-looking responsibility focuses on a patients' capacity to be healthier in the future, not their tendency to have engaged in unhealthy behaviors in the past. The focus on accountability encourages people who are serious about changing their behaviors to talk to their physicians candidly about their behaviors so that they can get the necessary resources. This will improve health outcomes, since physicians will be better informed about their patients' behaviors and can utilize this information to help the patients change their behaviors if needed. In addition, focusing on future outcomes will reinforce the idea that physicians are there to help patients be as healthy as possible. As a result, the trust between physicians and patients will be strengthened. As I have already discussed, this will have a positive impact on patient and healthcare provider satisfaction.

2.3 Likelihood of Successful Health Outcomes Post-Treatment

Perhaps the most important way that forward-looking and backward-looking personal responsibility differ is the way that accountability considerations lead to a higher frequency of successful health outcomes. Backward-looking personal responsibility does not allow healthcare

²⁵ Shors, T.J., Weiss, C., & Thompson, R.F. (1992) Stress-Induced Facilitation of Classical Conditioning, *Science*, 257 (5069), 537-539.

providers to distinguish cases based on how patients will act post-treatment. As demonstrated in *The Smoker vs. The Smoker Who Quit*, this distinction can have a large impact on how we intuitively view prioritization in these cases, but it also directly affects the outcomes of patients. Failing to consider the behaviors that occur post-treatment results in ignoring the likelihood of future complications. Forward-looking responsibility, in contrast, focuses on future actions. This results in better measurements of how successful a treatment will be based on the patients' willingness to engage in healthy post-treatment behaviors. This will be beneficial for healthcare providers because they can make sure that their limited resources are being utilized on cases with a higher probability of success. It will also be better for patients because of the improved health outcomes that result from the emphasis on post-treatment behaviors.

At this point, I would like to acknowledge a potentially troubling distinction between forward and backward-looking personal responsibility. Given the focus of accountability for future actions, forward-looking personal responsibility is basing its prioritization of care on factors that are inevitably uncertain in nature. There is no method of determining with one-hundred percent accuracy what a patient will do after receiving treatments. In contrast, there are ways to determine what a person has done in the past. This could be problematic for both healthcare providers and patients. Healthcare providers could be frustrated by the difficulty of determining what actions a patient will do in the future and potentially dislike having the responsibility of making judgments of a patients' character and willingness to engage in healthy post-treatment behaviors. For patients, being told that prioritization of precious resources can be determined by the perceived likelihood of engaging in future behaviors would seem arbitrary and unfair.

A way to deal with this concern is to bring up the distinction between accountability and blameworthiness in a different context: the risk analysis involved in giving out loans. For

investment bankers, it seems most beneficial for them to prioritize loan recipients based on the perception that they will be a good investment going forward. While this perception is based on an uncertainty, it can be informed by different factors, such as the past behavior of this loan recipient and whether they have paid back their loans on time before. If we consider the distribution of loans as a metaphor for providing care, it seems that we have an adept way to argue that accountability concerns should be of greater importance to healthcare providers. Ensuring that their resources are utilized on cases with high likelihoods of success is important, especially given that there is a scarcity of the provided resources. Prioritizing patients based on accountability for future actions allows healthcare providers to ensure that their limited resources are given to patients who will have the highest likelihood of successful outcomes.

There is another implication of this line of thought. Forward-looking personal responsibility is focused on the likelihood of successful outcomes. As a result, accountability should consider all post-treatment behaviors that affect the likelihood of successful outcomes. Therefore, even actions that could not be blameworthy for the specific health condition are worthy of consideration in forward-looking personal responsibility. For example, consider an individual who smokes who broke their arm. One account of forward-looking responsibility would argue that prioritization of this person's treatment would be based on the likelihood of them engaging in activities that put them at risk to break their arm again.²⁶ In this way, forward-looking personal responsibility increases the likelihood that the patient heals properly and does not break their arm again. However, another factor that influences bone healing is tobacco usage. Therefore, forward-looking personal responsibility should also prioritize the allocation of casts based on the patients'

²⁶ In this case, the assumption is that casts are a limited resource and cannot be distributed to all individuals who break their arms.

willingness to change all behaviors that impact health outcomes, not just the actions that caused the health condition in the first place.²⁷

3. Objections Based on the Arbitrariness of Time in Determining Personal Responsibility

Before moving forward with this conception of forward-looking personal responsibility, it is important to consider a potentially damaging objection about the nature of distinguishing actions that occurred in the past and those that will occur in the future. A distinguishing factor between forward and backward-looking personal responsibility is the type of actions that are considered relevant to prioritizing healthcare allocation. In one example it is whether or not the patient has smoked and in the other it is whether or not the patient will smoke. This seems counterintuitive to certain views of responsibility, since the action is the same in both instances.²⁸ The only thing that is different is the time of the action occurring relative to the allocation of care. As Albertsen puts it, this distinction between forward and backward-looking personal responsibility results in a depiction of responsibility that “passes vastly different judgments on identical situations.”

However, I argue that Albertsen’s critique of Feiring does not transfer to my conception of forward-looking personal responsibility. Feiring’s conception of forward-looking responsibility depends, in large part, upon the claim that past actions should in no way impact our prioritization of care.²⁹ (Feiring 2008) I do not believe that this claim is justified. My conception of forward-looking personal responsibility is based on the perceived likelihood of engaging in healthy outcomes in the future. The calculation of this potential likelihood should and would be influenced

²⁷ Albertsen, A. (2015) Feiring’s concept of forward-looking responsibility: a dead end for responsibility in healthcare, *J. Med. Ethics*, 41, 161-164, doi:10.1136/medethics/2013-101563

²⁸ *Id.* 163.

²⁹ This is based on the difficulty of separating past actions from the circumstances that surround decision making, a difficulty that Feiring argues does not apply to future actions. The grounds for this argument will be discussed in greater detail in chapter III of this paper.

by a patients' past behaviors, especially if the patient has a history of breaking promises about their future behaviors.

