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Who can blame who for what and how in responsibility for health?

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Abstract

This paper starts by introducing a tripartite conception of responsibility for health consisting of a moral agent having moral responsibilities and being held responsible, that is blamed, for failing to meet them and proceeds to a brief discussion of the nature of blame, noting difficulties in agency and obligation when the concept is applied to health threatening behaviours. Insights about the obligations that we hold people to and the extent of their moral agency are revealed by interrogating our blaming behaviour, and to facilitate this my own blaming attitudes and actions are analysed in respect of an imagined adult son who seeks thrills by jumping from a pier into the sea, an activity common around coastlines and intended to be analogous in varying degrees to a range of health-threatening behaviours. I consider my responses to this imagined act in relation to some features of moralism, the excess of morality, concluding that blame can be justified when it is proportionate and within interpersonal relationships. There is evidence that some nurses hold negative blaming attitudes towards groups of patients considered to have caused or contributed to their illness, but this is not justified, not only because of impaired agency, but because if there is responsibility for health, associated obligations are owed to those who share our lives, and it is those people who are entitled to hold individuals responsible. Nurses who hold negative blaming attitudes towards groups of patients are invited to identify the status of moral agency, the precise natures of their (failed) obligations and of the patient / nurse relationship. It is concluded that reflection on these matters, and the difference between justified blame and moralism demonstrates that blaming behaviour in the context of professional health care is built on nothing stronger than prejudice.

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Introduction

The concept of personal responsibility for health forms part of the political and philosophical landscape of professional health care, and yet it is poorly understood. Responsibility can be presented as a tripartite concept consisting of (1) a moral agent having (2) responsibilities understood as obligations and (3) being held responsible for them, that is being blamed in failing to meet them (Snelling 2012a). Each of these areas is problematic when the concept responsibility is applied to health, specifically to health-effecting behaviours. Moral agency, or at least the capacity for autonomous decision making, is assumed in professional health care, and yet is inhibited in much health threatening behaviour not only by so-called weakness of will (Kennett 2001) but also by developing insights into behaviour from neuroscience and psychology. Obligations related to health and health related behaviours are stated or implied in official documents like the National Health Service (NHS) constitution which asks that patients:

> Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.[1]
>
> (NHS 2013a, p.11)

This leaves unclear what exactly the 'significant contribution' is and what taking personal responsibility for it entails. Finally, when we say that we hold someone responsible for something, for an action or an omission, what we generally mean is that we blame her for it (Smith 2007), but despite being as 'common as water' (Sher 2006, p.vii), performing a necessary role in our moral experiences, blame is under-examined within professional health care. Recent events demonstrate that when things go wrong[2] nurses, managers and politicians are capable of blaming each other and being blamed, but blaming patients for causing their illnesses remains outside professional health care, even when outcomes are similarly poor.

This paper considers the nature of blame as part of personal responsibility for health. I will begin by briefly discussing the nature of blame and its application to health-effecting behaviours where both moral agency and moral obligation are problematic. Despite this, it is clear that we do sometimes blame others for behaviour that threatens health, and in order to interrogate this I question my own blaming behaviours in the case of my imagined adult son who has jumped off a pier into the sea, an activity known as tombstoning and which functions as an analogy for other health threatening behaviours. Questioning my own intuitions and imagined feelings in this case in relation to some features of moralism, the excess of morality, concludes that my blaming practices are proportionate. A discussion of the appropriateness of health care institutions and practitioners blaming patients for their

[1] The initial version of this clause of the NHS constitution stated that: 'You should recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.' It is interesting because the latter version reduced the normative force of the clause by changing the normative 'should' to the merely requesting 'please' at the same time as strengthening taking responsibility by amending the ambiguous 'take some personal responsibility' to the clearer 'take responsibility.' See Schmidt (2009) on personal responsibility for health and the NHS constitution.

[2] In the UK there has been a series of high profile failures of hospitals followed by investigations inevitably leading for public calls for accountability. The Keogh review into the quality of care in 14 hospitals identified as a common theme (2013 p.5) 'the imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement'. See also Cooke (2012) on blame in nursing and health care.

health threatening behaviour follows. It is noted that Codes of Professional Conduct do not permit this, though refraining from blaming patients because of fear of being blamed for unprofessional moralism requires an impoverished understanding of compassionate nursing. The paper concludes by arguing that a critical reflective analysis of an instinctive and emotional blaming attitude, which exists in places within the nursing profession, will challenge assumptions that health threatening behaviours are wrong, that patients are always fully morally responsible, and that nurses stand in such a relationship to patients that blaming is permitted, providing support for regulatory injunctions against blaming patients for their choices.

The nature of blame

Though there is a deep and necessary connection between the three constituent parts of responsibility, they can to different extents be considered separately. We can conceive of the notion of a full moral agent, probably counting ourselves among their number, whilst recognising difficulties where moral agency is compromised. We can also make some sense of the notion of a health related obligation separate to issues of agency and blame. At a simple level, a claim could be advanced that we ought not to smoke cigarettes, that smoking is morally wrong. We know what this means and what sorts of arguments are required to defend a claim about the moral status of smoking. However, the notion of blame is more difficult to conceive of in isolation because we have to blame someone for something in a certain manner. It is not so much a unidirectional and rational process from agent through (failed) obligation to justified blame, as a complex bidirectional and often emotional interaction between the elements. We do not, initially at least, generally consider the extent of moral agency and the nature of an unmet obligation in order to arrive at a considered blaming regime. When we blame someone we make assumptions about unmet obligations and moral agency, apportioning blame to agents as a reaction which can be revised in the light of information about agency and intention.

