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"Crises in the way Patient Responsibility for Illness is Considered"

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In our society there is currently a crisis regarding what it means to be responsible for health and illness. The increasing emphasis on the treatment of chronic disorders that are behaviorally-generated and behaviorally-managed focuses attention on volition and the control of behavior by those who are ill or are at risk for illness. The confusion is compounded by the determinist interpretations of medical and biological research findings combined with an over-weaning faith in technology.

The first step to unraveling the confusion surrounding personal responsibility is to review the health care trends that bring the issue into focus. Current trends and confusions in assigning responsibility can then be considered prior to examining the historical and conceptual basis for commonly held assumptions regarding personal responsibility. Practical and personal implications for the assigning and denying of patients' personal responsibility for their health arising from the Western paradigm of personhood are explored in terms of the ethical clinician-patient relationship.

The word responsibility can be used in several related senses. In the health care literature the most commonly used sense of responsibility is a clinician's obligations, for example, nurses are responsible to teach patients about post-surgical conditions prior to the surgery and physicians are responsible to fully inform patients about the hazards of surgery prior to the procedure. This sense of responsibility is closely tied to a clinician's liability and accountability. However, this article discusses responsibility as the degree to which a patient is culpable for the consequences of his or her actions in terms of a resultant state of health or illness. This is the meaning used in ordinary speech when assessing and assigning blame. The currently used phrase is "personal responsibility." In this sense responsibility is understood both retrospectively, one acted in a way that one is now responsible for the consequence, or prospectively, if one commits a certain act one will be responsible for particular consequences. For any condition considered as a consequence, one may have complete personal responsibility or some other person or external force is held to be all or partially responsible. In these cases one is not held personally responsible or is considered to have diminished responsibility. In this article the pattern and meaning of assigning or denying the responsibility for illness as a consequence of personal behavior and lifestyle will be explored.

Personal Behavior and Health

Many of the health problems dominating US health care are related to personal behavior and lifestyle. Tobacco, diet/exercise and alcohol alone account for 38% of deaths in US with firearms, sexual behavior, motor vehicles and illicit drug use also among the top ten killers [1]. Many of the deaths related to these behaviors come only after long periods of illness and disability, for example smoking leading to emphysema, and poor diet leading to heart disease and diabetes. Alcohol and drug dependence are also often long-term relapsing problems leading to a variety of chronic medical and psychiatric problems.

In addition, research has found that people often do not follow the treatment recommendations of clinicians. A large meta-analysis of adherence studies found that patients with long-term self-administered medication regimes follow their prescriptions only 50% of the time and for those receiving short-term administration of antibiotics the rate on non-adherence is as high as 75% [2].

Compounding this trend, technology has improved health care to the point where many acute diseases, such as infections, are curable and others are treatable by long-term management requiring patient cooperation, such as AIDS, diabetes, heart disease and many forms of cancer.

Further, society's current tendency to medicalize problems creates a reinforcing spiral in the trend toward long-term treatment. As more problems are medicalized, the idea of treatment as a response to a wider set of problems becomes more common and treatment itself becomes more continuous in nature. As society become inured to medicalization, the tendency to medicalize becomes greater which increases the emphasis on health as the primary social good thus expanding the conceptual scope of health. The increasing prominence and regularity of journalistic health reporting in the past 30 years affirms this spiral. The current public concern with prevention of disease and maintenance of health creates an atmosphere where life itself is treated as a chronic condition requiring regular professional contact and close attention clinical advice regarding the correct way to conduct everyday living.

Both chronic disorders and prevention measures involve long-term clinical management with multiple treatment options having different degrees and types of benefits and risks. Lifestyle modification and behavioral change are prominent among patients' options and clinicians' recommendations. Each option chosen or disregarded entails consequences and can thus be considered in terms of responsibility. There is little need to weigh personalized costs and benefits of treatment for acute curable conditions, such as strep throat or a leg fracture. However, the treatment of chronic disorders requiring management, such as rheumatoid arthritis or emphysema, entails many treatment difficult assessments of cost and benefit in choosing including the choice to not cooperate with clinical recommendations.

The primary avenue for preventing and minimizing health problems related to behavior and lifestyle are clinicians' counseling and other similar psychosocial interventions designed to influence patients' decisions. The modern healthy lifestyle is like chronic illness requiring constant vigilance to recommendations. And so, trust and the clinical relationship become issues of central clinical and ethical concern as health and health care grow in scope and become more a function of a series of decisions made by patients and less dependant on single option cures.

The Concept of Responsibility

In Western thought autonomy, atomistic individualism and freedom are intimately bound up with the conception of responsibility. It has become a platitude of bioethics to note that the Western bias is toward individualism, however the sense of the individual as unit of concern goes beyond bias and is intrinsic to the world-view of the Westerner. Personhood as individually possessed and ultimately isolated from all other persons is a paradigmatic assumption forming the background to the thinking of Westerners [3-5]. The view of self as isolated individual is not something a Westerner can simply shake off through intellectual discussion, it is an intrinsic to the Western understanding of the social world. It would be a false analogy to say it is like imaging the sky as red instead of blue, a red sky would seem odd but one can easily imagine it, a more accurate analogy would be to imagine that the sky is not up. This doesn't make sense within our shared grasp of a world in which "up" is intrinsic to the concept of "sky." And so, isolation, individuality, and primacy are all intrinsic when a Westerner uses the word person.