To demonstrate the feasibility of this argument, let us consider a liver transplant candidate. This person has a history of alcoholism that directly led to their need for receiving a liver transplant. The healthcare providers responsible for determining prioritization in this example have determined that the patient is a good candidate for a liver transplant given their recent enrollment in Alcoholics Anonymous and their seriousness about becoming sober. However, one year after the transplant, the patient begins to experience liver complications. The healthcare provider discovers that these are the result of more alcoholic drinking, as the patient stopped being sober only weeks after receiving their transplant. This patient should now be considered lower priority than before because they have demonstrated a willingness to break promises about future behaviors and this increases the perceived likelihood that this behavior will repeat itself. In this way, both past and future behaviors can influence the perceived likelihood of engaging in healthy post-treatment behaviors. Therefore, there is no arbitrary distinction between actions based on time since all behaviors are considered in the context of how behaviors affect the likelihood that the patient will be healthy going forward.

4. Conclusion

At the beginning of this chapter, I set out to distinguish between two different components of personal responsibility and determine which one was better suited for considering priority of patients in allocation of limited healthcare resources. By distributing my own survey, I demonstrated that blameworthiness was not the strongest justification for prioritization based on personal responsibility. I then set out to argue normatively why the consequences that resulted from a forward-looking personal responsibility model were more beneficial to both patients and

healthcare providers than a backward-looking personal responsibility model. In conclusion, I have demonstrated that appeals to personal responsibility as a method of prioritization should focus on forward-looking behaviors as compared to backward-looking ones.

II: Justifications for Prioritizing Healthcare Allocation

Now that I have demonstrated the benefits of implementing forward-looking personal responsibility, I will attempt to determine whether implementing these principles is compatible with our conceptions of health needs, healthcare, and healthcare providers. Specifically, I will address arguments that believe that personal responsibility violates the human right to healthcare.

³⁰ In addition, I will discuss Elizabeth Anderson's "goals of egalitarianism" and how forward-looking personal responsibility does or does not meet these goals.³¹ Overall, the justification for forward-looking personal responsibility will rely on accounts of just prioritizations of healthcare, especially as they are described in Daniels' *Just Health*.³²

1. Human Right to Healthcare

For a definition of the human right to healthcare, I will use the definition provided by Yvonne Denier. According to Denier, "there is a collective [stringent] moral obligation to ensure that everyone has access to some level of healthcare services...and access to healthcare is owed to those who have that right...because they are human."³³ Proponents of this definition of healthcare generally argue against healthcare access being contingent on other factors, such as a patients' accountability for future actions. One advocate for the human right to healthcare who is strictly opposed to personal responsibility is Lasse Nielsen. I will analyze and attempt to refute his conclusions in the next section.

³⁰ Nielsen, L. (2013) Taking health needs seriously: against a luck egalitarian approach to justice in health, *Med Health Care and Philos*, 16, 407-416. doi:10.1007/s11018012-9399-3

³¹ Anderson, E. S. (1999) What is the Point of Equality? *Ethics*, 109 (2), 287-337.

³² Daniels, N. (2008) *Just Health Meeting Health Needs Fairly*, New York, New York, *Cambridge University Press*.

³³ Denier, Y. (2005) On Personal Responsibility and the Human Right to Healthcare, *Cambridge Quarterly of Healthcare Ethics*, 14, 224-234.

1.1 Lasse Nielsen's Account of Healthcare

According to Lasse Nielsen, considerations of personal responsibility are not justifiable since healthcare is a basic human entitlement.³⁴ As such, healthcare providers cannot take away a person's right to healthcare since it is guaranteed to them based on their intrinsic value as humans, not based on whether they deserve receiving treatments. Nielsen acknowledges that this guarantee means that responsibility should not be considered even in cases where all other factors are equal. In other words, Nielsen would have selected "No Preference" for all of the questions on the Health Allocation Survey since his conception of healthcare is that it should not be contingent on responsibility-based factors.

However, a pitfall of this line of thought is that there are already factors that affect prioritization of receiving care, specifically urgency of care and the likelihood of successful outcomes. Nielsen spends a large portion of this paper discussing considerations of urgency. Specifically, he argues that models of healthcare allocation should be able to prioritize patients base on the urgency of their treatments.³⁵ Therefore, Nielsen would have to agree that urgency is a reasonable justification for prioritization of healthcare. Once this has been established, the question is not whether people can have their right to healthcare prioritized higher or lower than other people, it is whether forward-looking personal responsibility qualifies as a reasonable justification for prioritization.

³⁴ Nielsen, 415.

³⁵ Nielsen, 410.

1.2 Nielsen and Scarcity

At this point, it could be useful to consider a key distinction between inequalities in health and inequalities in healthcare.³⁶ (Albertson & Knight 2015) As defined by Albertson and Knight, health inequalities are concerned with how health outcomes are distributed whereas healthcare inequalities are concerned with how healthcare access is distributed. Nielsen's claim that healthcare access is a basic human right is primarily focused on inequalities in healthcare access. The justification for focusing on healthcare access seems to be based on the relatively greater control societies can have over the distribution of healthcare as compared to the distribution of health outcomes. In most instances, this is an accurate assessment. However, in the instances of scarcity that have been discussed thus far, societies cannot guarantee equal access to healthcare since healthcare resources are limited. This allows for consequentialist considerations to be utilized as a way of prioritizing different patients. As such, the positive outcomes that result from forward-looking personal responsibility can justify distinguishing between patients where all other factors are equal.³⁷ In this way, forward-looking responsibility is more beneficial to the society's health needs than not distinguishing between the patients, as Nielsen advocates. This demonstrates that focusing on healthcare access, the primary concern of healthcare as a basic human right, does not lead to the positive outcomes that result from considerations of forward-looking personal responsibility in healthcare prioritization.

³⁶ Albertson, A., & Knight, C. (2015), A framework for luck egalitarianism in health and healthcare, *J Med Ethics*, 41, 165-169.

³⁷ Discussion of these benefits were included in chapter I, section 2.

2. Anderson's Democratic Equality

Luck egalitarianism is a theory of justice that focuses on the unequal distribution of 'bad luck'.³⁸ Luck egalitarianism focuses extensively on people's responsibilities for the inequalities they experience. These are said to be inequalities that arise from personal responsibility, and are allowed in this system of egalitarian justice. Given the emphasis on personal responsibility, it is likely that the forward-looking personal responsibility model would be associated with luck egalitarianism. In order to avoid the pitfalls of luck egalitarianism, it is important to distinguish between the failures of luck egalitarianism and why these objections do or do not apply to the forward-looking personal responsibility model.