Blame defies simple definition, but can be considered as a range of responses to perceived wrongdoing by a responsible agent. Strawson's (1962) celebrated paper, *Freedom and Resentment*, developed by many (notably Wallace 1994), conceptualised blame as a range of reactive attitudes we feel in response to others' acts, omissions or character. We feel indignant or resentment if someone wrongs us and more objectively we disapprove if the wrongdoing does not directly affect us. Martin's (1991) typology of blame starts with the simple *judgement* blame, the attribution of a morally wrong act to a morally accountable agent. *Attitude* blame consists of negative attitudes and emotions including the sort that Strawson described. Martin's third category is *censure* blame, constituting acts of 'public criticism…to include all verbal and physical expressions, from snide remarks and hostile denunciations to shunning and other body language' (1991, p.96). Finally, the fourth category is *liability* blame, involving costs in the form of penalties and punishments. Care is required here not to conflate moral responsibility with other forms of responsibility such as contractual responsibility which more clearly assigns penalties and can do so outside any notion of moral responsibility.

There are two ideas generally encompassed within understanding of blame (Scanlon 2008): assessment and sanction. In Martin's scheme, judgement and attitude comprise assessment and censure and liability comprise sanction. The component parts are variously expressed elsewhere though are not exactly coterminous. Coates and Tognazzini (2013) refer to blame and expressed blame; or we can refer to an initial backward-looking, emotional or cognitive

assessment in contrast to a forward-looking response which follows. Or we can refer to a person being blameworthy if we think or believe that he has done a wrong thing that can be attributed to him, and blamed if some action on the part of the blamer follows. Linguistic confusion is apparent here because on the accounts that I have offered - judgement and attitude / censure and liability; blameworthy / blamed; assessment / sanction; blame / expressed blame - the word "blame" can mean either or both component parts. For clarity I will follow Scanlon's nomenclature, assessment and sanction. There are two obvious differences in these orientations: control and purpose.

Assessment blame can respond emotionally to what has happened and this part of it at least is generally not under conscious control. We *feel* anger, irritation and resentment, we do not think them. It is possible that there is no outward manifestation of these emotional blaming reactions, or there may be some unconscious facial grimacing or suchlike which can communicate disapproval to the supposed transgressor and everyone else. In contrast, sanction blame takes these assessments and acts upon then them in a variety of ways including Martin's categories, censure and liability. These acts are under conscious control, or at least they are more capable of being so than immediate reactions. We choose to remonstrate with someone we think has wronged us, or to use this wrong as justification for a further act of liability or even retribution. Policies that define sanction blame are considered, capable of critique and defence. Some examples of sanction blame, uttering a hasty rebuke to someone knocking over a drink, may be more of a reflex action than a considered one, but nevertheless this is under conscious control. If instead of remonstrating we were to threaten or punch someone who spilt our drink, saying that it was a reflex would certainly not be considered sufficient defence in law.

The second difference is purpose. At a general level it is claimed that there is an evolutionary purpose for morality (Machery and Mallon 2010), and the reactive responses we feel are part of this. As, generally, we care what people think of us, we want to avoid being thought badly of and this has a powerful effect on social cohesion, encouraging observation of societal norms. Similarly we want to be thought well of. We may seek to avoid these negative assessments but they are confirmed and enhanced by expressions of displeasure, privately or in public. Individual acts of blaming reinforce the sentiments as a forward looking deterrent in a number of ways; by persuading the transgressor not to repeat his bad act, and as a warning and motivation to others. It is not suggested that all acts of blame are devised and undertaken having carefully considered their purpose, but it is possible; and having stated a purpose, efficacy can be considered and in some cases evaluated. For example, Callaghan (2013, p.39) argues for 'stigmatization lite' against obesity as part of a series of measures designed to make obesity socially unacceptable, with the aim of reducing its prevalence. This may have some effect on preventing obesity, but it does not appear to have an effect of those already obese. Sutin and Terracciano (2013) found that perceptions of discrimination are likely to have the opposite effect.[3]

The relationship between the elements is complex. Strawsonian reactive attitudes or more considered judgements of the moral status of an act might be considered prior to and necessary for sanction blame, but the component parts do not necessarily have to exist together. Negative reactions can be felt or judgement made but a choice can be made not to voice them; an agent may be blameworthy but not (outwardly) blamed. Alternatively, acts of sanction can be performed in the absence of a reactive emotion or a judgement of

[3] See also Schafer and Ferraro (2011).

wrongdoing in pursuit of an overall aim. Having a purpose which can be evaluated tends to a utilitarian account of considered blaming behaviour, stated boldly by Smart (1973 p.49-50):

> A utilitarian must therefore learn to control his acts of praise and dispraise, thus perhaps concealing his approval of an action when he thinks that the expression of such approval might have bad effects and perhaps even praising actions of which he doesn't really approve.

On Smart's thoroughgoing version of utilitarian blame it does not follow from it being right to blame someone that that person is blameworthy (Arpaly 2000); and seeking a purpose for our blaming actions does not commit us to a thoroughgoing utilitarian account of blame, much less a utilitarian morality. Blaming someone who is not blameworthy may simply be a malicious or self-serving act.