History and Individualism

The history of individualism begins with the Greeks who fought for individual honor and glory in the *Iliad* [6] and later invented democracy because each man's honor needed to receive equal accord to prevent trouble [7]. The spread of Christianity and its eventual adoption as the *de facto* Roman state religion in 313 AD was a change from religion for the purpose of maintaining the state and, thus for communal goals and protection, to religion for individual salvation [8]. Christianity furthered the trend toward greater regard for the individual in the Protestant Reformation, in which salvation could no longer be mediated through church authority but required each individual's personal and complete commitment to God, which in some factions meant individual interpretation of scripture [5,9]. The humanistic art and thought of the Renaissance further emphasized the individual [10].

This trend took another major leap forward with enlightenment era philosophy much of which was centered on establishing the rights of the individual as preeminent particularly in the face of state authority [11-14]. This ethos became enshrined in the US Declaration of Independence and continues guide much formal and informal discussion of policy in the US.

Even in its repudiation of the enlightenment emphasis on rationality, romantic era thought developed a cult of the individual with an emphasis on individual expression culminating in the creation of an image of the artist as pursuing his or her unique vision to the exclusion of all else [5].

Literature throughout the period from the late Renaissance through the romantic era reveals the progressive emphasis on individualism through progressive refinement in the exploration of the individual and his or her concerns. Cervantes (1505) explored the singular quest and vision of one man in contrast to the ethos of his society, followed by Montaigne's and Shakespeare's explorations of self-revelation and character definition through essay and fiction [5]. Later Boswell invented the modern 'warts and all' biography [15]. This trend reaches a peak with the exquisitely detailed revelations of internal personal experience in Proust [16] and then Joyce [17]. Each of these works and many others teach those educated in Western society how to interpret experience and what it means to be a person. In US health care, this individualistic paradigm lead to the adoption of informed consent and the advanced directive, both logical extensions of the enlightenment era desire to protect the individual against authority. This helped create an adversarial atmosphere where liability is a primary concern in planning care and the ability to assign blame is highly refined [18]. The spirit and danger of individualism for health care is summed up in an aphorism of Sancho Panza's offered in response to one of Don Quixote's many injuries, "The aches of others hang by a hair" [19].

Autonomy and Responsibility

In the Western paradigm individuals are seen as having the property of autonomy, that is, humans are self-motivating and self-directing. When this property is combined with an assumption of the moral equality of individuals, then the right to pursue one's self-chosen ends, that is liberty, is an accepted conclusion. In health care this has been interpreted to mean that clinicians take on the moral obligation to respect patients' autonomy by honoring their choices regarding the goals and means of treatment to maximum extent possible [20].

However, while liberty is a passive right -- to grant liberty to others one leaves them alone -- respect for autonomy in health care requires positive action. First the clinician must create the possibility of an autonomous choice by providing the information essential for choice as well as an informed recommendation. Clinicians are also expected to provide counsel to patients to clarify thoughts and values as well as to enhance patients' autonomy through the treatment process itself [20,21].

In health care the principle of respect for autonomy is believed by some to have initiated the bioethics movement and become its primary guideline [22]. So that treatment choices in clinical care

are guided by a respect for patients' autonomously generated desires unless there is a compelling justification to override a patient's stated preference. Further, many of the moral dilemmas that do arise are resolved by reference to the principle of respect for autonomy either though granting the patient's autonomy or finding specific justification to override individual autonomy.

In keeping with the emphasis on the autonomy of the individual, the chief instrumental techniques of clinical ethics are informed consent and advanced directives. Informed consent is essentially a procedure to ensure that a patient's autonomy is respected regarding each particular decision. Beauchamp and Childress (2001) offer three requirements for an act to be considered autonomous: intentionality, understanding, and lack of coercion. These are then used to derive three elements essential for informed consent as a technique for ensuring that patients' decisions are made autonomously: 1) The patient must be competent to make the decision; 2) The patient must understand the parameters of the decision, and 3) The patient must make the decision without coercion [20].

The connection between informed consent and enlightenment era philosophy is clear in the ostensible function of informed consent to prevent abuse of the clinicians' power, as conferred by social standing and expert knowledge. Despite the flaws of informed consent and the criticisms made of the concept [23], it is an effective way to prevent egregious abuses of power, such as the Nazi medical experiments. No competent person would agree to participate in the experiments which Nazi physicians forced on captives. Indeed, the Nuremburg Code for medical research was a landmark in health care ethics placing emphasis on the need for informed consent in research. And so, informed consent operates as individual rights were intended by enlightenment thinking; it clarifies boundaries to prevent those with authority from taking advantage of patients.

Advanced directives extend patient autonomy to situations where the condition of competence. Advanced directives were initially conceived to handle end-of-life situations in which patients lack competence or even consciousness and treatment seems futile in the face of approaching death. However, advanced directives are now being used by psychiatric patients who anticipate presenting for treatment with an impaired mental status [24]. Advanced directives are also used to give advanced consent for research in the face of progressive dementia [25].