In *What is the Point of Equality?*, Elizabeth Anderson argues that luck egalitarianism fails to accomplish the two primary goals of egalitarian justice: to ensure the absence of oppression and create a society in which all members are viewed as equals.³⁹ She then argues for her own form of egalitarian justice, called "Democratic equality", that ensures that the two primary goals of egalitarian justice are met.

I will consider what the goals of egalitarian justice guarantee in instances of healthcare prioritization. According to Anderson, egalitarian justice, when applied to healthcare prioritization, should ensure that patients are empowered to be viewed as equals. What does this equality guarantee? Given the inevitable condition that some patients will not receive treatment, this equality cannot guarantee equal access to care. However, it can guarantee that all patients have a right to be considered equally. At first glance, this guarantee could advocate for a form of prioritization that would respond "No preference" to all the questions in the Healthcare Allocation

³⁸ Anderson, 289.

³⁹ Anderson, 288-289.

Survey. However, considering “patients equally” implies that the judgments for prioritization are based on criteria that apply equally to all patients. At this point, I will analyze the objections that Anderson raises against luck egalitarianism to determine if similar objections can be said to apply to forward-looking personal responsibility.

2.1 Anderson’s Problems with Luck Egalitarianism

Andersons argues that there are three ways that luck egalitarianism fails to realize the two primary goals of egalitarian justice. The first objection is that luck egalitarianism “excludes some citizens from enjoying the social conditions of freedom on the spurious ground that it’s their fault for losing them.”⁴⁰ This objection is quite relevant to the backward-looking model of personal responsibility in healthcare.⁴¹ However, an appealing feature of forward-looking personal responsibility is that no patients are ever excluded from consideration. The basis of forward-looking personal responsibility, the likelihood of patients engaging in healthy post-treatment behaviors, never justifies excluding an individual from considerations of accessing resources. In this way, the social conditions of freedom are not taken away from any patients. While patients can be prioritized according to their accountability for post-treatment actions, there is no basis for excluding patients from consideration for accessing healthcare.

The second objection is that luck egalitarianism “makes the basis for citizens’ claims...the fact that some are inferior to others in the worth of their lives.”⁴⁷ Since the basis of luck egalitarianism is implementing reparations for victims of “bad luck”, it makes sense why Anderson makes this objection for luck egalitarianism. However, I argue that this objection does not apply to forward-looking personal responsibility. The basis for citizens’ claims in forward-looking

⁴⁰ Anderson, 289

⁴¹ See discussion of motivation for individuals who have already engaged in unhealthy behaviors in chapter I, section 2.1.

personal responsibility is not redistributing goods from the lucky to the unfortunate. The basis of claims in forward-looking personal responsibility is the right to be prioritized based on a demonstrated willingness to engage in healthy post-treatment behaviors. However, these claims to prioritization are claims to be prioritized over those who will not engage in healthy post-treatment behaviors. This could be said to be based on the superiority of individuals, a serious problem for Anderson's goals of egalitarian justice. However, Anderson acknowledges that Democratic equality promotes individual responsibility by requiring that "Individuals still have to exercise responsible agency to achieve most of the functionings effective access to which society guarantees."⁴² In this way, egalitarian justice allows for societal guarantees to be "conditioned on responsible performance of one's duties." Therefore, forward-looking personal responsibility does not break the requirements of egalitarian justice in this sense.

Anderson's final objection to luck egalitarianism is that the model, "in attempting to ensure that people take responsibility for their choices, makes demeaning and intrusive judgments of people's capacities to exercise responsibility and effectively dictates to them the appropriate uses of their freedom."⁴⁷ This seems to be the most damaging objection for forward-looking personal responsibility. The basis of valuing post-treatment behaviors seems to qualify as regulating the appropriate use of patients' freedom. The way to counter this objection by Anderson is to claim that since healthcare prioritization concerns a limited, public good, there can be certain conditions of the reception of treatments. In this way, healthcare providers are entitled to implement conditional requirements for receiving limited resources using a similar justification that was utilized for Anderson's second objection to luck egalitarianism. In this way, denying access to

⁴² Anderson, 328.

certain societal guarantees is justified in instances where individuals do not fulfill performance of their duties.

While it is difficult to determine if forward-looking personal responsibility is unaffected by Anderson's objections to luck egalitarianism, it is true that the forward-looking personal responsibility model of healthcare prioritization is better than luck egalitarianism at ensuring the goals of egalitarian justice. As such, forward-looking personal responsibility can be said to value viewing all patients as equals.

2.2 Prioritization and The Abandonment Problem

Another interesting objection Anderson has against luck egalitarianism is its "problem of abandonment of negligent victims."⁴³ At this point, I will attempt to apply this example to a model of forward-looking personal responsibility. From this example, it will be determined if the "abandonment example" demonstrates a flaw in forward-looking personal responsibility.

I will create an example, called the pseudo-abandonment example, that demonstrates how the "abandonment of negligent victims" is applied to considerations of post-treatment behaviors. In this hypothetical scenario, a reckless driver has gotten into a life-threatening accident. Upon arrival in the hospital, the healthcare providers are presented a note that was written by the reckless driver. It professes the driver's intention to continue getting into accidents even if they fully recover from the hospitals' treatments. In this case, forward-looking personal responsibility would advocate for abandoning the reckless driver based on the fact that they will not engage in healthy post-treatment behaviors. It will be granted that this is a bad outcome, since abandonment of patients seems unethical provided *that it is possible to provide treatments*.

⁴³ Anderson, 296.

However, a condition that has been articulated throughout this paper is that forward-looking personal responsibility is intended to help with healthcare prioritization, not determine allocation on a broader scale. For the pseudo-abandonment example to apply to forward-looking personal responsibility, there must be another driver that has a higher likelihood of engaging in safe post-treatment behaviors AND it must be impossible to save both this driver and the reckless driver. In this situation, forward-looking personal responsibility would advocate for prioritizing the second driver receiving treatment. At this point, however, I wonder if Anderson would still consider this a problem? These instances of prioritization necessarily require that a patient would be abandoned. Forward-looking personal responsibility allows healthcare providers to prioritize the second patient; it does not allow healthcare providers to abandon the reckless driver when they are capable of saving both drivers.