Blame is clearly a phenomenon which is both complex and wide ranging, and yet similar to other concepts like responsibility and autonomy it stands in need of an everyday understanding because it forms such a central part of moral life. Additionally, within professional health care, an understanding of blame is needed if only so it can be avoided. In the literature of health promotion, for example, victim blaming is often raised only so that it can be dismissed with no explanation. Downie *et al.* (1996, p.31) simply state that 'care should be taken to avoid victim blaming', and Holland (2007) notes that the problem with making behaviour modification the focus of health promotion is that it 'smacks of victim blaming', indicating that even the suggestion of blaming is problematic. Draft guidance from the National Institute for Health and Care Excellence (NICE) on managing overweight and obesity in adults (2013, p.6) recommends that 'dialogue is respectful and non-blaming.'

Blame is often paired with what is considered to be its opposite, praise. There are clear similarities between processes and elements of praise and blame, but there is no similar restriction on praising patients within professional health care. It might be considered that since praise and blame both generally follow a process of assessment, that it is the expression of blame rather than any notion of moral assessment which is outlawed in health promotion. The NICE draft guidance recommends that health professionals be trained to provide 'support and encouragement' rather than praise, though there is clearly some overlap. Praise certainly does follow from blood donation (Snelling 2012b), and in the UK a nurse[4] was recently honoured for whistleblowing about poor care, both activities which might be regarded as obligatory rather than praiseworthy.

Thus far I have discussed the features of blame rather than its justification. I take it as axiomatic that justified sanction blame requires the attribution of a wrong act to a moral agent, and so it can be objected to on the grounds that the agent is not morally responsible, or that the act or omission is not morally wrong. These conditions are both problematic within responsibility for health.

Moral Agency

Unlike the issue of capacity for decision making, which in practical application at least requires an binary assessment of capacity, blame depends in varying degrees on moral agency with full blame being reserved for those with full agency - that is being fully morally

[4] http://www.bbc.co.uk/news/health-25549054

responsible. We blame people differently, or not at all, depending on their level of agency. A nurse in an emergency department assaulted by a person with dementia would regard her assailant differently from someone who assaulted her while drunk, differently again from someone who was simply impatient or frustrated. Individuals with dementia are not blameworthy, those who are simply frustrated are. Those who are inebriated may not have capacity as defined in the Mental Capacity Act but may still be regarded as blameworthy for an assault while drunk because they decided to get drunk in the first place[5]. A person confused because of a urinary tract infection may not be blameworthy for an assault, but a person with diabetes equally confused because of hypoglycaemia may be to some extent; he might have been able and obliged to prevent the hypoglycaemia[6].

Attribution of acts to agents can be further reduced in the case of health-effecting behaviours in a number of ways. For example, smoking cigarettes is widely acknowledged to be an addiction, a state of affairs defined by impaired control (Kranzler and Li 2008) and which results in breaking an addiction being widely regarded as praiseworthy. It could be said of course that an individual's first cigarettes are smoked from choice before the addiction that will bind him to his habit takes hold, but in many cases considerable peer and marketing pressure influences choice especially in younger people. Some smokers started smoking before the dangers were fully known to them. Similarly, obesity and overeating can be characterised as addictive behaviour (Gearhardt *et al.* 2012). It is clear that it is more difficult than might have been expected to attribute agency to behaviour and thence to ill health, and that this impedes holding people responsible for their health.

The problems of moral agency extend to all people for all acts. Attribution of responsibility for an act to an actor has hitherto been regarded in discussions about free will and determinism in terms of whether he could have done otherwise, though the 'new compatiblists' regard this as the ability to decide on the basis of reasons (Sie and Wouters 2010). The continuing position of respecting autonomy as the predominant principle of bioethics may need increasingly robust defence in light of the challenges from behavioural, cognitive and neurosciences (Sie and Wouters 2010), and the view that, particularly when future and current desires are concerned, different versions of autonomy can coexist (Coggon 2007). That the simplistic image of individuals as free and autonomous choosers is increasingly being accepted as questionable is demonstrated by the use of choice architecture based on behavioural insight (Cabinet Office 2011, Thaler and Sunstein 2008) as well as the presentation of health promotion information in a way that does little to facilitate personal autonomy, and much to manipulate choice (Snelling 2014).

Holding individuals responsible for their health status

To say that we are responsible for our health could be read to imply that health *per se* is the thing that we are responsible for, that we have failed in our responsibility if our health is bad. It cannot follow that being well *per se* is a moral obligation. Likewise, being ill cannot be morally forbidden, even if it is considered to be a moral harm, because the range of acts and omissions relating to health is not fully determinative of a person's health status, regardless of how health is defined. The famously all-encompassing World Health Organisation (WHO)

[5] It could be that the response would be different if it was a dependent rather than an infrequent drinker.
[6] See Rumbold and Wasik (2013), for discussion of a case where a man who managed his diabetes well was convicted of causing death by dangerous driving following an unheralded hypoglycaemic episode. Also, Rumbold (2013) on the legal defence of automatism.

definition that health 'is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[7] is inconsistent with a simplistic version of 'personal' responsibility for health. Not only are many of the determinants of physical and mental health (environmental, social, genetic, luck and the availability of good health care) outside personal control, but physical and mental health, understood in terms of the absence of disease are but one part of health widely conceived following the WHO model or something like it. Personal behaviour can contribute to poor health and good health, even on the wide model, but not to the extent that discourse on personal responsibility implies; a narrower conception which tends to regard health as the absence of disease and personal behavioural influences on health as overriding. Under a narrow, disease reducing, life lengthening approach, behaviour that threatens health is wrong; under a wider health and wellbeing approach it might not be if it contributes to wellbeing in other ways.