Like autonomy, liberty and respect for autonomy – responsibility, as the sense that people can be held morally accountable for the consequences of their actions, is also closely tied to the Western individualism. Hans Jonas offers a straight-forward common-sense model of responsibility within the Western paradigm. He says that three criteria must be fulfilled for an agent to be considered responsible for the consequences of an act: 1) The agent's act must cause the consequence; 2) The agent must control the act; and 3) The agent must have had foresight of the consequence [26]. Note that intending the act or the consequence is not a criteria, that the agent has control of the act with prior knowledge of the consequence is sufficient.

When the criteria for informed consent as a way of ensuring autonomous decisions are compared to the Jonas' criteria for responsibility, it is apparent that a decisions made with informed consent confer responsibility for the consequences. When the criteria for informed consent for treatment are met - a patient who is capable of understanding, is told about the consequences of the decision and so has foresight, and the patient makes the decision deliberately, that is without coercion and so has control. If that decision does indeed cause a consequence, then we must conclude that the person is responsible for that consequence. The adversarial nature of the individualistic paradigm is revealed in the informed consent situation that not only respects the patient by allowing an autonomous choice but also shifts responsibility away from the clinician onto the patient. This arrangement then provides a framework for assessing blame when negative consequences occur. That informed consent functions this way in US society is amply demonstrated by the number of legal actions related to informed consent where the patient claims lack of responsibility because of inadequate information and the clinician counters that the patient is responsible because of foresight and control through informed consent [20]. Table 1 demonstrates the relationships between autonomy, informed consent and responsibility.

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AUTONOMY	INFORMED CONSENT	RESPONSIBILITY
(Assumed causal relationship between act and consequence)	(Assumed causal relationship between decision and consequence)	Causality
Intentional ➔	Competence ensures that decision can be intentional ➔	Foresight – is enabled by competence
With understanding ➔	Clinician makes proper disclosure of reasonable information and assesses patient's understanding ➔	Confers foresight
Without coercion ➔	Without coercion ➔	Control – lack of coercion ensures control

Table 1. Comparison of criteria for autonomy, informed consent and responsibility

Assigning responsibility is essential in the individualistic paradigm because the person or persons responsible for a consequence are expected to bear any burden involved and are liable for condemnation. Conversely, persons responsible for good consequences are considered entitled to the benefit and are praised. Implicit in this perspective is that when one is responsible for an act, one deserves the consequences, whether positive or negative; to be responsible is to be morally culpable. Working within the autonomy/responsibility framework, Gauthier (2002) [27] makes the case that patient responsibility for behavior has been lacking in current discussion of health care ethics and should be made a feature of how the clinician-patient relationship is conceived, however, she only applies the patient responsibility to care planning, informed consent and the other typical "ethical" issues of health, such as futility, organ donation and assisted suicide and does not discuss assigning patient responsibility for illness-inducing behaviors.

Despite the discussion of consequences, the paradigm of autonomy and responsibility owes more to Kantian moral theory then utilitarian theory because the critical emphasis in assessing the morality of individual acts is on foresight and control and not the nature of the consequence. Moral blame hinges on the person's prior awareness of the potential outcome and still choosing to act.

The result is that, in today's health care, an inherent adversarial cast to the clinician-patient relationship tends to distance and de-value the relationship making it more of a barter than an encounter based in concern. And so, while the most egregious transgressions are either prevented or when they do occur, a clear line of blame can be established; there is a cost in the quality of the relationship. The autonomy-responsibility worldview with its penchant for blame, which has been amply played out in the prevention of clinician abuses, continues in the current situation of increasing predominance of chronic diseases related to lifestyle and behavior thus creating increased opportunity to assign blame to patients.

Responsibility and Health

There is a tradition of connecting health with personal behavior choices and thus with personal responsibility. In classical Greece and during the Roman Empire, great stress was laid on caring for one's health through diet, exercise and moderation in pleasure -- and illness was often seen as a result of bad behavior [3]. Foucault (1986) further demonstrates, how during classical times, the care of one's self in the moral sense became increasingly connected to physical health and medical practice. He further relates the increased interpretation of physical health as part of moral self-care as connected to three distinct senses of individualism: 1) "Individualistic attitude," as independence from the community; 2) "Positive valuation of private life," that is family and domestic concerns; and 3) Relations to the self, where the self is taken as an object of knowledge. (pg. 42.) Charles Taylor demonstrates the accelerating trend in the West to conceive of the self as an atomistic individual in these three senses through the medieval, enlightenment and romantic eras into the present, though he is less specifically concerned with the effect of these developments on health than is Foucault.

Liechter (2003) [28] demonstrates two opposing trends in assigning blame for health that have carried through from the early part of the last century through the present: The first is to blame personal behavior for health problems and the other is to assign the blame on social conditions, mostly poverty. Both perspectives can claim an empirical base. For example, smoking, which is the archetype personal choice with negative heath consequences, has an empirically demonstrated connection to many health problems but it is also practiced predominately by the poor, implying the behavior is somehow linked to poverty. This implication of a link between smoking and poverty makes the moral condemnation of smokers for bad personal choices appear like "blaming the victim," that is blaming the individual for the social conditions leading to smoking, and over which the person has little or no control. This same dichotomy is currently being observed in discussions of obesity. On the one hand diet, poor or healthy, is seen as a deliberate choice while at the same time unhealthy diet choices are linked to low socio-economic class [29].