3. Norman Daniels' Account of Health

At this point I would like to dedicate some thought to Norman Daniels' *Just Health*. Daniels does extensive work that is beneficial to the argument in favor of forward-looking personal responsibility. In his book, Daniels considers three main Focal Questions: "Is health, and therefore health care and other factors that affect health, of special moral importance?", "When are health inequalities unjust?", and "How can we meet health needs fairly under resource constraints?"⁴⁴ Of these three questions, the first and third will be the primary focus of this discussion. After explaining the basis of Daniels' claims, I will attempt to demonstrate how each argument fits into the context of this discussion on forward-looking personal responsibility.

⁴⁴ Daniels, 11-12

3.1 Moral Importance of Health

To begin his discussion on the importance of health, Daniels lays out a detailed definition of health needs as “things we need in order to maintain, restore, or provide function equivalents to (where possible) normal species functioning.”⁴⁵ This list of health needs includes: adequate nutrition, sanitary and safe living and work conditions, exercise rest and such important lifestyle choices, preventative curative restorative and compensatory medical services, nonmedical personal and social support services, and an appropriate distribution of other social determinants of health. The importance of these services relies on the “normal species functioning” aspect of Daniels’ argument.

According to Daniels, the justification for the special moral importance of health and normal species functioning can be separated into intrinsic and instrumental considerations. Daniels acknowledges that being able to function properly and being healthy promote happiness and reduce suffering, which could conclusively argue for the importance of health from a utilitarian perspective.⁴⁶ However, Daniels believes that the more compelling justification for the special moral importance of health stems from the instrumental benefits that health promotes, the same benefits that are lost when someone does not have their health needs met. Daniels argues that impairments to our health inhibit our ability to exercise our freedom of opportunity, which is a key trait of “normal species functioning.”

Daniels then connects the normal species functioning and freedom of opportunity to various accounts of justice, especially Rawls’ conception of “justice as fairness”, that emphasize the importance of the freedom of opportunities. As a result, Daniels normatively argues that

⁴⁵ Daniels, 42

⁴⁶ Daniels, 35

accounts of justice that value freedom of opportunity must also value the special moral importance of health needs given the causative relation between having health needs met and being able to exercise freedom of opportunity.

“In the name of freedom of opportunity, society should continue to be forward-looking, both in providing incentives to avoid hazardous behavior and in offering medical help.”⁴⁷ From Daniels’ conception of the importance of health, as well as Denier’s quote about the importance of freedom of opportunity, I will reiterate the legitimacy of basing prioritizations on forward-looking personal responsibility. Daniels’ account on the moral importance of health is primarily focused on the future opportunities that can be lost as a result of not having health needs met. This emphasis on healthcare as a way to guarantee future opportunities seems to parallel the emphasis of forward-looking personal responsibility on the likelihood of patients engaging in healthy post-treatment behaviors. If we are to believe Daniels and claim that meeting health needs is of special moral importance as a result of the instrumental increase in freedom of opportunity, then meeting the health needs of individuals who choose to discard their freedom of opportunity (by engaging in unhealthy post-treatment behaviors) might not qualify as a morally important obligation. Therefore, prioritizing allocation of healthcare resources based on the increase in the respective patient’s freedom of opportunity seems perfectly in line with Daniels’ conception of health. As such, it seems justifiable for healthcare providers to prioritize patients based on forward-looking personal responsibility.

3.2 Accountability for Reasonableness

To answer his third focal question, Daniels focuses primarily on the conditions that healthcare providers and other legitimate regulators of healthcare allocations must follow. These

⁴⁷ Denier, 232

conditions guarantee that there is a fair process to deal with limit setting and scarcity. Daniels begins the discussion by considering the difficulty of determining universal guidelines that are preferable in all instances. Specifically, Daniels discusses the conflicts between treating the worst off and treating those whose treatments result in the greatest net health benefit per dollar spent. Arguments in favor of these two positions in different circumstances demonstrate a central part of Daniels argument: that guidelines that are utilized to determine distribution of care in instances of scarcity and limit setting are based on “value judgments about which reasonable people can disagree.”⁴⁸

Since Daniels acknowledges the controversial nature of these distinctions, he sets out to define certain conditions that must be met by morally legitimate entities, such as healthcare providers, in order to ensure that distinctions are the result of a fair processes. These conditions are listed as follows: the Publicity Condition, the Relevance Condition, the Revision and Appeals Condition, and the Regulative Condition.⁴⁹

Explicit requirements for meeting all these conditions are defined in Daniels’ book. However, I will focus my discussion primarily on The Relevance Condition. A shared trait of The Publicity, Revision and Appeals, and Regulative Conditions is that they all focus on the implementation of prioritization measures, specifically how the general populace is informed and can influence these distinctions. For our conception of forward-looking personal responsibility, it can be assumed that all of these conditions can be met by considering the conditions and implementing regulations in accordance with these conditions. However, the importance of the Relevance Condition is that if forward-looking personal responsibility does not meet the

⁴⁸ Daniels, 105

⁴⁹ Daniels, 118-119

requirements of this condition, it is not salvageable as a fair process according to Daniels. With this assumption, I will explain the requirements of meeting the Relevance Condition and determine whether or not the conception of forward-looking personal responsibility meets these requirements.

3.3 The Relevance Condition

In Daniels' assessment of the Relevance Condition, he determines that "limit setting decisions should aim to provide a reasonable explanation of how the organization seeks to provide 'value for money' in meeting the varied health needs...under reasonable constraints"⁵⁰ In his more in depth evaluation, Daniels emphasizes that reasons are relevant when they focus on the "public good" that is pursued by all medical professionals involved in the distribution of care. However, at this point Daniels makes an interesting distinction that demonstrates the potential role of forward-looking personal responsibility. According to Daniels, this public good is not only affirmed by the healthcare professionals and providers, it is "avowed by patients seeking care who also want a cooperative scheme that provides *affordable, nonwasteful care*."⁵¹ The implications of this claim seems to be that relevant conditions for managing limit settings and scarcity involve both healthcare providers and patients valuing the public good of promoting good health outcomes.