Simple binary distinctions nearly always oversimplify but are useful heuristic devices and can identify the polar extremes of a continuum whilst acknowledging that the truth (if there can be one) lies in between. But for both positions, the moral appraisal of health-effecting acts and omissions is only necessary because they threaten our health. There is little *necessarily* wrong with smoking, for example – it is wrong insofar as it harms others and harms our health. It would be unjust to hold someone morally responsible for a state of affairs (poor health), unless he is also causally responsible for it. A problem for smoking and drinking more than we are told is good for us, is that there is no *necessary* connection between smoking and poor health. This does not deny at a population level a causal relationship between smoking and heart disease (which would be foolish given the weight of evidence); but at an individual level, smoking is neither necessary nor sufficient condition for (say) having a heart attack, much less smoking this or that cigarette. Many smokers die in old age having never suffered a heart attack, and many never-smokers suffer heart attacks. And some smokers who have suffered a heart attack would have had one anyway, had they never smoked. The heart attack cannot be attributed solely to smoking and hence to the agent. Other diseases or disabilities can be attributed to acts or habits more readily, but even here it does not follow despite clearer lines of causality that illness-causing behaviour is necessarily wrong. It may, for example, have been undertaken in the pursuit of a higher value. A fireman burned rescuing someone from a fire would be praised, whereas a smoker similarly injured in a fire caused by smoking in bed would be blamed. Smoking or drinking to excess may contribute so much to an individual's conception of his own wellbeing, that he is prepared to take the risk of contracting the diseases that his habit may contribute to.

The concept of personal responsibility for health is beset with difficulties and inconsistencies. The problems of moral agency, the ambiguous and individual value of health and often uncertain causal links between health threatening behaviours and an individual's poor health (narrowly defined), make it difficult to identify each person's obligations in respect of his health. It would be easy to dismiss the very idea that we can be morally responsible for our health, and therefore we cannot justly be held responsible for it, but this would negate the proven group correlations between behaviour and health, which most people value highly. Given the link between a failure to meet an obligation and being blamed for it, one way to interrogate the obligations that we have in respect of our health is to examine the way that we react to individuals who may have failed in them, that is how we blame them.

[7] For example http://www.who.int/suggestions/faq/en/

Methodological and reflective interlude

Philosophy can be seen, by some, as something of a puzzle divorced from personal or professional experiences and the need or desire to change them, and perhaps this is especially the case in the philosophy of an essentially practical profession like nursing, whose very existence in the academy is questioned (Thompson 2009). Books and papers in academic philosophical journals use a variety of methods to link their normative or empirical claims to everyday life including testing outcomes of analysis against intuitions. In applied analysis, factual claims are often made, as I did at beginning of this paper. Scanlon, for example (2008, p.123) states: 'This account seems to me to fit in with much of what we say about blame…', but it is not always clear what is meant by this sort of statement; whether embedded in the 'we', is an empirical claim involving more than one person, a few, a majority or nearly everyone. An uncontroversial explanation would be that a claim is being made here about plausible rather than actual facts.

Seeking a psychological explanation for blaming behaviour starts by asking not why, but how we blame. As Korsgaard (1992) suggests, there does seem to be something unappealing about taking the assessment of others as the starting point, but on the reactive attitudes account of blame that is exactly what we do. The developing field of experimental philosophy (Alexander 2012) offers some insight in establishing how we blame but this does not of course settle the question of how we ought to blame. When presented with an abstract scenario presenting information about determinism, people tend towards incompatiblism, a position that is reversed when concrete emotional examples are used in experiments (Nicholls 2011). It is also argued that incompatiblist intuitions are explained by errors in popular understanding of what determinism is (Murray and Nahmias 2012), which, when addressed result in compatiblist views.[8] These experiments concerned causal determinism, more complete than the partial determinism influencing health and behaviour. If the philosophical work on blame is still in its 'infancy' (Coates and Tognazzini 2013, p.3), the issues of free will and determinism are less discussed today than in Strawson's founding essay with contemporary work being more inclined to address the psychology and significance of blame within moral life (Coates and Tognazzini 2013).

A blameworthy and analogous tombstoning son.

The necessity for blaming judgements forming part of an overall understanding of responsibility for health does more than offer an opportunity for introspection, it probably requires it, and in pursuit of this I have interrogated my intuition in a case involving health-effecting behaviour. I imagine that my (adult) son has jumped thirty feet from a pier into the sea after enjoying a lunchtime drink. The activity of tombstoning has been subject to disapproval and regulation but also has been defended as an enjoyable outdoor activity whose risks can be minimised (Snelling 2014). It can be regarded as analogous to the whole range of health threatening behaviours that are the standard targets of health promotion and regulation. There are similarities and differences between all these activities; in the level of enjoyment, addictive nature, the requirements for preparation, whether harm is accumulated or the result of a single instance, and the extent of wider societal harms. The discussions about blaming my son can be transferred to varying degrees to other sons and daughters, fathers and mothers, spouses, friends, neighbours, acquaintances and other individuals more inclined, perhaps, to a more sedentary lifestyle, a 'poor' diet, 'excessive' drinking, and smoking.