The debate whether social conditions or personal choice is to blame is critical because in the Western individualistic paradigm assignment of blame is essential to assess who deserves to bear the burden of the consequences, which is justice in the Western sense. The consequences of behavior related to health can be monetary, illness, or bearing the righteous moral censure of others. In heath care, a society may decide to shoulder the monetary burden regardless of personal responsibility, but this does not relieve sick persons of a personal sense of blame or condemnation from others, especially clinicians. Further it can create the sense that treatment is an undeserved gift and heighten a sense of obligation to the clinicians who provide this "gift."

Personal blame and social blame are conflicting perspectives that are often characterized as conservative and liberal politics, respectively. However, both arise within the Western paradigm of atomistic individualism with autonomy and responsibility. The argument made by the Kelly Brownell, an expert in obesity, that corporations unfairly exploit a biological inclination for fatty foods reducing the possibility of autonomous choice falls squarely within this paradigm as coming from the social blame perspective [30]. He is essentially stating that people have less personal responsibility for poor food choices because they were unduly influenced, that is, they have less control which negates their autonomy and thus their responsibility. The implication of the argument is that people do not deserve and should not be made to bear the consequences, especially the social approbation and that the large food corporations should be held accountable in moral and monetary terms. The argument alarms many because it counters the view that obese people made themselves that way through deliberate, autonomous choices and thus deserve the consequent health problems. The smoking debate follows a similar pattern with the current trend toward placing blame on manufacturers for knowingly exploiting an addiction. Indeed advocates for healthy eating are beginning to model their campaign on the battle against cigarette companies. Both sides of the argument, personal and social causation, rely on an understanding of responsibility that is based on an understanding of personhood as an atomistic individual.

Genetic and biological determinism, that is that one's behavior patterns are determined by genetic or biological forces, which

"the self" cannot control is a third cause making increasing headway in popular understanding. The popular understanding of this works mostly in the negative, that is, an autonomous self exists and is self-governing as described by enlightenment philosophy for many choices, but that certain bad choices are biologically controlled outside the "self's" sphere of influence. The usual popular formulation is to consider a behavior determined when a biological factor can be identified which differs between those who have the behavior and those who don't [31]. The trend manifests as a collusion between science and the press to increase the scope of possible negative behaviors which can be attributed to biologically determined and thus not "self-determined" forces. While not a coherent philosophy, it a common implicit formulation in popular accounts of health behavior.

Working within the autonomy/responsibility framework these three strains of the public dialog, personal responsibility, social responsibility and no responsibility through biological determinism create a confused picture for patients and clinicians alike. The assignment of responsibility is so fiercely debated because it has implications for resource allocation, the tenor of clinical relationships and the general feeling of society toward individuals with behavior related health problems. These debates seem so compelling because blame is essential to sorting priorities within the Western world view. Unfortunately, this search for who is really to blame leads in the wrong direction for creating a system of optimum care given the current trend toward treatment of longstanding conditions within ongoing clinical relationships.

Implications of personal responsibility – Assignment of personal responsibility predominates when: 1) It is assumed that a specific behavior has a substantial causal link to an illness; 2) It is believed that individuals can freely choose to abstain from the behavior; and 3) It is believed that individuals are aware of the health-related consequences - thus meeting the three Jonas' criteria of responsibility (1984) [26].

When personal responsibility is the predominant model for allocation of blame in behavioral illnesses, it follows that individuals can be held accountable the consequences of their illness which are primarily the discomfort and disability associated with the illness but may also be construed to include the financial and other social burdens of the treatment. This has led to suggestions that those who suffer from behaviorally related illnesses be asked to carry a greater share of the burden of care than those who are sick though no fault of their own [32-34]. This has even been put into practice in some cases, for example Hershey and U-Haul corporations have higher co-pays on health insurance for overweight employees [28]. This rationale can also be seen behind the palatability of so-called "sin" taxes in addition to the rationale that it is a disincentive to unhealthy behavior.

Staying within the autonomy/responsibility framework of the Jonas' criteria, it can be shown that aggregate incentives and disincentives, like advertising campaigns and "sin" taxes, are justified while increasing the individual burden of consequences beyond the illness itself and the customary personal financial costs to include additional, perhaps punitive, consequences is not justified. Even with a behavior such as smoking, which appears volitional and is linked to lung cancer, unambiguous responsibility is difficult to assign as causation is mixed, there are other factors determining who gets the disease; control is questionable, as smoking is addictive; and foresight may be lacking, as in the case of those who started at a young age [35]. Thus while the behavioral link justifies preventative interventions at the aggregate level, a precise enough determination of the level of individual responsibility could never be determined to ethically increase the burden to individuals. Even so, any increase of burden based on personal responsibility could only appear ethical within the strongly Western paradigm of atomistic individualism.