While Daniels does not explicitly argue for or against responsibility based accounts of health prioritization, it seems that his position on patient responsibility would consider forward-looking personal responsibility relevant to the patients' desires to ensure that healthcare benefits

⁵⁰ Daniels, 118.

⁵¹ *Id.*, 124. Emphasis added.

are “nonwasteful.” This, combined with his ‘value for money’ distinction, seem to imply that forward-looking personal responsibility regulations would meet the Relevance Condition.⁵²

4. Conclusion

This chapter has examined different accounts of healthcare and health in the hopes of justifying the implementation of forward-looking personal responsibility. Nielsen, Anderson, and Daniels’ different accounts were used to determine if forward-looking personal responsibility conflicts with varying conceptions of healthcare access. As a result, it was confirmed that forward-looking personal responsibility could be instituted as a fair process for distinguishing the cases we discussed in chapter I. Going forward, it will now be important to determine what factors limit the large-scale implementation of forward-looking personal responsibility as well as deal with other negative consequences that could result from this form of healthcare prioritization.

⁵² For further explanation of how forward-looking responsibility leads to an increase in value, see section 2.3 in chapter I. By promoting outcomes that have a lower likelihood of future complications, forward-looking personal responsibility increases the value of healthcare treatments by decreasing the likelihood of the need for follow-up treatments.

III. Limitations for Forward-Looking Personal Responsibility

At this point in the paper, I will attempt to address the arguments that have been levied against personal responsibility models in healthcare prioritization.⁵³ (Brown 2013) Since a substantial portion of the arguments that I will address in this chapter were primarily focused on the backward-looking conception of personal responsibility, I will attempt to demonstrate whether or not these criticisms are relevant to the discussion of forward-looking responsibility in addition to determining how to best respond to these criticisms. At the end of this chapter, the goal is to have a more accurate conception of how the limitations of forward-looking personal responsibility impact the implementation of these principles in non-ideal conditions.

1. Circumstances and Autonomy

An intrusive problem with both backward and forward-looking personal responsibility is that the nature of behaviors makes it difficult to determine an individual's autonomy over their lifestyle choices. Extensive sociological research has demonstrated that health outcomes and health behaviors can be negatively impacted by factors that are outside of an individuals' control: such as environmental factors, genetics, and other forms of social inequality.⁵⁴ As a result, it becomes difficult to separate these factors from an individual's behavior in order to determine how much a person should be considered responsible for their actions.⁵⁵

⁵³ Brown, R. C. H., (2013) Moral responsibility for (un)healthy behaviour, *J. Med. Ethics*, 39, 695-698. doi:10.1136/medethics-2012-100774

⁵⁴ For an example of these studies, see:
Hill, K. G., Hawkins, J. D., Catalano, R. F., Abbott, R. D., Guo, J. (2005) Family influences on the risk of daily smoking initiation. *Journal of Adolescent Health*, 37 (3), 202- 210, doi: 10.1016/j.jadohealth.2004.08.014.

⁵⁵ One advocate for personal responsibility is Buyx, who argues that advancements in sociological research will eventually result in a quantifiable way to measure how much a person is responsible for their actions.
Buyx, A. (2008), Personal Responsibility for Health as a Rationing Condition: Why We Don't Like It and Why Maybe We Should, *J. Med. Ethics*, 34 (12), 871-874, doi:10.1136/jme.2007.024059

In *Lifestyle, Responsibility, and Justice*, Feiring argues that one of the benefits of a forward-looking model of personal responsibility is that it does not succumb to the the same complicated distinctions between circumstances and voluntary actions.⁵⁶ According to Feiring, since forward-looking personal responsibility is focusing on future behaviors, it is operating under the assumption that the patient is an autonomous being that has the capacity to engage in the expected healthy behaviors. However, I do not believe that Feiring's claim about forward-looking responsibility is accurate. There does not seem to be a relevant difference between the same action that occurs at two different times relative to the present. If a man smoking a cigarette five-years-ago is a complicated action in which the effects of his voluntary choice cannot be separated from his circumstances, then I see no reason to believe that his smoking post-treatment can distinctly be traced to his voluntary autonomy, as Feiring suggests. Therefore, if healthcare providers cannot reasonably distinguish between the circumstances and voluntary motivations in past actions, it would be unreasonable to assume that they could do so for future ones. Given the emphasis of personal responsibility taking into account factors that are in a person's control⁵⁷, these circumstances that impair our ability to trace voluntary autonomy cast doubt over the primary principle of personal responsibility. As a result, advocates of forward-looking responsibility must accommodate for the complicated impacts of circumstances on patient behaviors in their model. A thorough explanation on how different factors can influence behaviors will be the focus of the next few sections. I will then attempt to salvage forward-looking personal responsibility so that it can deal with these complications.

⁵⁶ Feiring, 35.

⁵⁷ By in a "person's control", it means outcomes on which an individual can be considered to have quantifiable and significant influence.

1.1 Environmental Influences on Behaviors

This past summer, I did a volunteer internship at a non-profit organization in inner-city Baltimore. As a part of this program, I got to take a city-wide bus tour to learn about Baltimore and how different social determinants of health affected patient outcomes. As I toured the city of Baltimore, one of the most noticeable features was that over the course of the entire bus tour, I did not see a single grocery store. The only sources of food I could find were corner drug stores and fast-food restaurants. As I sat on the bus driving through the city, I wondered to myself, “Where do these people get their fruits and vegetables?”

It is conditions like this that demonstrate the importance of environmental considerations on a patients’ lifestyle choices. If patients’ in this environment were prioritized based on their likelihood of engaging in healthy eating habits, healthcare providers would have to lower these patients’ priority based on the inability of these patients to improve their eating habits since healthy foods are not available to them. The justifications of forward-looking personal responsibility included motivating patients and strengthening the physician-patient relationship. It can be demonstrated that these types of limitations on healthy patient behavior would severely damage the positive impacts of forward-looking personal responsibility.⁵⁸ Patients are likely to be unmotivated and feel resentful toward their physicians if they are expected to engage in a behavior that requires large-scale changes to their environments, such as implementing a local grocery store.