[8] For an excellent overview of asymmetries in blaming behaviour, see Knobe and Doris (2010).

I think that I would feel some disapproving emotions upon hearing of his behaviour, but even after detailed consultation with the thesaurus it is difficult to capture what these feeling would be. I would feel, I think, disappointment and exasperation, cross and concerned that he has put himself at risk. The episode and the provoked emotions seem to fall between the categories of reactive attitude given by Strawson. The harm to me is minimal and there is no intent, so resentment seems too strong a response. But the dispassionate and uninvolved disapproval of the objective reaction does not capture the special feelings I would have in virtue of the relationship I have with my son, though I may simply disapprove of unknown others doing the same thing in another seaside town. There would be a feeling that he had done something that was wrong as well as unwise, and of course overwhelming relief that he hadn't been hurt. The next time I saw him I would certainly explain in no uncertain terms why I am cross and why he should not repeat it.

What would I feel had he been harmed? The act that provoked my negative reaction is the same; what would be extra here is that moral luck would have frowned upon him instead of smiled. Now knowing of his injury if I retain the blaming stance (or even if it is deepened) in light of the injury would I be blaming the victim? Robbennolt's (2000) systematic review confirmed that we are more likely to apportion blame for the same act when the consequences are severe. Thankfully these are imagined reactions, but Sonny Wells' parents had to face this exact issue when their son was paralysed in an accident after jumping from Southsea pier into three feet of water. Sonny and his parents made videos after the accident to publicise the dangers; his mother spoke of 'stopping' (BBC 2011) others from doing what Sonny had done, and his father spoke of Sonny's 'selfishness' (BBC 2008a) in seeking his post drinking excitement in such a disastrous way.

My instinctive reactions to my imagined tombstoning son suggest that I am blaming him and in large measure this guides an account of justified blame consistent with my intuitions. Having carefully considered my blaming judgements and sanctions, though not against an external and objective measure, I think that my reactions are proportionate. Fairly to blame not only requires that the blamed person is a responsible agent, but also that he has failed in an obligation, that the blamer stands in an appropriate relationship to the actor and that the blame is proportionate. Failure in any of these areas renders the blamer blameworthy, guilty of the 'vice' of moralism[9] (Taylor 2011).

Simply, moralism is the excess of morality. Like many things which are defined in terms of 'excess' it can be difficult to draw the line, and those on the wrong side of it, or deemed to be or accused of being on the wrong side of it may want to redraw the line or even deny that there is one. Moralism takes many forms (Driver 2005) some of which apply to the case under consideration.

The nature of the obligation

Moralism is overly demanding, regarding the supererogatory as obligatory, the permissible as forbidden. My concern and displeasure upon hearing of my son tombstoning must be based on an implicit assumption that the blaming stance that I have taken means that I think that he has done something wrong, but it is not immediately clear what it is. Tombstoning (and cream cakes and cigarettes and drinking too much) does threaten health but it is also

[9] In a similar vein, Watosn (2013) discusses judgmentalism, but points out that nonjudgementalism can be considered a vice.

undertaken in pursuit of an individual notion of the good life. Or at least I would hope that it is. If I found out that my son had jumped just because everyone else had, or just to impress a girl or a gang of lads, my reaction would be more severe than had he made a cool calculation about the benefits and risks involved. The obligation that I hold him to, and blame him for not meeting is one of process rather than outcome (Snelling 2014). In arguing that the moral status of tombstoning is not linked to an absolute view that it is wrong I hope to escape the charge that I am regarding the sometimes permissible as always forbidden, that I place too much emphasis on impersonal and universalisable moral precepts, seeing them away from their lived experience. Blaming my son, initially by means of an emotional reaction, invites me to reflect upon and assess exactly what it is that he has done wrong.

The nature of the relationship

There appears to be something of a paradox between two positions that are taken to be standard in ethical analysis. First that ethics is everyone's business, that we have at least minimal obligations to other people just because they are people. Many health care scandals in recent years have arisen and continued because people knew what was happening and yet did not intervene[10]. Yet, 'minding our own business' is widely considered a virtue (Radzik 2012), and as every parent knows, you admonish other people's children very rarely and only with good reason and great caution. Understanding whether you are situated such that an intervention, including taking the public blaming stance is permitted or even obligatory, or an act of moralism is an important part of our everyday moral fabric. Partly it is concerned with the nature of the act which is objected to; the more serious the moral transgression, the stronger the justification or obligation to intervene, but generally this must be tempered by the nature of the relationship or the standing that the blamer has to the blamed (Bell 2013; Watson 2013).

A full account of friendship or kinship is not required for friends or relatives to understand that at least reciprocated emotional ties and feelings allow open moral appraisal that would be considered self-righteous undertaken by a stranger or an acquaintance. Friendship and kinship may require the outward expression of such moral appraisal in order to conserve the relationship, but repeated blaming behaviour even in the presence of repeated wrongdoing would probably threaten it. We can make sense of general rules and categories of friendships but they are best considered unique, such that, as Williams (2013, p. 11) claims:

> Both parties must, in order to sustain their relationship, find a mutually agreeable way to deal with whatever wrongs one or both of them perceive. […] the standing involved is not quite the authority to *hold* responsible, but rather to share responsibility (emphasis in original).

This is not restricted to the wrongs the friends do each other, but also applies to more general wrongs. It is significant that Williams suggests that the purpose is sustaining the friendship rather than preventing or compensating for a wrong act. But this may not be possible; Scanlon defines blame it in terms of impairment of a relationship: 'to claim that a person is *blameworthy* for an action is to claim that the action shows something about the agent's attitudes towards others that impairs the relationships that others can have with him.' (Scanlon 2008, p. 128).

[10] In the UK, the 'official' nursing response to highly visible episodes of very poor care was the 'Compassion in practice' strategy which includes 6Cs, including Courage, [which] enables us to do the right thing for the people we care for, to speak up when we have concerns…' (Cummings and Bennett 2012)

The imagined relationship that I have with my adult son is of a different order, though of course it need not be. In the case of a strong relationship at least, it is easier to conceive of the notion of shared lives and responsibility. It is not just that the relationship is such that my obligations to him would result in my caring for him if he was injured, impeding my ability to realise my own life ambitions. It is substantially that emotionally at least, his interests, success and pain are shared with me and it is this stake that each of us has in the other's life that partly settles the obligations in the first place and then makes it allowable for each of us to hold the other responsible[11]. Those outside our relationship would need compelling justification to blame at all.

The nature and purpose of the blaming behaviour.

Blaming appropriately requires proportionality and consistency[12] within if not between relationships. The concern that I would feel would proceed to a stronger and considered remonstration that for his sake and mine, that he should not repeat the behaviour unless he has undertaken reflective calculations on risk and benefit. My purpose here is to encourage that he make the calculations rather than to prevent him from undertaking the activity. If he considers that he has done this it is open for me to disagree and regard him unfavourably as a result, but this is likely to represent an attempted imposition of my values upon him, something that could be considered moralistic. My expressed crossness as to the wrongness of his action and the inadequate reasoning that preceded it seems enough to do what I require of it, and I would be justified I think, if I reminded him of his obligations the next time he went out on a sunny day. But it probably would not be justified if stronger expressions of sanction blame were used – if I used surveillance to monitor his activity, or withheld what would normally be his due if he continued, or at the extreme sought to prevent him from going out at all or to pick and choose his friends and activities for him. It could be argued that some of these actions are not properly regarded as blaming actions, but in any event my repeated or prolonged censure or the imposition of strong sanctions in respect of his behaviour would probably fail in their intended purpose, and worse, cause such resentment that the nature of the relationship would be impaired. I would be blamed, and not only by him, for excessive blaming.

If his repeated tombstoning resulted in an injury, my immediate and unreflective emotions would probably be similar if not deeper than I would have experienced previously, exacerbated no doubt by his failure to heed my pleas. This might extend to unconscious expression of this attitude in what would be a highly emotional hospital visit. On reflection, it would be clear to me that the considered and expressed blame I previously subjected him to has failed, that what I was trying to prevent has materialised and so further sanction blame would serve no forward looking purpose in changing my son's behaviour. It might be argued, similarly to Callaghan in relation to obesity, that even though there is no prospect for purposeful blaming in this individual case, it nevertheless is justified or required *pour encourager les autres*. In effect this is what Sonny Well's father did in giving the interview cited earlier. The difference is that Callaghan seeks prevention of obesity through individuals wishing to avoid stigma, whereas the stated intention of both Sonny and his father is to

[11] I don't claim that the relationship between a father and his adult son is or should be symmetrical.
[12] This is more objective in law in sentencing guidelines with associated appeals by the convicted if the sentence is considered too harsh, or by the Attorney General if too lenient.'The Sentencing Council for England and Wales promotes greater consistency in sentencing, whilst maintaining the independence of the judiciary' available at http://sentencingcouncil.judiciary.gov.uk/

educate others (BBC 2008b) in the midst of what must have been a devastating and deeply emotional time for the family.

The examples of what I regard as justified blame offered in this paper have highlighted that unless the moral wrong is severe, blaming attitudes and behaviour are best justified proportionately and within interpersonal relationships. Within the criteria identified, some variables admit to wide gradation and subjective interpretation, diminishing the prospect of a simple and generalised account of justified blame. Consulting my intuitions in an emotionally driven case has helped identify some features of justified blaming which can be considered rather than applied elsewhere. There are analogies to be found between my blaming my imagined tombstoning son and the apportion of blame elsewhere, but the normative force of comparisons often lies in differences rather than similarities between cases (Mertes & Pennings 2010). These differences can only be identified on considered reflection, which, it is to be hoped, forms a significant part of professional health care. What I have considered this far is how individuals may be blamed for failures in relation to their responsibility for health and I conclude the paper by considering whether the blaming stance can legitimately be taken within professional health care.

Blaming and health care practice (i) institutions.

In England it is the NHS, via its constitution, which sets the normative 'request' that people accept responsibility for their health, and it is implied in policy documents concerning the health of the nation and the role that behaviour has upon it. We can conceive of such a thing as institutional blaming, but this is more meaningful in contractual or legal responsibility, as this is restricted to considered sanction blame. The socialised nature of most health care in the UK, and the constant pressure placed upon it, means that there are opportunity costs for every intervention, so that wasting the time of health care professionals, for example by not turning up to an appointment, risks not only poorer health outcomes for the individual but also missed opportunities to improve the health of others[13]. Fees for cancellation of appointments are made in some places[14], but generally despite setting the expectation it is difficult for the NHS as an institution to hold individuals responsible for their health threatening behaviour.

One way in which this could be considered is in institutional policies which exact sanction blame, for example in denying treatment to smokers for lung or heart disease on the grounds that the patients have caused the disease themselves and so are less entitled than 'blameless' patients. There is some discussion in the literature about the ethics of denying or de-prioritising treatment to individuals (normally categorised into groups) deemed to be responsible for their poor health[15] though currently policy is that this cannot be considered.

[13] According to the Health and Social Care Information Centre (2013) there were 6.7 million missed appointments in the year to September 2012, representing 7.3% of all appointments. It is claimed that this costs hospitals £600 million per year (Dr Foster Intelligence, undated). It is worthy of note that Section 5 of the Criminal Law Act makes it an offense to cause wasteful employment of the police, and the Fire and Rescue Services Act makes raising a false fire alarm also unlawful.

[14] Fees for missed appointments are allowed by dentists in Scotland, but not in England. See http://www.scotland.gov.uk/publications/2011/01/25085008/1 and http://www.nhs.uk/chq/Pages/1789.aspx?CategoryID=74 According to the King's Fund, the extension of this measure has public support (Galea *et al.* 2013).

[15] For example: Buyx (2008), Feiring (2008), Sharkey and Gillam (2010), Buyx and Prainsack (2012). In addition, research funding (US) for lung cancer is considerably lower per death. See Wilson (2013) for a discussion.

Public attitudes have been reported in favour[16]. As well as identifying procedural problems, Harris (1995) argues that this would constitute double jeopardy by punishing people twice; once by them contracting a disease linked to their habit, and then again by refusal to treat it. It may look sometimes that overweight people, for example, are being prioritised minimally or even denied treatment, but care is always taken to defend decisions on the basis of forward looking considerations outside desert, that is, outcomes are poorer.[17] It seems clear that in an increasingly litigious environment any attempt to deny treatment or to reduce its priority on the basis of desert would be likely to be resisted by individual patients and their advocates making open discussion and clear policy making key. In contrast, using positive desert as an acknowledged criterion for advanced priority seems less problematic to policy makers. In 2007 the UK government made it clear that service veterans should be afforded priority for conditions caused by military service, whilst attempting to retain priority for clinical need (Donaldson 2010), and the recent strategy document from National Health Service Blood and Transplant (2013) recommends a national discussion about prioritising prior registered donors for receipt of organs (Jarvis 1995), as is already law in Israel (Lavee *et al.* 2010).

Blaming and health care practice (ii) healthcare practitioners

Blaming is more likely to be undertaken by individual health professionals, through both assessment and sanction. Research over many decades and in many countries has found that a persistent minority of nurses hold negative attitudes to groups of patients, for example to substance misusers (Howard and Chung 2000a, b), obese people (Poon and Tarrant 2009, Mold and Forbes 2013) and people who self-harm (McAllister *et al.* 2002, Saunders *et al.* 2012). Negative attitudes may contribute to feelings of stigmatisation for example in lung cancer (Chambers *et al.* 2012) obesity (Puhl and Heuer 2009, Creel and Tillman 2011) and HIV (Nyblade *et al.* 2009). All of these conditions are to large extent caused by personal behaviour. Holding blaming attitudes and acting upon them is clearly identified as being unprofessional by the UK nursing regulator, the Nursing and Midwifery Council (NMC) (2008) which states in its professional code that:

- You must treat people as individuals and respect their dignity
- You must not discriminate in any way against those in your care
- You must treat people kindly and considerately[18]

(NMC 2008, p.2)[19]

These statements appear to rule out disapproval and blame, because to do so would not (arguably) be respecting dignity, might result in discrimination, and would not be treating people kindly or considerately. The medical code of practice in the UK deals with the issue of blame more directly.

> You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.

[16] For example in the US Gollust and Lynch (2011). And see Bowling (1996).
[17] See for example http://news.bbc.co.uk/1/hi/england/southern_counties/4717764.stm . And see Salih and Sutton (2013) for a review.
[18] Of interest is the corresponding clause in the General Medical Council document 'Good Medical Practice' is You must be *polite* and considerate (my italics) (GMC 2013, p. 16).
[19] Addressing the issue more directly, the previous version of the Code of conduct stated that 'you are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients irrespective of…lifestyle' (NMC 20004).

(General Medical Council 2013, p. 19)

As if to emphasise the importance this is re-stated on the following page:

> You must not unfairly discriminate against patients or colleagues by allowing your personal views* to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance.
>
> (General Medical Council 2013, p.20)

The * is elaborated upon in a footnote: 'This includes your views about a patient's or colleague's lifestyle, culture or their social or economic status…'

The NMC Code also requires that nurses advocate for their patients; MacDonald (2007) goes so far as arguing that it is a universally held moral obligation. Advocacy itself is contested and complex, but it is clearly connected with arguing for personal choice[20]. If a patient wants to stop smoking or lose weight then blaming him within the professional relationship is very unlikely to facilitate it; and if he does not want to change his behaviour, then blaming him is the opposite of advocating for his self-determination.

But it would be a thin and ironic compassion that dissuaded health care professionals from unprofessional blaming simply for fear of being blamed. The injunctions from professional bodies cover sanction blame only, and it is possible that individual practitioners retain blaming assessments whilst being careful to avoid giving them outward expression. This behaviour complies with the letter of the codes, and yet falls short of what most people take a good nurse to be; an account which includes reference to character as well as acts (Sellman 2011), requiring open-mindedness (Sellman 2003) in challenging their attitudes. A good nurse not only follows the Code's injunctions against discrimination but also understands why she should.[21]

An initial critical interrogation of any emotional or unconsidered response should start with asking what, exactly, the person has done wrong such that they are blameworthy for doing it. This requires detailed thinking about the nature of obligation in relation to their own and others' health. Simply uncritically accepting the mantra that health is an intrinsic good to be prioritised and valorised above all else is insufficient and it provides a challengeable initial premise from which procedurally correct but nevertheless similarly criticisable conclusions follow, and stands in tension with a further valorised principle in healthcare, the supremacy of personal autonomy. If a case can be made that a wrong act has been undertaken, consideration is also needed as to the extent to which it can be attributed to the agent, and health care professionals are in a better place than the public (or at least they should be) to understand the social, genetic and pathological determinants of health and behaviour.

If the case of attribution can be made then it may be that the agent is blameworthy, but it does not follow from this that blame by any health care practitioner is justified because the standing of the relationship does not allow it. Patients are simply not accountable to health care professionals. Justified blame of sorts does contribute to close relationships as I have

[20] See for example the NMC's Guidance for the Care of Older People (2009).

[21] This argument is strikingly similar to Clouser and Gert's (1990) much cited critique of ethical principlism. Practitioners respect autonomy because the principle tells them to but without theoretical justification, they do not know why they should.

described, but the albeit emotional and caring relationship that can characterise professional nursing excludes blaming attitudes. The relationships are fundamentally asymmetrical and blame is as illegitimate within them as it is within similarly asymmetrical but more hierarchical relationships between doctors and patients. While I would consider it appropriate that my injured tombstoning son may apologise for his actions, any apology would be offered to me because I (and certain others) would be ourselves be harmed in light of the harm to him, but it would make no sense for him to apologise to his carers, apart perhaps from a cursory apology more associated with politeness rather than genuine moral behaviour.[22] Similarly, it makes no sense, for him to seek forgiveness from the nurse for his actions (Allais 2008).

Finally, brief mention is needed where it might be appropriate for health care staff to blame patients, where the wrongdoing is to them directly, when patients are violent and abusive towards them. Though the relationship is asymmetrical, it isn't *that* asymmetrical, and it seems perfectly reasonable for nurses to feel the resentment that would characterise an assault outside professional health care. Much of the incidence and literature about violence to healthcare staff occurs within mental health services and accident units and here the question of impaired moral agency may be expected to lessen the force of the reactive attitudes. As far as sanction blame is concerned in addition to standard options to prosecute abusers through the criminal law system, the Handbook to the NHS Constitution makes it clear that though violent and abusive patients can be expected to be denied treatment by local policies, these 'should reflect that violent and abusive patients can only be denied access to NHS services if it is clinically appropriate to do so…' (NHS 2013b p.88). As an example, the policy from the University Hospitals Birmingham NHS Trust (2012) states that denial of treatment lasts for a year, excludes emergency treatment, and that arrangements are made to transfer care elsewhere.

Conclusion

To deny that people cannot be held responsible for their health-effecting decisions is to deny that there is such a thing as responsibility for health, to say that there are no health related obligations. However, obligations for individuals' own health are best understood and defined within interpersonal relationships and derive their strength from mutual obligations within shared interests and individual versions of the good life. This must mean that the obligations for each of us are individual in strength and, importantly, direction. We owe obligations of various sorts and in varying strengths to those who share our lives, and it is to these companions that we owe an account, because we fail them when we fail to meet our obligations. There are blameworthy acts in relation to responsibility for health and taking the blaming stance within and as part of interpersonal relationships may be justified if proportionate.

This account inevitably results in inconsistency because of variety in relationships and accounts of the good life, and this means that there can be no universalizable rules beloved by over-zealous health promoters (Fitzgerald 2001). Analysing the features of health related obligations and of justified blaming should explain why there is no place, in this account, for the notion of nurses and other health care professionals blaming patients for their health-effecting behaviour by their attitude and/or actions. At the risk of perpetrating an 'education reflex' (Paley 2007), an appropriate response to the minority blaming attitudes and behaviour

[22] See Smith (2005) for a detailed analysis of apology.

in respect of individuals deemed to have caused their own poor health and not fully deserving of health care is to mount an education challenge which will expose the simplistic 'philosophy' of much professional health care practice which values health for itself rather as part of a good life chosen according to the (allegedly) overriding principle of respect for personal autonomy. The challenge is first to identify what, exactly, individuals are doing wrong by undertaking behaviour that harms their health, and the extent to which it can be attributed to the them. A further examination of the nature of the relationships in professional health care and of the difference between justified blame and moralism will help practitioners to the view that the reactive emotions and their consequent blaming behaviours are built on nothing stronger than prejudice.

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