In addition certain behaviors that may damage health and where individual choice exists, are restricted on the basis that it is unfair for society to bear the burden of self-induced injury. This is an invocation of Mill's (1985) justification for restricting liberty in cases where a person uses his or her freedom of action to restrict or deny the liberty of others; and thus is firmly planted in the Western paradigm of atomistic individualism [14]. Seat-belt laws for drivers and helmet laws for motorcyclists provide examples of this rationale.

Assignment of personal responsibility and thus the possibility of individual blame also has emotional implications for the patient, the clinician and society. The concept that one creates one's own health comforts and a re-assures the person who is not sick because it confers a sense of control over illness and adds to the sense that the person is behaving in a correct even moral manner. This formulation encourages the link between illness and immorality and helps to make the sick person appear as "other" or outcast in the eyes of the righteous healthy. A recent study showed that obese shoppers were treated with more discourtesy by clerks that non-obese shoppers, but that if the obese person expressed efforts to diet the clerk's discourtesy decreased [36].

Research in the area creates an emotional circularity as behavioral factors that can be controlled are identified as precursors to illness; reinforcing the central position of personal responsibility for illness; which then encourages further searching for more behavioral factors. This circular formulation has become imbedded into the push for and belief in an empirical research base for health interventions. The zeal and regularity with which research on personal behavior and health is reported by the popular media testifies to the strength of the association between behavior and illness in the popular view.

The connection between poor health and bad behavior, which easily slides into the consideration of that behavior as immoral, has a long history, going back to biblical times, "Because he hath oppressed and hath forsaken the poor; because he hath violently taken away a house which he builded not. Surely he shall not feel quietness in his belly." (Job 20; 19-20), continuing through the classical period [3] and into early modern times [37]. And so, the rigor of the science linking certain behaviors to particular illnesses may be modern, but the popular interpretation in terms of autonomy and responsibility is ancient in Western thought.

The assignment of personal responsibility can decrease the sense of empathy or personal concern felt for the affected person. This is easily seen by looking at everyday language. For example, one tells a friend that a mutual acquaintance, John, has divorced and is suffering terribly. One then asks the friend about his or her feelings toward John, to which the friend replies, "He treated her dreadfully." Both understand this to mean that the friend has no sympathy for John's suffering and that his suffering is deserved. Or consider the mother who says to the child running alongside the pool, "I told you not to run, I won't feel bad when you fall

and scrape your knee." The emphasis on the phrase "innocent victim" further reveals this bias.

The connection between a sense of empathy or caring concern toward the patient and the degree of perceived responsibility for the illness has been demonstrated in nurses. In a phenomenological study with 25 nurses of the relationship between nurses and patients, Kahn and Steeves [38] found that caring by nurses was limited when patients' actions seemed to cause problems. Podrasky and Sexton [39] found that patients were more likely to be labeled difficult when the patient had "characteristics or behaviors that are modifiable rather than those that are essentially 'not one's fault'" (p. 19). While Morrison [40] found that nurses were more tolerant of violent patients considered "sick", meaning unable to control behavior due to illness, and less tolerant of those considered "bad" because the behavior was perceived as intentional. In another study, 51 nurses were asked about clinical vignettes in which the patients had different degrees of possible perceived responsibility, including a child with cancer, a man who contracts AIDS from an unfaithful lover, and a suicidal woman addicted to cocaine. More than half the nurses stated that the degree of perceived responsibility had a direct bearing on their ability to empathize with patients [35].

The autonomy/responsibility paradigm supports a decrease in the clinician's empathy with the suffering of culpable patients and creates a situation in which empathy can be engendered through an insidious distortion. The desire to help others is the ostensible reason for entering any health care profession, and so most clinicians are looking for rationales that increase not decrease their sense of caring concern. On encountering the patients who create their own suffering, this can happen in two ways within the autonomy/responsibility paradigm: 1) The patient's responsibility is recognized, but deliberately ignored. This is called the non-judgmental attitude and clinicians are universally taught that it is essential when dealing with patients who cause their own problems [41]; or 2) The clinician can find reasons why the patient is not actually responsible because of lack of control or foresight.

From the autonomy/responsibility perspective taking a non-judgmental attitude when one's inclination would be to blame patients, even partially, for their illness is a highly moral act. Further the non-judgmental stance is considered vital in good clinical work because patients who sense moral condemnation from the clinician will tend to withdraw from treatment or become less forthcoming in discussions with the clinician. The problem is that as human beings, and not computers, judgment is intrinsic to thought. Taylor [5] has shown that the modern trend is to objectify judgments of right and wrong as a procedural process, in his terms to use "strong evaluation." He argues that these must still have a basis in some higher, not strictly procedural, concept of morality which then remains implicit. And so, one may attempt to be non-judgmental or objective about a patient's illness-causing behavior but guiding moral concepts remain intrinsic to the encounter and evaluation of others and their behavior. Thus, the autonomy/responsibility paradigm for moral evaluation, which itself necessitates the non-judgmental attitude, becomes implicit and thus lost to either the clinical discussion of a patient's behavior or public discussion of health policy.

The non-judgmental attitude is inherently non-authentic because it is only invoked when a clinician's inclination is to morally condemn the patient's behavior. No one invokes the need to be non-judgmental about positive judgments of patient behavior. However, the non-judgmental attitude is only needed within the autonomy/responsibility framework and is unnecessary if the autonomy-responsibility-blame cycle is not invoked by a perception of the patient as disconnected individual. A non-judgmental attitude makes no sense to the clinician who does not link self-caused suffering to moral blame.

The second way to increase positive feelings for patients is to believe that they are not actually responsible for the problem. It is here where the trend toward biological determinism in the popular view runs directly into the trend toward personal responsibility for the behaviors causing today's health most common health problems, leaving society in confusion regarding the meaning and role of responsibility. If the patient cannot control the behavior, then the patient is not responsible for the consequences and thus deserves to be regarding sympathetically and shielded from as many consequences as feasible. In this case one sees the patient as innocent-- a victim. A lack of control can also be attributed to social determinism, for example, negative behavior due to poverty or childhood abuse.

However, biological determinism is currently making greatest impact [42,43]. Further, there is a trend to interpret social determinism through biology (Wright, 1994) [44]. While knowledge of causality and factors of influence can play an important role in clinical treatment, the search for etiology and the vigor of debate and public reporting of biological etiologies for health related behaviors is often fueled by the need to assign or mitigate responsibility. Typical of this formulation is what one scientist told the *Boston Globe* about his research on the genetics of obesity, "What it [his study] says is that obesity is better viewed as a medical condition like heart disease, and if someone has heart disease or cancer it's not generally considered their fault" [45]. Whether or not researchers make the connection with mitigation of responsibility, this is often how the public, and professional community uses and interprets much research data [46].

Borderline personality disorder is a good example. This is a difficult disorder to treat both because it does not respond well to many treatments and because the patients themselves tend to be difficult to get along with as a result of the behaviors which define the disorder. When the connection between borderline personality disorder and childhood trauma was first identified [47], educators and experts trumpeted the fact to their fellow practitioners not because it was useful for treatment, which is limited, but because it was felt to engender an empathy for these patients by mitigating the patient's responsibility for the difficult behavior via determinism.

The same dynamic is currently underway using brain scans to show that the difficult behavior seen in Attention deficit disorder is biologically determined and not willful bad behavior by the child. One newspaper editorial with the authoritative title, "Science weighs in" reports that a brain scan study will, ". . .help to remove some of the stigma and misconceptions about it [Attention Deficit disorder]" [48]. Obesity provides another example where the all three formulations are being publicly aired simultaneously, social determinism, biological determinism and personal responsibility.

While patients benefit from interrupting the cycle of self-blame in most behavioral disorders, such as depression or alcoholism

and in behaviorally related health problems, such as obesity or smoking-induced emphysema, there is a price. The benefit comes in two areas, first the clinician is better able to view the patient in a positive light when responsibility is mitigated and the patient is believed to be better able to cope with the problem when raised out of self-defeating pity. However, these two benefits both arise from the same source, the patient benefit occurs when the patient is drawn into the clinician's perspective of mitigated responsibility. An emphasis on mitigating responsibility can ignore or pass over that many problems that can be controlled through invocation of what is phenomenologically experienced by the individual as volition. And so the clinical situation becomes distorted in service of the clinician's desire to see the patient in a more positive light.

A favorite formulation attempting to have it both ways, personal responsibility and determinism, is to say that the patient is not responsible for getting the disease but for controlling it. However, this just regresses the problem justifying a negative view of treatment failures. The redefinition of alcoholism as a "relapsing disease" may be seen as an attempt around this by increasing the scope of the determined behavior beyond initial treatment. The "responsible for treatment but not disease" formulation while attempting to synthesize responsibility and determinism to enhance the positive view of patients fails because it remains firmly rooted in the autonomy/responsibility paradigm.

All sides of vigorous public and scientific debate regarding the mix of social, biological and personal causal factors leading to disease and behaviors related to diseases are operating within the autonomy/responsibility framework. Increasing clinicians' ability to view patients empathetically and decreasing society's stigmatization of various health conditions are worthy goals, but it is only within the autonomy/responsibility framework that these goals are reached by using deterministic models to mitigate personal responsibility. If the connection between Borderline personality disorder and childhood abuse is an acceptable rationale to feel more empathetic toward such patients, the reverse implication is that clinicians are justified in feeling that the 30-60% of persons with Borderline personality disorder who did not have abusive rearing are less deserving of empathy [49]. Similarly, if an overly active child did not have a brain scan typical of Attention deficit disorder, perhaps the teacher would be more justified in punishing him or her.

In psychiatry, Sabin and Daniels [50] have offered a formulation of medical necessity which defines those having a disease, determined by the DSM, as deserving reimbursement while those without a "disease" as not deserving reimbursed treatment. These authors note that clinicians tended to equate their judgment about the patient's ability to control symptoms with the presence of "disease" or lack of "disease." While the Sabin and Daniels formulation makes sense within the autonomy/responsibility paradigm, it is notable that degree of suffering or efficacy of treatment play no role in determining the allocation of resources.