While environmental factors can make certain healthy behaviors impossible, they can also make them more difficult without them being quite impossible. This raises the question of whether it is fair to expect patients to engage in the same healthy behaviors if it is substantially easier for some patients to engage in these behaviors than others. For example, returning to the healthy eating

⁵⁸ These consequences are discussed in detail in section 2 of chapter I and they are: patient motivation, physician-patient relationship, and likelihood of successful health outcomes.

example, if one patient lives within walking distance of the only grocery store in town and the other patient is a 30-minute bus-ride away, it is substantially easier for the first patient to make the time to go to the grocery store to buy the fruits and vegetables necessary for maintaining healthy eating habits.

Forward-looking personal responsibility seems to have a rather difficult time dealing with circumstantial discrepancies. Thus far, our discussion of forward-looking personal responsibility has been focused on the perceived likelihood that a patient engages in healthy or unhealthy future actions. Forward-looking personal responsibility is worse than even backward-looking personal responsibility at discriminating against people who live in environments with negative determinants of health, such as a lack of grocery stores. It seems backward-looking personal responsibility is simply blind to circumstances that influence actions, given its focus on how past actions affect health outcomes. In contrast, one could reasonably infer that forward-looking personal responsibility actively punishes victims of circumstantial factors when it calculates the likelihood that someone engages in unhealthy post-treatment behaviors. Forward-looking personal responsibility does not take into account whether circumstances have affected behaviors; it takes into account the fact that circumstances might affect behaviors, which can be utilized to calculate the likelihood that someone will engage in unhealthy post-treatment behaviors.

1.2 Genetic Dispositions

Another factor that affects patients' ability to engage in healthy post-treatment behaviors is their genetic code. Research has shown that there are genetic traits that correlate strongly to unhealthy behaviors, such as proneness to addiction.⁵⁹ These factors are once again outside of a

⁵⁹ Bevilacqua, L., & Goldman, D. (2009) Genes and Addictions, *Clin. Pharmacol. Ther.*, 85 (4), 359-361.
:10.1038/clpt.2009.6

persons' control, and can have a strong impact on the behaviors that are used as the basis for distinguishing cases in personal responsibility. As such, forward-looking personal responsibility should accommodate for the fact that patients' who have genetic dispositions to have more addictive tendencies will have a harder time changing their unhealthy behaviors. Much like the example in the previous section, these patients have a relatively higher degree of difficulty in complying with the requirements of forward-looking personal responsibility. As a result, these patients could be prioritized substantially lower based on factors that are outside of their control.

1.3 Responsibility and Other Forms of Inequality

A concern that relates directly to the past two sections is whether forward-looking personal responsibility, and personal responsibility more generally, can be accused of actively widening the gaps between the worst-off and best-off in society. Basing healthcare prioritization on behaviors that are directly impacted by these circumstantial factors would result in large numbers of marginalized individuals being prioritized lower than the individuals at the top of the social hierarchy. This would directly conflict with a Rawlsian theory of justice, a key focal point of Daniels' book, as well as Anderson's goals of egalitarian justice: to end oppression and promote a community of equals.

In addition, there is research that has shown that historically marginalized groups can have different tendencies in engaging in unhealthy behaviors.⁶⁰ (McCann 2005) As a result, these groups could be considered at higher likelihood of engaging in unhealthy future behaviors, which would lower their prioritization in forward-looking personal responsibility.

⁶⁰ McCann, J., Artinian, V., Duhaime, L., Lewis J.W. Jr., Kvale, P. A., & DiGiovine, B. (2005) Evaluation of the causes for racial disparity in surgical treatment of early stage lung cancer. *Chest*, 128 (5), 3440-6.

2. Pettit's Fitness to Be Held Responsible

The implications of the previous sections seem quite damaging to the current conception of forward-looking personal responsibility. However, there remains hope that this method can be edited so as to better accommodate the difficulties discussed in this chapter. I will attempt to construct the new version of forward-looking personal responsibility by considering Phillip Pettit's *fitness to be held responsible*.⁶¹ (Pettit, 2007) In this way, the new construction of forward-looking personal responsibility will be made in such a way that it better accommodates individuals who are victims of uncontrollable circumstantial disadvantages.

2.1 Pettit's Conditions of Fitness to Be Held Responsible

In Pettit's *Responsibility Incorporated*, Pettit is trying to determine the qualifications for holding entities such as corporations responsible for their conduct. As such, Pettit defines what makes an agent deserving of being held responsible as contingent on three conditions: Value relevance, Value judgment, and Value sensitivity.⁶² Pettit argues that someone who does not have all these conditions met is not fit to be held responsible for a given choice.

Applying this conception of fitness to be held responsible does significant work for answering the concerns raised in the previous sections. This application could be achieved by shifting the focus of forward-looking personal responsibility from *the likelihood of patients engaging in healthy post-treatment behaviors* to *the likelihood of patients who have the fitness to be held responsible for their behaviors engaging in healthy post-treatment behaviors*. As a result, the new forward-looking personal responsibility model will do a better job of accommodating

⁶¹ Pettit, P. (2007) Responsibility Incorporated, *Ethics*, 117, 171-201.

⁶² *Id.*, 175.

patients whose circumstances inhibit their fitness to be held responsible. The new conception of forward-looking personal responsibility as contingent on fitness to be held responsible will be labeled throughout the rest of the paper as forward-looking personal responsibility*. I will now attempt to demonstrate the implications of Pettit's fitness to be held responsible on the forward-looking personal responsibility* model. Specifically, I will focus on how the forward-looking personal responsibility* model refrains from lowering the prioritization of patients based on uncontrollable factors.

2.2 Value relevance

Meeting the condition of value relevance implies that the agent is autonomous and faces a value-relevant choice. The purpose of this condition is that agents can not be considered fit to be held responsible in instances where their actions are considered trivial and non-value relevant. For example, in the forward-looking responsibility* model, a patients' treatment could be contingent on them engaging in safe post-treatment behaviors. The condition of value relevance implies that actions that do not qualify as safe or unsafe should not warrant blame or praise. For example, if a patient is walking down the sidewalk, it is generally not considered an especially safe or especially unsafe practice. I justify this distinction in the context of the future behaviors a healthcare provider would actively support or oppose based on the requirement that the patient be safe in their future behaviors. For example, if a patient suffered from a liver problem, the physician would likely not make a distinction that walking on the sidewalk is a particularly safe or unsafe practice. In contrast, actions such as limiting the amount of alcohol one drinks or engaging in binge drinking would be considered safe and unsafe behaviors, respectively. Therefore, if the patient injures the treated condition as a result of this walk, the healthcare provider has no basis for claiming the patient

broke his pre-treatment promise to engage in safe practices since they are not fit to be held responsible in cases where their actions were not value relevant.