The public and professional debate between those touting biological or social causal models and others favoring personal responsibility only has power when personal feelings and public resources are allocated based on a perception of patients being more or less deserving of suffering the consequences of their behavior, as determined by the Jonas criteria of responsibility, which arises from the long Western tradition of an atomistic understanding of personhood.

Conclusion

The long history of Western thought leading to the current assumption of personhood as isolated and individualistic and of society as a collection of individual "atoms" has the implication that good health is the result of morally laudable behavior and bad health is a consequence self-chosen, indulgent behaviors. The trend toward the attribution of personal responsibility for health and its companion but converse trend to mitigate responsibility for health problems both fall squarely in the Western paradigm. The first trend is illustrated by the self-management movement in health care research. These interventions are extremely valuable given the current trend toward disease requiring long-term management often involving lifestyle. However, as these interventions leave a sophisticated research environment and are applied broadly by clinicians and patients both conceiving personhood through the autonomy/responsibility formulation there is a danger of increasing a sense of blame for illness. On the other side the danger of seeing behavior as either socially or, increasingly, as biologically determined is that the possibilities of self-management will be de-emphasized and misunderstood.

Clinicians, patients and the public generally understand that the causality of most problems is mixed and contains components of personal choice and the strong influence of factors outside autonomous control. And so, clinicians and the public are bombarded with information, some from research and some from clinical or personal experience about both volitional and non-volitional factors resulting in health problems, often presented with an emphasis on the volitionality of the factor, with self-control as either present or absent depending on the agenda of the person doing the reporting. However, confusion and a sense of paradox results from attempts at a commonsense understanding of this information as the responsibility/autonomy paradigm increasingly fails to explain the modern phenomenal world. Attempts to reconcile the confusion such as assigning a percent of responsibility and the "not responsible for having the disease but responsible for treating the disease" formulation are ultimately unsatisfying because are simply re-working the same autonomy/responsibility formula. The Western paradigm of personhood requires responsibility to be assigned to determine the legitimacy of suffering resulting in positive or negative feelings toward individual patients and guiding health policy. The confusion surrounding responsibility should be recognized as a symptom of the paradigm's breakdown.

This breakdown is seen in the variety of misdirected and contradictory endeavors engendered to incorporate responsibility: 1) Attempts to distinguish illness from bad behavior while ignoring suffering as the primary object of treatment, such as seen in the Sabin and Daniels (1994) [50] definition of medically necessary psychiatric treatment; 2) An overly close attention to etiology beyond the clinical utility of the knowledge as seen with borderline personality and history of abuse and in the early days of the AIDS epidemic; 3) The division of suffering into legitimate and illegitimate; as Morrison (1990) [40] showed

nurses doing by dividing patients into mad and bad categories; 4) The increased perception of behavior, especially bad behavior as genetically determined and 5) the contradictory trend in an increasing perception of health as morality.

Two alternatives are offered by the autonomy/responsibility paradigm to legitimize patients' suffering and thus increase empathy, first is to be non-judgmental and ignore responsibility and second is to see patients' autonomy as diminished and thus mitigating their responsibility.

But there is a third alternative for developing a positive connection with patients; it is to go beyond the autonomy/responsibility framework and detach causality from the legitimization of suffering, moral evaluation as an assessment of autonomy from the assignment of responsibility and allocation of resources, including empathy, and to relief suffering from the assignment of blame. To resolve the confusion, first we must recognize its source in an outmoded way of thinking.

References

1. McGinnis J, Foege W. Actual causes of death in the United States. *JAMA.*1993; 270: 2207-2212.
2. Stephenson BA, Rowe BH, Haynes B. Is the patient taking the treatment as prescribed? *JAMA*. 1993; 269: 2779-2781.
3. Foucault M (R. Hurley, trans). The care of the self. (1986); New York: Vintage Books.
4. Foucault M (R. Hurley, trans). Ethics: Subjectivity and truth. (1997); New York: The New Press.
5. Taylor C (1989) Sources of the self: the making of modern identity. Cambridge, MA: Harvard University Press.
6. Homer (R. Fagles, trans). The Iliad. (1998). New York: Penguin.
7. Meier C (R. Kimber & R. Kimber, trans). Athens: a portrait of the city in its golden age. (1998); New York: Metropolitan Books.
8. Ogilvie R. The Romans and Their Gods in the Time of Augustus. 1969; New York: Norton & Co.
9. Gray M. The Protestant Reformation: Beliefs and Practices. Brighton, East Sussex, UK: Sussex Academic Press. 2003.
10. Robinson D. An Intellectual History of Psychology. Madison, WI: University of Wisconsin Press. 1995.
11. Hume D. A treatise on human nature. (1984/1739); New York: Penguin.
12. Kant I (L. Beck, trans). Critique of Practical Reason. New York: Macmillan Publishing. 1993.
13. Locke J. Two Treatises of Government. (1988); Cambridge: Cambridge University Press
14. Mill J. On liberty. (1985/1859); New York: Penguin.
15. Barzun J. From dawn to decadence: 500 years of Western cultural life. 2001; New York: Perennial.
16. Proust M (C. Moncrieff, trans) (1992/1913). In search of lost time. New York: Modern Library.
17. Joyce J, (1990/1922). Ulysses. New York: Vintage.
18. Tauber A. Sick autonomy. *Perspectives in Biology and Medicine*. 2003; 46: 484-495.
19. De Cervantes, M. (19xx/1505) Don Quixote.
20. Beauchamp T, Childress J. Principles of biomedical ethics (5th edn). 2001; New York: Oxford University Press.
21. Cassell E. From: What is the function of medicine? In Moral Problems in Medicine. (2nd Edn). S. Gorovitz, R. Macklin, A. Jameton, J. Oconnor, & S. Sherwin, eds. Englewood Cliffs, NJ: Prentice-Hall. 1976; 73-78.
22. Wolpe P. The triumph of autonomy in American bioethics: A sociological view. In Bioethics and society: Constructing the ethical enterprise, ed. R. DeVries and J. Subedi. Upper Saddle River, NJ: Prentice Hall. 1998; 38–59.
23. Gaylin W, Jennings B. The perversion of autonomy. 1996; New York: Free Press.
24. Savulescu J, Dickenson D. The time frame of preferences, dispositions, and the validity of advance directives for the mentally ill. *Philosophy, Psychiatry, & Psychology*. 1998; 5: 225-246.
25. Dresser R. Research involving persons with mental disabilities: A review of policy issues and proposals. In Research Involving Persons with Mental Disorders that May Affect Decisionmaking Capacity. Commissioned papers by the National Bioethics Advisory Commission. 1999.
26. Jonas H. The Imperative of Responsibility: In Search of an Ethics for a Technological Age. Chicago: University of Chicago Press. 1984.
27. Gauthier C. The virtue of moral responsibility in healthcare decisionmaking. Cambridge Quarterly of Healthcare Ethics. 2002; 11: 273-281.
28. Leichter H. Lifestyle correctness and the new secular morality. In Morality and Health. A. Brandt & P. Rozen. Eds. New York: Routledge, 1997; 359-378.
29. Drewnowski A, Specter S. Poverty and obesity: the role of energy density and energy costs. American Journal of Clinical Nutrition. 2004; 79: 6-16.
30. Brownell K. Fast food and obesity in children. Pediatrics. 2004; 113: 132.
31. Rose S. Neurogenetic determinism and the new euphenics. British Medical Journal. 1998; 317: 1707-1709.
32. Downie R. Is there a right to be unhealthy? *Nursing Mirror*. 1983; 156: 30.
33. Grand J. Equity and Choice: An Essay in Economics and Applied Philosophy. 1991. Harper Collins, London.
34. Underwood M, Bailey J. Should smokers be offered coronary bypass surgery? *Br J Med*. 1993; 306: 1047–1050.
35. Olsen D. When the patient causes the problem: The effect of patient responsibility on the nurse-patient relationship. *J Adv Nurs*. 1997; 26: 515-522.
36. Turner S, Singletary S, Shapiro J, King B, Hebl M. Remediation Strategies and Consequences of Interpersonal Discrimination Toward Obese Customers. Abstract from 20th annual Conference of The Society for Industrial and Organizational Psychology, Los Angeles, CA. 2005.
37. Leichter H. "Evil habits" and "personal choices": Assigning responsibility for health care in the 20th century. *The Milbank Quarterly*. 2003; 81: 603-626.
38. Kahn D, Steeves R. Caring and practice: construction of the nurses' world. *Scholarly Inquiry for Nursing Practice*. 1988; 2: 201-216.
39. Podrasky D, Sexton D. Nurses' reactions to difficult patients. Image. 1988; 20: 16-21.
40. Morrison E. Violent psychiatric inpatients in a public hospital. *Scholarly Inquiry for Nursing Practice*. 1990; 4: 65-82.
41. Clark L. The role of moral judgment in personality disorder diagnosis. *Journal of Personality Disorders*. 2006; 2: 184-185.
42. McCabe S. Bringing psychiatric nursing into the 21st century. *Archives of Psychiatric Nursing*. 2000; 14: 109- 116.
43. Mohr W, Mohr B. Brain, Behavior, Connections and Implications: Psychodynamics No More. *Archives of Psychiatric Nursing*. 2001; 15: 171-181.
44. Wright R. The moral animal: Why we are the way we are: The new science of evolutionary psychology. New York: Random House. 1994.
45. Smith S. Genetic discovery one day could lead to weight loss. The Boston Globe. Accessed via Lexus-Nexus 9/29/2006.
46. Williams N. Genes in behaviour scrutiny. *Current Biology*. 2002; 12: R711-R712.

47. Herman J, Perry J, Van der Kolk B. Childhood trauma in borderline personality disorder. *Am J Psychiatry*. 1989; 146: 490-495.
48. Editor. (8/12/2002). Science weighs in. St. Louis Post-Dispatch. Accessed via Lexus-Nexus 9/29/2006.
49. Lieb K, Zanarini M, Schmahl C, Linehan M, Bohus M. Borderline personality disorder. *The Lancet.* 364; 453-461.
50. Sabin J, Daniels N. Determining "medical necessity" in mental health practice. *Hastings Center Report*. 1994; 24: 5-13.

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