2.3 Value judgment

Meeting the condition of value judgment requires that the agent understands that her value-relevant choices would have different impacts, and understands that her decisions can influence her fitness to be held responsible. The purpose of this condition is to ensure that the agent understands the ramifications of their actions, specifically how different actions will be deserving of praise or blame. For the sake of the discussion on forward-looking personal responsibility*, the emphasis of this condition parallels Daniels' requirements for a fair process of limit setting.⁶³ An obligation of forward-looking personal responsibility* is to ensure that patients have an accurate understanding of how their future actions will affect their prioritization for healthcare treatments. This would involve thorough education initiatives to ensure that all people who need limited healthcare resources have the potential of being judged on these criteria. In addition, education programs should implement values of self-control and will-power so that the condition of value judgment can be met in these cases.

2.4 Value sensitivity

Meeting the value sensitivity condition requires that the agent has the necessary control to choose between options based on their value-based judgments of the options. This is the condition that deals most directly with the objections that were addressed earlier in this chapter. To say that an agent has the control to choose between options based on the value-based judgments of the options protects both individuals who are forced to make unnecessarily difficult decisions to engage in healthy behaviors and those who do not have any access to the necessary resources to

⁶³ Daniels, 118.

engage in healthy behaviors. In this way, both the patient who lives in a city without grocery stores and the patient who lives thirty minutes away should not be considered fit to be held responsible for their potentially unhealthy eating habits.

A potential pitfall of this line of thinking is that there seems to be an arbitrary distinction between individuals who make value based judgments when choosing not to pursue an action and those that make choices based on other relevant factors. For example, two patients can live the same distance away from the closest grocery store, but one has a car and the other does not. What is it about the patient-without-the-car's situation that inhibits them from making a value based judgment about the benefits of choosing to walk to the grocery store? The answer seems to depend on assessments of people's means to access the factors necessary to make a value-based judgment. While this will not be spelled out in detail here, it is worth considering in further implementations of forward-looking personal responsibility*.

Conclusion

As a result of implementing Pettit's fitness to be held responsible into our account of forward-looking personal responsibility*, the model gained an improved ability to accommodate individuals who engage in actions as part of uncontrollable factors. This should be a reassuring way to demonstrate that forward-looking personal responsibility* does not reinforce social hierarchies based on allocations of uncontrollable circumstances.

However, it is important at this time to revisit Anderson's concerns with luck egalitarianism, specifically, her concerns that reparations for 'bad luck' institute a societal inclination to base claims to the less fortunate individuals on pitying their circumstances. The intention of this chapter is not to allow for societal discriminations against individuals who are victims of uncontrollable circumstances. The goal of considering the limitations of forward-

looking personal responsibility was the opposite: to ensure that forward-looking responsibility* could be better utilized as a tool that creates a society where people are correctly assigned the proper level of responsibility they have to engage in healthy post-treatment behaviors.

This completes my assessment of the nature of forward-looking personal responsibility* and its benefits as a tool in healthcare prioritization. In the conclusion of this paper, I will shift my discussion from the nature of forward-looking personal responsibility* to the ways in which forward-looking personal responsibility could be best implemented in our modern healthcare system.

Conclusion

The original goal of this project was to demonstrate the benefit of considering forward-looking personal responsibility in instances of healthcare prioritization. By comparing the outcomes of forward-looking personal responsibility with other methods, I was able to demonstrate the consequentialist benefits of implementing this model. However, the past chapter demonstrated some of the issues involved in applying forward-looking personal responsibility to non-ideal scenarios. I will now recommend certain regulations that both healthcare providers and society as a whole should implement to ensure that the benefits of forward-looking personal responsibility can be applied to the modern healthcare system.

Healthcare providers should acknowledge the benefits of implementing forward-looking personal responsibility* to deal with instances of scarcity and limit setting. In the United States, these can be especially helpful in considerations of organ transplants and other limited health resources, such as rooms in a hospital. However, the scope of forward-looking personal responsibility* gets larger in less developed countries where considerations of scarcity and limit setting are relevant to more health resources, such as vaccinations. Forward-looking personal responsibility* could be especially useful for international health groups, such as Doctors Without Borders, that provide care in third-world countries. Given the scarce nature of health resources in these countries, implementing forward-looking personal responsibility would be a beneficial way for these physicians to maximize the likelihood of successful health outcomes, motivate their patients to engage in healthy post-treatment behaviors, and strengthen the relationship between physicians and their patients.

Implementation of forward-looking personal responsibility* prioritization should be a long-term goal of healthcare providers. As a short-term way to try to improve the healthcare

system, physicians should emphasize the importance of healthy post-treatment behaviors with their patients instead of emphasizing past behaviors. Even if a forward-looking personal responsibility* model is not implemented, the positive benefits that have been discussed in this paper demonstrate the importance of accountability for future behaviors. Healthcare providers should realize the role of motivation in enacting behavioral change and learn the necessary techniques to best motivate patients' willingness to change their behaviors. The goal of this education would be to increase the rate that healthcare providers successfully motivate people who are currently engaging in unhealthy behaviors to change their behaviors. Formatting the detriments of smoking in the context of the future complications that could result from continued smoking, with special emphasis on how these complications can inhibit future autonomy and opportunity, should be a successful tool for motivating patients to engage in healthier behaviors. The implementation and emphasis on teaching healthcare providers how to successfully motivate their patients to engage in healthy post-treatment behaviors will lead to a healthier society as a whole.

The last chapter demonstrated how instances of societal injustice can impact both health outcomes and the effectiveness of the forward-looking personal responsibility model to correctly determine prioritization of care. To compensate for these injustices, the model was edited to take into account *fitness to be held responsible*. (Pettit 2007) However, a larger social project should be negating the impact that social determinants of health have on health outcomes. This can be achieved through public health measures that distribute the necessary resources to engage in healthy activities, as well as societal programs to grant more people the means necessary to have full autonomy over their decisions. While this may seem like a never-ending endeavor, it is important that societies dedicate significant resources to ensuring that their citizens' health needs are met.

In the introduction to this paper, I explained that by focusing on positive outcomes, I could justify the usefulness of forward-looking personal responsibility as a way to distinguish prioritization of healthcare treatments in cases where all other factors were equal. In this way, the forward-looking personal responsibility model was a pluralistic model that considered other common factors that are utilized to prioritize healthcare allocation: such as urgency, likelihood of successful outcomes, and when a claim to care was made. As such, the analysis of this paper intended to demonstrate that ignoring forward-looking personal responsibility would be detrimental to patient outcomes and utilizing forward-looking personal responsibility would be compatible with different conceptions of healthcare. I believe that I was successful in this task. Going forward, the implications of this view should be expanded to determine just how influential accountability should be in the pluralistic model of healthcare prioritization. In addition, future considerations will likely attempt to apply forward-looking personal responsibility to healthcare distribution models, not limit its impact to healthcare prioritization. I will make no predictions about the success of these attempts. My purpose here was simply to deal with the question, “Should forward-looking personal responsibility be considered a relevant factor in determining healthcare prioritization,” for which I have concluded, the answer is yes.

Appendix A. Healthcare Allocation Survey.

4/18/2017

Healthcare Allocation Survey

Healthcare Allocation Survey

INTRODUCTION: For each question, there will be two patients. The patients are identical twins and have grown up in the same environment. The only difference between them is that they have made different choices in their lives. In each scenario, you are a healthcare professional who only has enough resources to provide care for one of them. Each patient has the same exact medical condition and seek treatment at the same time. Who do you give the care to and how certain are you?

1. **Person A: life-time smoker who has developed lung cancer as a result of smoking; Person B: has never smoked but has developed lung cancer. Who gets lung cancer treatments?**

Mark only one oval.

- Person A, strongly certain
 Person A, hesitantly certain
 Person B, strongly certain
 Person B, hesitantly certain
 No preference (i.e. flip a coin to determine who gets treatment)

2. **Person A: life-time smoker who has developed lung cancer as a result of smoking and who will continue smoking after receiving treatment; Person B: life-time smoker who has developed lung cancer as a result of smoking but quit smoking last year. Who gets lung cancer treatments?**

Mark only one oval.

- Person A, strongly certain
 Person A, hesitantly certain
 Person B, strongly certain
 Person B, hesitantly certain
 No preference (i.e. flip a coin to determine who gets treatment)


<https://docs.google.com/a/umich.edu/forms/d/19ZG9CZ21hQQ1-ZjIZtpoDzlGF7bFGoZUMj-DhIf-8Y/edit>

1/2

3. **Person A: life-time smoker who has developed lung cancer as a result of smoking and who will continue smoking after receiving treatment; Person B: has never smoked but has developed lung cancer, has told you that the stress of lung cancer will cause him to take up smoking after receiving treatment. Who gets lung cancer treatments?**

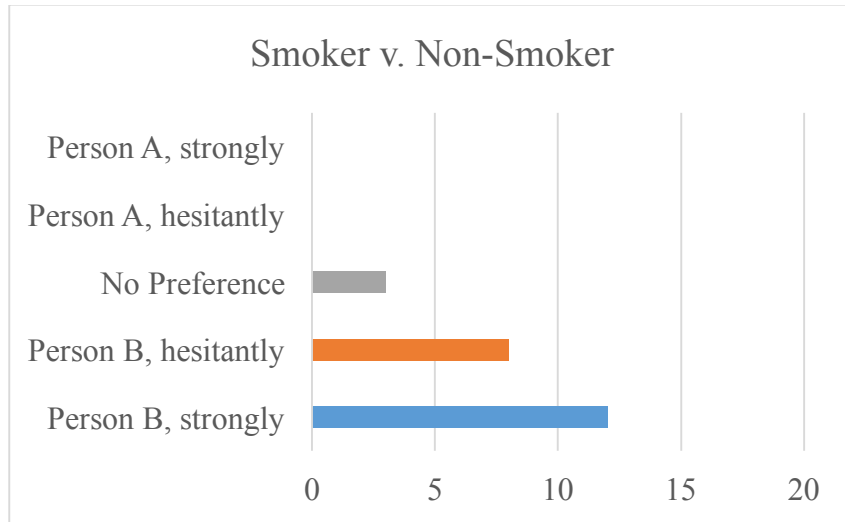
Mark only one oval.

- Person A, strongly certain
- Person A, hesitantly certain
- Person B, strongly certain
- Person B, hesitantly certain
- No preference (i.e. flip a coin to determine who gets treatment)

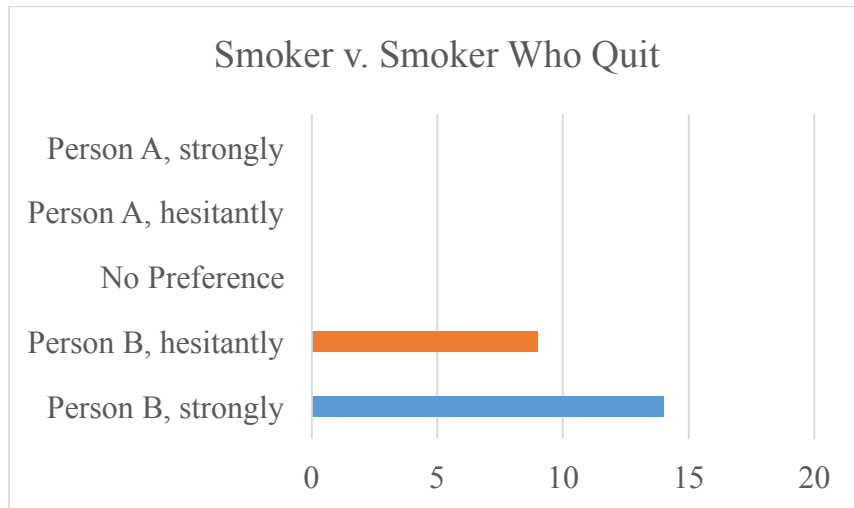
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Appendix B. Healthcare Allocation Survey Results.

Question 1:



Question 2:



Question 3:

