

Personal responsibility for health: meaning, extent and consequences.

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Contents

	Page
Abstract.....	7
Declaration and Copyright statement.....	8
Acknowledgements.....	9
 <u>PART 1: INTRODUCTION</u>	
Chapter 1 Introduction.....	11
Research questions.....	21
Structure of the thesis.....	24
Part I Introductory material.....	24
Part II Published papers.....	27
Part III Conclusion.....	31
A note on personal background.....	31
 Chapter 2 Background	 33
Personal responsibility for health: a brief history.....	34
The definition and value of health.....	41
Group cause and effect.....	45
Individual control and choice.....	46
Patient's duties	49
Codes and declarations: the NHS constitution.....	55
Conclusion.....	59
 Chapter 3 Legal context.....	 61
Legal and moral responsibility.....	62
Autonomy, legal paternalism and criminalisation.....	68
Legal regulation short of criminalisation.....	74
The Rampton smokers: A judicial and policy challenge to Mill.....	78
Lawful consequences of smoking: denying treatment.....	91
Conclusion.....	95
 Chapter 4 Philosophical Approaches.....	 97
Analytical approach.....	98
Normative approach: bioethics and public discussion.....	100
Public discussion (1): moral expertise.....	101
Public discussion (2): arguments.....	103
Rationality as the basis of the philosophical approach.....	105
Deductive arguments: moral theory.....	109
Philosophical approach: broad dual level utilitarianism....	112
Empirical justification.....	113

Normative justification.....	115
How and what to calculate.....	117
Act or rule.....	118
R.M.Hare's dual level account.....	120
Inductive arguments: case studies and analogies.....	123
Conclusion.....	128

PART II: PUBLISHED PAPERS

Chapter 5	Saying Something interesting about responsibility for health.....	131
	Abstract.....	131
	Introduction.....	132
	Two concepts, many conceptions.....	133
	Work required of the concept.....	135
	Concept analysis (1): responsibility in use.....	135
	Concept analysis (2): responsibility as social function.....	139
	The philosophical Literature.....	143
	Causation.....	143
	Other forms of responsibility.....	144
	Moral responsibility (1): Strawson and the reactive attitudes.....	146
	Moral responsibility (2): the accountability version.....	150
	Applying the framework to the case studies.....	151
	Applying the framework to health policy.....	152
	Moral agency.....	153
	Obligation.....	156
	Holding responsible.....	159
	Conclusion.....	162
Chapter 6	What's wrong with tombstoning and what does this tell us about responsibility for health?.....	165
	Abstract.....	165
	Introduction.....	166
	The case of Sonny Wells.....	167
	The moral appraisal of tombstoning.....	169
	Three moral positions.....	170
	Utilitarianism, public health and private morality	172
	Acts and rules.....	175
	The maximization of health.....	176
	What does this tell us about responsibility for health?.....	177
	Epistemic duty.....	179
	Reflective duty (1): harms.....	179
	Reflective duty (2): benefits.....	180
	Reflective duty (3): calculations - act or rule?....	182
	R.M.Hare's dual level account.....	184

	What to maximize and how.....	184
	Policy implications.....	186
	Conclusion (1): what’s wrong with tombstoning?.....	190
	Conclusion (2): responsibility for health.....	191
Chapter	Challenging the moral status of blood donation.....	193
7		
	Abstract.....	193
	Introduction.....	194
	Analytical framework.....	195
	Part 1: description.....	197
	The ‘official’ position.....	198
	The ‘official’ position: a critique.....	200
	Free will or legitimate pressure.....	201
	A very brief review of the empirical literature.....	202
	Part 2: normative.....	205
	The ‘official’ position: supererogation inferred....	205
	An alternative normative position.....	211
	The argument from beneficence.....	211
	The argument from justice: the wrongness of free riding.....	216
	Arguments extended.....	220
	Advertisements, nudges and a threat to the framework.....	222
	Conclusion.....	224
Chapter	Who can blame whom for what and how in responsibility for health?.....	229
8		
	Abstract.....	229
	Introduction.....	230
	The nature of blame.....	232
	Moral agency.....	238
	Holding individuals responsible for their health status.....	240
	Methodological and reflective interlude.....	242
	A blameworthy and analogous tombstoning son.....	244
	The nature of the obligation.....	246
	The nature of the relationship.....	247
	The nature and purpose of blaming behaviour.....	249
	Blaming and Health care practice: institutions.....	251
	Blaming and Health care practice: health care practitioners	253
	Conclusion.....	257

PART III: CONCLUSION

Chapter	Conclusion.....	261
9		
	Summary of the thesis.....	263
	A challenge to current practice: epistemic duty.....	265
	A challenge to current practice: reflective duty.....	269
	Impact of the thesis.....	273
	<i>Nursing Philosophy</i> (journal and activity).....	276
	A return to a smoking patient - advocacy and autonomy...	278
	Concluding remarks.....	281
	References.....	283
	Appendix (pdf versions of published papers).....	329

Word count: excluding references, including footnotes: 80,394

Tables

Table 1	Similarities between smoking and tombstoning.	127
Table 2	Costs and benefits of acts of tissue donation.	226-7

ABSTRACT

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Personal responsibility for health: meaning, extent and consequences.

Like the rest of the western world, the UK faces a significant increase in the prevalence of diseases associated with lifestyle. Smoking rates have reduced, but increasing obesity has contributed to alarming increases in diabetes. Discovery of the correlation between behaviour and poor health has, since the 1970s, resulted in public health policies emphasising behaviour change, and personal responsibility; an emphasis that survived later research which demonstrated social, genetic and psychological determinants on behaviour and health. The latest version of the NHS constitution exhorts us to ‘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.’

This thesis seeks to clarify the meaning and extent of personal responsibility for health, and at its core are four papers published in peer-reviewed journals. The first clarifies the concept concluding that it is best understood in a tripartite conception of a moral agent having obligations and being held responsible if he fails to meet them. The following two papers discuss the nature of the obligations, using utilitarian reasoning and arguments from analogy. First, an exploration of the moral obligations for our own health is undertaken via an analysis of the practice of tombstoning, jumping from height into water. I conclude that the obligations are of process rather than outcome, consisting of an epistemic duty to determine the health related consequences of our acts, and a reflective duty to consider these consequences for us and for those who share our lives. Second, following an examination of the moral status of blood donation, I conclude that despite its presentation as a praiseworthy and supererogatory act, it is more properly regarded as a *prima facie* obligation, supported by arguments from beneficence and justice.

The final paper discusses the final part of the tripartite conception of personal responsibility for health: being held responsible. I discuss the nature of blame and extend the tombstoning analogy as a way of testing my own intuitions in response to an imagined adult son who has undertaken this dangerous activity. I argue that the notion of blame is not generally allowed as part of the patient – professional relationship, and yet without considering blame, the concept of personal responsibility for health is incomplete. I conclude that if the epistemic and reflective duties, individually applied, conclude that an obligation is owed, it is owed to those within personal relationships, and holding people responsible for their health-affecting behaviour is also best undertaken within these relationships.

I conclude the thesis by considering the implications for professional practice. Inevitably this leads to consideration of the promotion of personal autonomy in health care. A more relational account of autonomy is suggested. Facilitating the epistemic duty so that individuals are better able to understand the risks of their behaviour requires rethinking of the way that health promoting material and information are presented.

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Part I: Introduction

CHAPTER 1

Introduction

In 2008, as I started work on this thesis, the *American Journal of Clinical Nutrition* published a large UK study, which recruited over 5000 sets of twins aged between the ages of eight and eleven (Wardle *et al.*, 2008). The study aimed ‘to quantify genetic and environmental influences on BMI (Body Mass Index) and central adiposity in children growing up during a time of dramatic rises in paediatric obesity’ (p. 398), finding that heritability for both BMI and waist circumference was, at 77%, substantial. If the editors of the journal had some minor queries about methodology and inferences (Musani *et al.*, 2008), they nevertheless commended the study, noting that it confirmed the genetic influence of obesity that had been known for two decades.¹

Unusually for a scholarly study, publication was widely discussed on the television news (British Broadcasting Corporation [BBC], 2008a), and in the print media. Reported in *The Times*, the study’s principal author was quoted as saying: ‘This study shows that it is wrong to place all the blame for a child’s excessive weight gain on the parents’ (Henderson, 2008). The study did not suggest that all childhood obesity was genetically determined, and the comment leaves open the possibility that

¹ And as I complete the thesis six years later, the study has been cited 345 times.

some blame might legitimately be attached to the parents of obese children. If these complexities are recognised in philosophical analyses (For example, Holm, 2008), more popular discussions, even those in broadsheet newspapers, can readily reduce the issue to a crude ‘nature-nurture’ dichotomy. Under the title, ‘Face it, fatty, your genes are innocent’, a comment article in the *Sunday Times* included:

I hate to blithely dismiss a whole swathe of scientific findings but I don’t believe a word of this. Fat gene, my foot. Funny how it seems to manifest itself only in the prosperous, cake-guzzling, carb-and-sugar-laden West. Where are the obese Sudanese toddlers? The porky Ethiopians? [...] You can choose to make sacrifices or choose to be lazy and remain fat – and if you choose to be lazy and remain fat, then fair enough, but accept that it’s your own doing and take responsibility for it. [...] Above all, we need to get to grips with the fact that fatness is a personal choice, one that can’t be blamed on anybody or anything other than our own greedy behaviour’ (Knight, 2008).

Such strongly expressed views² would perhaps be unlikely in philosophical or health journals, but they represent a popular position concerning an individual’s responsibility for his health. If he knows that certain behaviour causes or is implicated in a certain disease, but continues undertaking the behaviour nonetheless, is he not at least partially responsible if he contracts the disease? Is he obliged to refrain? And, if there is some responsibility, can smokers be blamed for their cancers, alcoholics for their liver cirrhosis, and sexual hedonists for their sexually transmitted disease? And, in an environment of scarcity of health care resources, if he can justly be blamed for having the disease that his behaviour caused, can it follow that this blameworthiness be regarded as a legitimate consideration in treatment allocation?

² And the comment is not entirely disinterested; the author has written books about dieting.

There is some public support for the views that these questions imply. In a large survey conducted by the King's Fund (2004), 88% of respondents agreed that individuals are responsible for their own health, though more than 40% agreed that there are too many factors outside individual control to hold people responsible for their own health. A decade earlier, Bowling (1996) reported that 42% of respondents among the general public agreed with the statement that 'People who contribute to their own illness – for example through smoking, obesity or excessive drinking – should have a lower priority for their health care than others'. A further 15% expressed no view on the subject. Radcliffe (2000, p.143) found that 'approximately 71% of respondents agreed or strongly agreed that preference should be given to those individuals whose need for a liver transplant arises as a consequence of naturally occurring liver disease rather than their personal behaviour e.g. due to the excessive consumption of alcohol'. This issue was highlighted when the footballer George Best, known to be a heavy drinker, received a liver transplant in 2002, and returned to heavy drinking afterwards causing his death three years later, and has remained in the public eye; a typical comment from 2009 was reported in the Observer newspaper:

Eunice Booker, whose 26-year-old daughter, Kirstie, died in a car crash in 2006, said: "I find it offensive that one in four of the livers donated go to alcoholics. If there are two people side by side wanting a liver, and both have the right tissue match, and one is an alcoholic and one isn't, there's no contest - you take the one who's not an alcoholic, they are more entitled" (Doward and Campbell, 2009).

Later studies and reviews have demonstrated that public support for deprioritising those deemed to have caused their disease remains a popular view, though never a majority one (Dolan *et al.*, 2005), inconsistently held (Mason *et al.*, 2011) and difficult (for focus group participants) to sustain logically (Baker *et al.*, 2010). Unsurprisingly perhaps, Ubel *et al.* (1999, 2001) found in a US study that smokers

discriminated less against those deemed to have contributed to their need for organ transplantation.

It might be expected that prioritising decisions are at least influenced if not determined by the system of health care that requires them. In the UK, the large majority of health care is provided through direct taxation by the National Health Service (NHS),³ and so money spent on treating preventable illnesses is denied to others. Official government policy documents on health often highlight the financial costs of various behaviours.⁴ Over the last 100 years lifespans have increased significantly⁵ as has funding both as a total amount and proportion of Gross Domestic Product (GDP).⁶ Cause of death has changed from predominantly infectious diseases to cancer, cardiovascular and degenerative diseases, all of which are influenced by individual behaviour. Fourteen behaviours are estimated to cause over 40% of cancer (Parkin *et al.*, 2011) with tobacco smoking by far the largest. Despite recent falls in prevalence, over 20% of the population smoke regularly, of whom two thirds report wanting to give up (Health and Social Care Information Centre, 2013). Nearly a quarter of adults drink more than the lower risk guidelines, considerably more than half are either overweight or obese, and more than 60% of adults fail to meet physical activity guidance (Department of Health [DH], 2010a). Debate about personal responsibility for health in the UK is inevitably undertaken in

³ The Office for National Statistics give the figures for health care expenditure for 2011 as £142.8 billion of which £118.3 billion (82.8%) was publically funded (Payne, 2011).

⁴ For example, the coalition government's '*Our Health and Wellbeing Today*' (DH, 2010a) which states that smoking related illness costs the NHS £2.7 billion annually, the same figure as alcohol related illness.

⁵ In 1911, life expectancy at birth was 49 for men and 53 for women. In 2010 it was 78 and 82 years respectively (Office for National Statistics, 2012).

⁶ A précis lodged at the House of Commons library notes that expenditure has increased from 11.7 to 121 billion pounds from 1950 to 2011 (adjusted to 2010/11 prices), representing an increase from 3.5 to 8.2% of GDP (Harker, 2012).

the context of a large amount of preventable ill health which costs a good deal of money to treat.

Arguments presented as illustrative are from newspapers rather than academic journals because these debates are undertaken and policies evolved and settled in the public and political arenas; they are political as much as academic moral debates (Coggon, 2012). These arenas do not exclude academic contributions but nor do they necessarily value or invite them, and there are significant differences between the presentation of academic, public and political debates. Academic papers are longer and require knowledge and skills to engage with, and cost typically £25⁷ for access to those without institutional affiliations. Individuals tend to read newspapers that represent their political and moral outlook (Stroud, 2010) and so the articles are not perhaps intended for critical scrutiny, at least not the level of critical scrutiny which characterises academic debate.⁸

In debates in the popular press it is can be difficult to identify lines of argument so that they can be formally presented. However, and without claiming that this is a formally valid expression, the arguments exemplified by India Knight's forthright dismissal of the scientific findings and the attribution of blame proceed along these lines:

Premise	Health is good, illness is bad.
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⁷ As an example, *The Journal of Medical Ethics* charges £24 for one day access to an article. Some newspapers charge for on line usage but they can be read free at public libraries.

⁸ Garber (2001, p. 34) explains the difference between journalists and academics in these terms: 'The difference is rather that the journalist of ideas attempts to explain and describe them, while the scholar of ideas attempts to think through them, to enter into and advance an ongoing intellectual discussion. Every scholarly move is part of a dialogue. To hear only one side of the conversation and take it for the whole is almost inevitably to find the current speaker's contribution unaccountable, dogmatic or slightly ridiculous.'

Premise	Certain acts (smoking, drinking, and eating too much) cause (are responsible for) ill health.
Premise	These acts are under personal control.
Conclusion	We ought to refrain from undertaking these acts.

Similar arguments can be created within the discipline of public health ethics, which interferes in various ways and to different extents with the absolute liberty to undertake acts which threaten health. These interventions can be categorised within a ladder of intervention, a term introduced by the Nuffield Council on Bioethics (2007), and referred to in UK⁹ government policy (DH, 2010a). The bottom rung of the ladder does nothing or monitors the situation and then interventions ascend in strength starting with information giving, enabling choice and guiding choice, through incentives and disincentives, finally to restricting and eliminating choice. Arguments in support of interventions could be presented in this form, with the initial premise being very similar to the conclusion of the first argument:

Premise	Individuals should refrain from undertaking acts which threaten health.
Premise	X causes ill health.
Premise	Individuals undertake X.
Premise	Treating ill health caused by X costs a lot of money.
Conclusion	Intervention Y is justified to prevent, reduce or discourage X.

As before I do not present this as a formally correct syllogism but it does represent the sort of arguments presented in favour of policy and regulation from information giving to outright criminalization and anything in between. Examples can be found

⁹ HM Government is the government of the UK, but public health policies and the organisation of health and social care service differ throughout the UK. This document applies only to England. Throughout the thesis, I have made jurisdiction clear where it is important.

in recent campaigns and policy debates: A campaign from NHS England exhorts patients to seek medical advice about health problems early rather than waiting to see if it gets better; the ‘earlier the better’ campaign¹⁰ (information giving). Government plans to introduce a minimum price for alcohol¹¹ in England were ‘shelved’¹² but will be introduced in Scotland¹³ (disincentives), and there have been calls to criminalize what have become known as ‘legal highs’ (restricted choice) (Hughes and Winstock, 2012). The type of intervention within the range depends on many things: the number of individuals affected and the severity of the harm are important, but other considerations like the effectiveness of the intervention and wider political factors are also important. I will return to the issue of regulation in Chapter 3.

A separate argument, the one stated so vigorously by Mrs. Booker, follows not from a moral responsibility to act to preserve health but the desirability to treat ill health and the burdens that this places on the health care system:

Premise	We should refrain from undertaking acts which threaten health.
Premise	Health care is collectively provided.
Premise	Individuals who have contributed to their poor health are less deserving of the collective resources for health care.
Conclusion	(Causal) responsibility for ill health is a valid rationing criterion.

¹⁰ <http://www.england.nhs.uk/2014/01/18/the-earlier-the-better-campaign/>

¹¹ Secretary of State for the Home Department (2012). Also see Purshouse *et al.* (2010) and Black *et al.* (2011) for a scottish study arguing for the effectiveness of the policy.

¹² <http://www.bbc.co.uk/news/uk-politics-23346532>

¹³ Alcohol (Minimum Pricing) (Scotland) Act 2012. Not yet implemented.

I have presented simplified versions of the sorts of arguments that support public health policy and ethics in an environment where much of the burden of ill health is caused by personal behaviour. This has provoked responses within the health care system in terms of regulation of behaviour in an attempt to improve health and is discussed in relation to delivery of services, where a popular view deprioritizes services to those deemed to have caused their ill health (Buyx, 2008). Both areas of policy and practice are likely to increase in importance as demand on health services increases, fuelling anger and anxiety and, most importantly, affecting people's lives in ways that they would not choose.

However, the thesis does not address the legitimacy of either regulation or rationing in any great detail, instead addressing a moral issue of fundamental importance that precedes both of these important questions: moral responsibility for health – exemplified by the claim that we ought to refrain from undertaking acts which threaten health. This moral claim serves as a premise for arguments concerned with behaviour regulation and prioritizing debates and policies, both of which are important and pressing subjects within health care ethics. A claim that I shall develop throughout the thesis is that policies about behaviour regulation and prioritizing decisions assume that we ought to behave to protect our health rather than argue for it. This might be considered surprising given the weight of the conclusions that follow from it. A challenge to the assumption that there is a moral responsibility to act to preserve health threatens what can be considered orthodox health promotion practice, much of which follows from it. If it cannot be demonstrated that we ought not to smoke, how is it that such effort is spent on dissuading us from doing it?

It is possible to present reasons for regulation and prioritising regimes which do not rely on the implied or stated normativity of acting so as not to threaten health. Procedures for allocating financial resources for particular treatments may simply be a matter for contractual arrangements setting out which treatments are available to which patients and what exclusion criteria apply. In the United States (US), for example, where most health care is provided privately and paid for by insurance premiums, the Affordable Care Act (ACA) prohibits the levying of higher premiums for those in poor health, but it allows employers, within limits, to link premiums to tobacco use, weight and other lifestyle factors (Madison *et al.*, 2013). Almost half of States in the US allow employers to refuse jobs to candidates because they smoke (Schmidt *et al.*, 2013). When interviewing panels and insurers say that we ought not to smoke, it can be construed as a non-moral ought, a hypothetical imperative. You ought not to smoke *if* you want a job or lower premiums. The obligation is instrumental and does not depend on the inherent goodness of lower insurance premiums. It might be unwise to waste money on higher premiums but we would be hard pressed to say that it is immoral. Applied more generally to health, the argument would go along these lines: if you want to avoid lung cancer, you ought not to smoke. It is possible to conceptualise lung cancer descriptively as non-moral.

Arguments that do not rely on the inherent goodness of health can also be presented in favour of regulation of health threatening behaviour. These arguments might be politically self-interested or capricious, but are more likely to present in terms of wider harms. Avoiding the financial and personal costs of crime is given as a moral

reason to regulate drug use,¹⁴ and one criterion of public health intervention is given as:

[...] the Government will balance the freedoms of individuals and organisations with the need to avoid serious harm to others. We will look carefully at the strength of the case before deciding to intervene and to what extent. This must be based on a rigorous assessment of the evidence about health and wider harms, with the potential benefits balanced against the social and economic costs to individuals, organisations and wider society (DH, 2010a, p.28).

Here the harms to health and wider harms are conflated in a single calculation. Clearly this is not considered a problem though the arguments used are very different. Mill's harm principle or something very like it is invoked in preventing 'serious' harms¹⁵ to others, but it explicitly excludes the application of the argument to his own health; 'His own good, either physical or moral, is not sufficient warrant' (Mill 1998 [1859], p.14). The part of the criterion concerning the prevention of harm to others is clearly a moral argument but it does not rely on the intrinsic value of health. There can be non-moral arguments and reasons supporting health-enhancing behaviour, and moral arguments which do not rely on the inherent goodness of health, but a central assumption underpinning this thesis is that arguments of the sort identified are principally health-related moral arguments, and the research questions are moral questions, concerning moral responsibility.

¹⁴ See *Healthy Lives, Healthy People* (DH, 2010b, p.5). 'Changing adults' behaviour could reduce premature death [...] and saving society the £13.9 billion a year spent on tackling drug fuelled crime.'

¹⁵ It is worthy of note that the term 'serious harm' is used in the policy document but Mill's text refers only to 'harm'. This is more than a semantic quibble because it says something about the types of harms that stand in need of prevention. Nor can it only be a feature of the use of language separated by 150 years because we see similar ambiguity in regulations and laws, for example for confidentiality between professional codes (Nursing and Midwifery Council [NMC], 2008) and DH guidance (DH, 2003a).

Research questions

The research questions are implied in the title and addressed directly in part II of the thesis. They are:

- (1) What is the meaning of personal responsibility for health?
- (2) What are our obligations in respect of our health?
- (3) What are our obligations in respect of others' health?
- (4) How can individuals be held responsible for failure in their obligations?

The questions addressed by the thesis concern responsibility for health; and the model I propose, and the obligations that I argue for, are independent of any system of professional health care. However, the arguments have been formulated within the system operating in the UK, and my arguments and conclusions are placed largely in this context. Throughout the thesis, I draw attention to contrasts between what I take current professional health care practice to be and what it would be if my normative conclusions were embraced, and though these contrasts are not necessary for the normative conclusions, they are illustrative and helpful for identifying professional challenges.

I have described what I take to be the 'official' position relating to health policy, resulting in 'orthodox' health care professional practice, and this position assumes that government policy and professional practice are largely in alignment. This isn't to say that the positions are exactly the same, or that all health care professionals practise in the same way, but the underpinning assumptions and general direction are consistent in areas important for the thesis. The two most important elements of this

position for the normative conclusions of the thesis are in the definition and value of health, and in the understanding and promotion of personal autonomy.

I understand, firstly, that the ‘official position’ in health policy regards health predominantly in biomedical terms of disease, illness and lifespan. In a sense this is a result of the need to measure health so that policies can be evaluated. The position also tends to regard health as intrinsically good, tending to oversimplify and to assume that individuals have a responsibility to act to protect their health, narrowly defined, largely by following health promoting rules. This is discussed in more detail in the thesis, especially in Chapter 2.

My second and related claim is that the ‘official’ position claims to value personal autonomy and yet does much to undermine it. There is a tension in this position between health and respecting autonomy, which is a recurring theme throughout the thesis. As well as being identified, by many, as the predominant bioethical principle (for example, Gillon, 2003), self-determination within medical practice is a clear legal right in the UK, resulting in, notably, clear rules and processes in seeking valid consent for treatment.

The predominance of personal autonomy has come under increasing critique, principally from two directions. Our ability to access and process information has been questioned by social psychology research, resulting in renewed arguments for various forms of paternalism ranging from the libertarian paternalism of nudge techniques (Thaler and Sunstein, 2008), which manipulate choice, to thoroughgoing coercive paternalism (Conly, 2013). In addition, an emphasis on individual rights

tends to regard individuals as distinct from their social situation and society, a position challenged from, amongst others, communitarianism and more relational understandings of autonomy. What I have characterised as the ‘official’ position recognises but fails to resolve the tension so that it both claims personal responsibility for health, that people ought to maximise their health, and yet at the same time states, unconvincingly as I argue, that information is presented in order to facilitate individual choice. In respect of others’ health, the tension between health and autonomy results in donation behaviour being presented as both morally obligatory and morally supererogatory.

The account that I develop in the thesis stands in opposition to the ‘official’ position as I have characterised it. By regarding health as instrumentally rather than intrinsically good, responsibility for health, characterised as obligations in acts rather than rules, depends on an individual’s life, their goals and the places that others have in it. Taking account of the interests of others also results in *prima facie* obligations to act for others’ health, most obviously where the gains are significant and the costs small, exemplified by some donation behaviour. The primary obligations are to make informed individual health related decisions: to enquire about the consequences of health-affecting behaviours and to place the risks of these consequences in the context of their life, recognising that other people also have a legitimate if not determinate interest in our health. The arguments are developed by analogy and within a dual level utilitarian framework which requires reflection and knowledge in order to maximise utility. The thesis develops an account of the process of determining the moral status of health-affecting behaviour, which can be applied by individuals to their own circumstances and life goals.

If accepted, this account challenges the current account of responsibility for health exemplified by orthodox health promotion and education. I do not claim that there are no such obligations, only that they are of process rather than outcome. Detailed exploration of the implications for health policy and professional practice is not covered by the research questions, but it is suggested that since the moral status of health-affecting behaviour depends, in my account, on individual circumstances, at the last compelling reasons are required for regulation of these behaviours. Inevitably this will result in a more libertarian regulatory regime than that currently operated and would require respecting individual autonomy by providing information that facilitates rather than manipulates choice, operated at the levels of policy and within patient-professional relationships.

Structure of the thesis

Part I – Introductory material

This thesis is presented for the award of PhD in Bioethics and Medical Jurisprudence. The structured programme ‘is designed to provide a solid skills basis for independent research, and to guide participants steadily towards the completion of a structured doctoral thesis, which is based on publishable journal articles and book chapters.’¹⁶ Unlike a traditional PhD, the original contribution is presented in the form of four publishable papers but within the context of a single presented thesis.

The thesis is constructed in three parts. The first part consists of background and explanatory material. Three chapters follow this introductory chapter. Chapter 2

¹⁶Programme description: <http://www.law.manchester.ac.uk/healthcare-ethics-and-law/postgraduate-research/course-list/course/?code=06250&pg=2>

introduces the historical and political background of responsibility for health in response to changing patterns of disease and also discusses and critiques the background to the assumptions presented earlier which together form an argument concluding that we ought to refrain from health threatening behaviour. The statements that I suggested formed the premises of the popular arguments that I critique are common themes throughout the thesis, and so the chapter addresses questions of the definition and value of health, group cause and effect, and individual control of behaviour. The operationalised conception of responsibility for health in the NHS constitution is introduced.

Chapter 3 discusses the connection between legal and moral responsibility. The thesis is concerned with moral responsibility and so this chapter primarily sets the scene and legal context in which people make moral decisions. Legal prohibition and consequent punishment offer self-regarding reasons to avoid proscribed behaviour, but it can be argued that there is a moral duty to obey the law. As an example, legal regulation of smoking is discussed in some detail, particularly in relation to recent contradictory legal cases in England and Scotland concerning the rights of smokers in mental health units.

Chapter 4 introduces and explains the philosophical approach taken in the thesis. In a traditional doctoral thesis of 80,000 words, similar in length and form to a book, considerable space can be given to developing and defending a theoretical approach, and since in its initial presentation at least, a traditional thesis is considered as a whole, there can be forward and backward references to the theoretical underpinning as well as between individual chapters using it. This is not to say, incidentally, that

chapters from ‘traditional’ theses are not adapted and published in peer-reviewed journals, as well as transferred into books,¹⁷ but generally, these publications appear after the thesis is examined and passed. The thesis as presented here differs in that papers from it have already been published, predating the revision of the philosophical approaches chapter so that it is as much *post hoc* justification for the methods used in the published papers than unified guiding theory; more scaffold than underpinning foundation.¹⁸

Papers in bioethical journals rarely have well developed theoretical bases, evidenced in an exchange between John Coggon and Hugh McLachlan. Coggon (2008) criticises the absence of an indication of an account of morality that McLachlan (2008) is committed to in a paper about active and passive euthanasia, and part of McLachlan’s (2009, p.457) response is simply to state that ‘articles published in the *Journal of Medical Ethics* do not normally contain an account of the author’s general theory of morality.’¹⁹ Theoretical justification and references between the papers/chapters in this thesis is similarly undeveloped and to enable the papers to be read alone there is some necessarily repetitive scene-setting.

Reflecting its roots in professional relationships (Harris, 2001), much of the normative literature in bioethics is directed at health care professionals; and much of the literature in public health ethics (a subset of bioethics) relates to coercive behaviour regulation of various sorts. Unusually, much of the normative attention in

¹⁷ Among the books consulted during the writing of this thesis, Brassington (2007a), Mulgan (2001) and perhaps most notably, Harris (1980) started their life as PhD theses.

¹⁸ For this reason, literature reviews which form part of the published papers cannot be updated in the light of new research, and this is potentially a problem most tellingly faced by part time students whose PhD journey is of longer duration, and also poses challenges for those whose analyses depend in part on government policies which are apt to change direction abruptly.

¹⁹ I have not submitted to the *Journal of Medical Ethics* but the point has wider resonance.

this thesis is directed at individual citizens rather than professional providers of health care, individuals and institutions. A normative analysis of the obligations that citizens have in respect of their own and others' health (as I attempt in chapters 6 and 7) is of a different form to an analysis both of the view about the moral status of the acts in question and the responses to them from within professional health care, though the extent to which the analyses differ is open to question. This means that the philosophical approach concerning the patient-professional relationship is arguably more general than usually seen in bioethics papers. The chapter outlines the approach taken by the four papers that follow, discussing deductive and inductive approaches used and synthesised in the papers which are a combination of analytical and normative philosophy. Normative arguments are developed inductively by analogy and deductively by application of dual level utilitarianism which is introduced and defended.

Part II – Published papers

The second part of the thesis consists of the four papers which have been published in peer reviewed academic journals. The papers in the thesis must form a coherent whole, yet were written for slightly different readerships and at different times and their initial presentations, including theoretical input, have been written following different publication guidelines and rewritten at the behest of peer-reviewers and editors in order to fulfil the primary objective of being published. The significance of the publication process for the papers is that they must not only be capable being read alone, but written in the assumption that they will be. They are presented in a sequence slightly different to that in which they were written, so that conceptual

analysis precedes two papers on obligations, for own and others' health, with the final paper discussing the consequences of failing to meet them.

Chapter 5 (Paper 1), entitled 'Saying something interesting about responsibility for health'²⁰ was published in the journal *Nursing Philosophy* on 6th June 2012.²¹ The journal, published by Wiley, 'is an international peer reviewed journal for nurses and healthcare professionals seeking to articulate a more theoretical basis for their practice,²² and has an impact factor (2014) of 0.875. The paper is a conceptual analysis of responsibility for health and discusses the concept by way of a brief analysis of the uses of the word 'responsibility' in health care literature, and by application of philosophical meaning of responsibility. The concept is characterised as having three constituent parts: (i) a responsible agent (ii) having obligations and (iii) being liable to being held responsible in failing to meet them. Each of these areas is problematic within professional health care and it is concluded that clarification is urgently needed if it is to retain its place in health policy. Following this conceptual discussion, the next two chapters form the normative strand of the thesis, discussing, via analogous examples, the nature of obligations to self and others.

Chapter 6, entitled 'What's wrong with tombstoning and what does this tell us about responsibility for health?' was published²³ on 9th April 2014 in the journal *Public*

²⁰ The title is a reference to a paper by John Paley (Paley, 1996) which criticised 'concept analysis', a method of inductive analysis rarely seen outside the nursing literature. In retrospect, I think that a more descriptive title (like the others) may have been more advisable.

²¹ Originally submitted on 16th June 2011. Resubmitted following revision on 14th November 2011. Accepted on 20th November 2011.

²² Overview of journal on Wiley website. [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1466-769X/homepage/ProductInformation.html](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1466-769X/homepage/ProductInformation.html)

²³ Originally submitted on 21st June 2013. Resubmitted following revision on 3rd January 2014. Accepted on 6th March 2014.

Health Ethics. Published by Oxford Journals, and with an impact factor of 0.788, the journal is 'is the first peer-reviewed international journal to focus on a systematic analysis of the moral problems in public health and preventive medicine.'²⁴ By way of an analysis of the practice of tombstoning, that is jumping from a height into water, the paper argues that obligations in respect of our health are best understood as obligations of process rather than outcome, specifically two obligations or duties. First the epistemic duty requires us to seek information about the likely effects of our health threatening behaviour. The information gained from meeting the epistemic duty then facilitates the reflective duty which obliges individuals to put their health threatening behaviour in the wide context of their lives, including the effect that it has on those who share them.

Chapter 7 shifts the normative gaze to our obligations in respect of the health of others. Entitled 'Challenging the moral status of blood donation', it was published in *Health Care Analysis* on 15th September 2012.²⁵ Published by Springer and with an impact factor of 1.02, the journal 'promotes debate about the fundamental rationale of all aspects of health systems and health care provision [...]'.²⁶ The paper notes that in the UK, blood donation is presented as a supererogatory act, evidenced by advertisements and videos aimed at potential donors, and this is contrasted with advertisements from India which present blood donation as an obligatory act. In the UK, and in contrast to blood donation, post mortem organ donation is also presented as an obligatory act, and yet the arguments are transferable from organ donation to blood donation. These arguments, from beneficence and from the wrongness of free

²⁴ About this journal. http://www.oxfordjournals.org/our_journals/phe/about.html

²⁵ Originally submitted on 14th March 2011; resubmitted following revision on 14th August 2012; accepted on 31st August 2012.

²⁶ Description. <http://link.springer.com/journal/10728>

riding are discussed and transferred and it is concluded that blood donation is, *prima facie*, also an obligatory act, but recognised that presenting it in this light may have unintended adverse consequences in terms of donor recruitment.

The concluding chapter in this section is entitled ‘Who can blame who for what and how in responsibility for health?’ and was published in the journal *Nursing Philosophy* on 29th May 2014.²⁷ The paper argues that holding someone to account for their health threatening behaviour amounts to blaming them for it, something that is underexplored in the literature on professional health care. The philosophical literature on blame is briefly reviewed, and since this partly concerns emotional responses to wrongdoing, I discuss my own responses to an imagined adult son when I discover that he has been tombstoning. These responses are discussed in response to features of moralism, simply understood as the excess of morality. I conclude that if there are obligations for health, then individuals are liable to be held responsible for failing to meet them, but this is best understood as a proportionate response within personal relationships. Blaming attitudes and behaviour remain outside professional caring relationships though there is evidence that negative attitudes to those perceived to have caused their illness persist. Nurses holding these attitudes are invited to reflect on the nature of their patients’ moral agency, the obligation that they are holding them to, and whether the standing of the relationship with them is such that it includes holding them responsible. All of these areas are problematic, and the conclusions provide analytical support for regulatory injunctions concerning blaming patients for their diseases and behaviour.

²⁷ Originally submitted 23rd January 2014. Resubmitted following minor revisions on 5th April 2014. Accepted 14th April 2014.

Part III – Conclusion

The final chapter of the thesis briefly revisits the papers and considers the implications that the epistemic and reflective duties have for health care policy and professional health care. It is concluded that facilitating these responsibilities inevitably questions current understandings of autonomy in practice. I discuss the possible impact of the thesis and the ideas in the papers and what these might mean to nursing practice and education. Finally I discuss how the conception of responsibility for health as I have presented it can be applied to smoking and nursing advocacy, illustrating fundamental quandaries in professional health care.

A note on personal background

An important consideration before proceeding to the substance of the thesis is to note my own personal background. This is important because my intuitions and general outlook have been influenced by my experiences over the course of my personal and professional life. I take critical reflection to be central to the enterprise of philosophy, and this requires awareness, as far as possible, of how formative influences affect our views and actions. Nearing 50 years old, I have been a registered nurse for almost half of my life, 15 years in practice in intensive and coronary care and general medicine, followed by 10 years in higher education, teaching pre and post registration nursing students. My interest in personal responsibility for health does not stem from an interest in philosophical puzzles but from thinking about whether and how I ought to engage in health promotion in conversations with patients and students. Prior to undertaking the programme of study that has resulted in the production of this thesis (including while I have been

writing it) I have published papers²⁸ mainly on nurse education, including some sceptical of nurse regulators and the manner in which assumptions about values are accepted uncritically by the profession and translated into regulatory requirements.

The tension between personal autonomy and the apparently problem free view that health is intrinsically good and should always be prioritised is immediate and compelling when a patient asks to be accompanied outside for a cigarette, or seems unwilling or unable to stop smoking after a heart attack. Those unable to stop are supported with nicotine replacement therapy; those unwilling regarded as foolish and wrong. Thinking about these practical concerns and how I can be a better nurse and teacher, rather than merely accepting conventional practice and regulation on these and other matters led me here, and also explains why I have discussed professional regulation and used it within examples throughout the thesis. It is not just that this is the environment that I am versed in and familiar with but also that it matters to nurses and patients that these issues are clarified. There has been much public debate recently about all graduate preparation of nurses,²⁹ but despite what is perceived as an expansion and deepening of nursing curricula, little if any time is spent on philosophy, apart that is, from spending considerable attention on attempting to ensure that the right people enter the profession and that the 'correct' values are promoted and regulated for, with little justification or critical engagement. This is an analysis for another day but it explains why there is quite so much nursing in this thesis on bioethics.

²⁸ An early exploration of uncritical nurse regulation can be found in an analysis of academic freedom in nursing and nurse education (Snelling and Lipscomb, 2004), and the latest in a challenge to uncritical orthodoxy in nursing practice by way of a critique of intentional rounding (Snelling , 2013a,b,c).

²⁹ Dr Vince Cable, the Business Secretary was the latest in a very long line to deride degree preparation of nurses (Morgan, 2013).

CHAPTER 2

Background

The moral questions addressed in this thesis lead to decisions and actions taken by agents, professionals and policymakers within a social context; and the social context influences the moral questions and the manner in which they are addressed. This chapter describes that context. Beginning with a brief discussion of the historical and political development of the notion of responsibility for health and health promotion, the chapter proceeds to discuss the three premises which were identified as leading to the versions of personal responsibility with which I introduced the thesis. In discussing the definition and value of health, group and individual causation, and individual control and choice, I will identify some of the problems that challenge this account. However complex the factors for disease causation are, it is certainly the case that the notion of patients' duties within responsibility for health is visible in the bioethics literature. A more detailed conceptual analysis follows in Chapter 5, but for now I will review some of the literature which addresses patients' duties, and finally discuss the way that these duties are presented in the UK within the NHS Constitution.

Personal responsibility for health: A brief history

The notion of personal responsibility for health is not new. As Reiser (1985) details, opinions about how individual behaviours have affected health and the moral choices that follow have been present throughout human history. In ancient Greece for example, Galen believed individuals to be blameworthy if they harmed their bodies in the face of knowledge to prevent it, and the Pythagorean life required preserving health by practicing moderation and self-control using diet, exercise and music (Tountas, 2009). Similar expressions of a moral duty to care for health can be seen throughout the middle ages and further, but the actions that followed from this duty depended on views about disease causation. Regardless of what was thought to cause disease, prior to improvements in sanitation¹ and nutrition in the 19th century and augmented by the discovery and widespread use of antibiotics in the mid-20th century, the main cause of mortality and morbidity was infections (Bynum, 1988). As the threat of infectious disease receded and life expectancy improved, cancers and cardiovascular disease became the commonest causes of death,² a process known as the epidemiological transition (Wilkinson and Pickett, 2010). Rather than the result of a single disease causing organism, these diseases were recognised to be multi-factorial (House, 2001), and from the 1960s onwards the language of ‘risk factors’ attempted to explain causation, initially in terms of behaviour (Aronowitz, 1998).³ Personal (mis)behaviour became the focus of public health. In 1977, John Knowles, an American physician and president of the Rockefeller Foundation wrote that:

¹ Readers of the *British Medical Journal* voted this as the most significant medical advance since 1840. Second was the discovery of antibiotics (Ferriman, 2007).

² The commonest cause of death for men in 2012 was ischaemic heart disease. In the list of most common causes of death, only one, pneumonia and influenza combined can be said to be of infectious origin, causing 4.6% of deaths (Office for National Statistics, 2013).

³ Doll and Hill first reported the link between lung cancer and smoking in 1956. Their sample consisted of 40,000 doctors.

[...] over 99 per cent of us are born healthy and made sick as a result of personal misbehaviour and environmental conditions. The solution to the problem of ill health in modern American society involves individual responsibility, in the first instance, and social responsibility through public legislative and private voluntary efforts in the second instance. [...] I believe the idea of a 'right' to health should be replaced by the idea of an individual moral obligation to preserve one's own health – a public duty if you will (Knowles, 1977, pp.58-9).

This emphasis on both causation of ill health and the associated moral imperative resulted in a number of important documents and policies. First, in 1974, the *Lalonde Report* from Canada, in opposition to the idea that health services determined health, proposed instead a health field model whereby health was the product of a number of factors: biology (including genetic factors), lifestyle, environment and health services (Lalonde, 1974). In 1976 the UK Government published a discussion paper *Prevention and Health-Everybody's Business* (DHSS, 1976), and in 1979 the US Surgeon General published a report, *Healthy People*, which, using the framework proposed by Lalonde estimated that 'perhaps as much as half of US mortality in 1976 was due to unhealthy behaviour or lifestyle' (US Surgeon General, 1979, p.8). These documents did not blame *all* of ill health on lifestyle as evidenced by the simplistic model proposed by Lalonde, but as the quotation from *Healthy People* demonstrates, personal behaviour was identified as the biggest contributory factor. Minkler (1989) suggested that the major contribution made by these documents and policies was to call attention to the major role of lifestyle in determining health, justifying an expansion of health promotion (Hubley and Copeman, 2013), which emphasised behaviour change and individual responsibility for health (Mold and Berridge, 2013).

It became apparent, however, that behaviour alone did not explain differences between social groups. In the UK, the Black Report (Black *et al.*, 1980) showed that life expectancy of the higher social classes was significantly better than those in the lower social classes, and that these differences persisted when lifestyle factors were accounted for. The report, commissioned by a Labour government, was virtually suppressed by the incoming Conservatives (Porter, 1997, Mackenbach, 2010). In an introduction, the Secretary of State for Health, Patrick Jenkin, made it clear that he was releasing the report for discussion, without any commitment by the government to implement its proposals, which included increased spending on welfare and social services to reduce poverty. If his justification was financial, it was also clear that the Conservative Party in government simply didn't believe the evidence. In her autobiography, Edwina Currie, Health Minister from 1986 to 1988 describes how she circulated a paper upon assuming office developing themes 'incorporating conservative philosophies of personal responsibility[...]' (Currie, 1989, p.5). She denied that health inequality is connected with poverty, blaming poorer health suffered by lower social groups firmly on their habits:

The 'health gap' is the result and relic of differences in behaviour over a very long period [...] Low income by itself is not a major cause of strokes or cancer or heart disease – health problems which are mainly found in affluent countries. Heavy smoking *is* a cause, horrible fatty diets are implicated, along with lack of exercise in these sedentary days, drinking to excess plays its part (Currie, 1989, pp. 24-25).

In 1997, the incoming Labour government turned its attention to investigating inequalities in health with the commissioning of an independent inquiry into inequalities in health under the chairmanship of Sir Donald Acheson (DH, 1998). Again recognising the impact of social factors on the health of poorer people, the report recommended a wide range of social policy initiatives to reduce poverty, some

of which were subsequently proposed in the government's response to the report in 1999 (DH, 1999). As far as the UK was concerned, this was the most extensive collection of social policies designed to tackle health inequality, though some had other primary purposes (Mackenbeth, 2010). Policies included a national minimum wage, higher benefits and pensions and increased spending on health and education.

A further review followed in 2002 (DH, 2002) with a subsequent revised strategy (DH, 2003b) which revisited some of the social policies but also emphasised strategies to address health-effecting⁴ behaviours. Further reviews and criticism followed, resulting in an assessment chaired by Sir Michael Marmot (2010) which found that, largely, the targets to reduce inequality had failed. Among the reasons for this was that

attempts to reduce health inequalities have not systematically addressed the background causes of ill health and have relied increasingly on tackling more proximal causes (such as smoking), through behaviour change programmes (Marmot, 2010, p.86).

Other explanatory factors included a failure to implement policies on a large enough scale (Mackenbeth, 2011). It is perhaps the lack of evidence for such policies (Bambra *et al.*, 2010) which will inhibit their further implementation, though it is likely that ideological and fiscal concerns arrested this 'remarkable story' (Mackenbeth, 2011, p.573) after the 2010 general election which saw a Conservative/Liberal Democrat coalition reduce public spending in the wake of a global economic crisis. The Health and Social Care Act 2012 passed into law

⁴ The difference between affect and effect has caused some vexation. Fowler's *Modern English Usage* (Oxford, 1999) notes that 'effect' is most common as a noun, and 'affect' is a verb meaning to 'have an effect on'. But effect is also a verb, meaning 'to bring about, to cause, to have as a result'. As a peer-reviewer for the paper included here as Chapter 8 remarked, both health-affecting and health-effecting can be used in the sense I am using it here, but rather than attempt to elucidate the difference and at the suggestion of the reviewer for the paper, I have used health-effecting throughout.

statutory duties on the NHS to have regard to the need to reduce health inequalities, and the NHS Constitution states that:

[the NHS] has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population (NHS, 2013a, p. 3).

There is no elaboration on how these goals are to be met, and given the relative failure of social policies under Labour, the chance of the NHS itself having an impact is slim. Mackenbach (2010) concludes simply that reducing health inequalities is currently beyond our means. The aim is not mentioned in the NHS outcomes framework (DH, 2013a). The most recent white paper on public health in England claims to take a radical new approach, but retains an emphasis on behaviour change, by setting out how the approach will

reflect the Government's core values of freedom, fairness and responsibility by strengthening self-esteem, confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier (DH, 2010b, p.6).

There is recognition that behavioural choice is multi-factorial. Borrowing terminology from John-Paul Sartre, Dougherty (1993) identifies the freedom and facticity models. In the freedom model, choices concerning health threatening behaviour are freely chosen, and this free choice obliges people to choose to behave healthily and be accountable for these choices. In the facticity model, human behaviour emerges 'from a nexus of factors over which no individual has control' (p. 114); individuals are therefore victims rather than authors of their health circumstances. Holding them to account for their health threatening behaviour, legitimate under the freedom model is, under the facticity model, unjust; a sort of double jeopardy where the ill are victimised first by their illnesses and then by being

held responsible for them (Harris, 1995). Dougherty goes on, as might be expected, to develop themes combining the polarised models. These, however, remain focussed on behaviour, and whilst acknowledging that individual behaviour is just one of many causes, Dougherty argues that the focus should be maintained on the facts that mitigate or remove individual control over health related behaviour. There is a nod to community and political action in improving housing and making cars safer, but even while accepting that the freedom model is simplistic, the focus on removing barriers to behaviour change underplays the role of wider social factors.

Baum and Fisher (2014) argue that behavioural health promotion has not been shown to reduce health inequality but that the lack of evidence has not prevented a succession of neo-liberal governments from adopting it on ideological grounds, with a strong ethos on individualism tending to blame the victim. In a review of policies from the World Health Organisation (WHO), The Organisation for Economic Co-operation and Development (OECD), and australasian and western countries, Carter *et al.* (2009) found that many policies acknowledged wider determinants of health, but went on to direct action towards behavioural change in specific social groups.

The tension between individual responsibility, causal and moral, and other factors can be seen in many other places. Engineering disasters like the Deepwater Horizon explosion in the Gulf of Mexico can be presented as errors by individuals by underemphasising commercial and contextual factors creating the environment in which individual decisions are taken (Coeckelbergh, 2012). Pollution can be blamed on individuals who drop litter, without considering whether an external actor can or ought to make their choices easier by providing easily accessible recycling facilities

(Fahlquist, 2009). Food waste is blamed on individuals rather than policies which entice over purchase (Evans, 2011). Debates about the causes of poor care in the NHS, most closely examined at Mid Staffordshire NHS Trust (Francis, 2010; 2013) can be cast as failures of individual health care professionals or the environment and pressure in which they worked (Paley, 2014). Reasonable judgements concerning the question of responsibility in these areas, assuming that they result in wrong situations worth avoiding, are inevitably found within the range between the extreme positions of complete and negligible personal responsibility, and they are likely to be as much the result of vested interests as cool philosophical examination. In the current examination of factors that lead to poor care, the government has an interest in blaming individual failings, by nurses and managers, whereas individual nurses and the organisations representing them have an interest in emphasising the importance of contextual factors. At least part of the interest is in avoiding uncomfortable personal blame but similarly there is the suspicion that its opposite, praise, is sought. India Knight lost a considerable amount of weight and in blaming those who fail to do what she did, she invites praise for herself. At the very least she is assuming that everyone can do what she did, and what is more that they ought to do it, and they are therefore blameworthy if they do not.

Since personal behaviour contributes significantly to health even under a model that also emphasises social and other determinants of health, it is the common factor which applies to all composite models. The extent to which it is determinate will vary according to other factors. The thesis cannot consider in detail the extent to which these factors combine in individual cases, changing the nature of our obligations to our health. It is known for example, that rates of giving up smoking

are better for those in higher social groups (Jarvis and Wardle, 2005). Poorer people find it harder to give up and this may affect the nature of their obligation to try. In discussing responsibility for personal choices and behaviour, it should not be assumed that the thesis accepts or supports the freedom model, which as I have described permeates policymaking and was given thoroughgoing expression by India Knight. I characterised the argument as making certain assumptions about the nature of health causation and choice and I will return to these themes throughout the thesis.

The suggested argument was:

Premise	Health is good, illness is bad.
Premise	Certain acts (smoking, drinking, and eating too much) cause (are responsible for) ill health.
Premise	These acts are under personal control.
Conclusion	We ought to refrain from undertaking these acts.

Further premises would be needed to turn this into a formally valid syllogism, but it represents a common enough argument, which even as it stands makes value and factual assumptions, each of which can be challenged. The assumptions, even outside this suggested argument are important foundational issues for public health but are rarely questioned. In the next section I will discuss each of the premises in turn.

The definition and value of health

Health is an elusive word and concept, at once descriptive and highly evaluative. We can have a healthy bank balance and a healthy sex life, phrases common enough so that meaning is clear. In chapter 5 I will argue that understanding of the concept ‘responsibility for health’ requires thinking specifically about responsibility, but the

responsibilities, that is obligations, depend on what we understand health to be. At one end of a continuum is Boorse's (1975, 1977) essentially descriptive account of health as the absence of disease, and at the other a wider account which sees health as one of many factors contributing to the realisation of life goals. The World Health Organisation definition of health,⁵ famously inclusive, is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' The WHO definition has been criticised (Huber *et al.*, 2011), not least because its emphasis on completeness can regard most of us as unhealthy for most of the time. Policies directed at improving health require an understanding of what health is, since it constitutes the target of their intervention, one that requires to be measured. Huber *et al.* (2012, p.2766) use 'health as the ability to adapt and to self-manage' in their study and Larson (1999) discuss four models; Medical, WHO, wellness and environmental.

Since, as I have suggested, the debate is as much as anything a political debate it is instructive to examine what the government says about health. Helpfully, this is a question addressed directly in *Our Health and Wellbeing Today*⁶ (DH, 2010a).

Under the heading, 'What is health?', the following is highlighted in a box (p.6):

We use a broad definition of health that encompasses both physical and mental health, as well as wellbeing. This means that we are not only interested in whether or not people are ill or have a health condition but also in how healthy and well they are.

⁵ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

⁶ This is a summary of evidence that informed the development of the white paper, *Healthy Lives, Healthy People*.

On this account there is an ‘interest’ in the wellness – illness continuum, and in the next paragraph (para 2.1, p.6), it is stated that ‘in *Healthy Lives, Healthy People* we take a broad view about what health means. We care about the physical and mental wellbeing [...]’ Here, health and wellbeing appear to be taken as inclusive in line with the WHO definition. However, the next paragraph (para 2.2, p.6), starts with ‘Good health and wellbeing brings many benefits for all of us. Healthier people tend to be happier [...]’, illustrating the separation of health and wellbeing by drawing attention to a correlation between them. Elsewhere the document refers to ‘harmful lifestyles’, (p.7), and ‘healthy behaviours’ (p.27) and goes on to discuss the narrower factors of health related to physical and mental health. The Office of National Statistics (ONS) measures health as part of well-being, albeit the constituent part that most people ranked as most important:

How people view their health was the most important factor related to personal well-being [...]. People who reported very bad health had much lower ratings of life satisfaction, feelings that things were worthwhile, levels of happiness and higher ratings of anxiety on average than those who said their health was good (Randall *et al.*, 2014, p.14).

These statistics use self-reports of health rather than any objective measure, and it is noted that subjective assessments of health matter more to wellbeing than objective measures (Oguz *et al.*, 2014; Diener *et al.*, 1999). At an individual level the difference in value and well as conceptualisation is illustrated by Lindsay (2010), who suggests that among Australian youth, health and wellbeing can have divergent goals where individuals manage their food and alcohol intake so as to maximise wellbeing within valued social practices. Relatedly, in Canada, Dumas *et al.* (2014) described how the health-affecting behaviour of young under privileged women was heavily influenced by other factors, principally family and financial responsibilities.

It looks like there is ambiguity in the Department of Health's understanding of what health is, captured perhaps in the difference between a definition and a conceptualisation. It seems to be taking wellbeing as both part of and separate from health. It might be suggested that a response to criticism of indistinct understanding and explanation in policy documents, research and academic papers would result in every publication spending a great deal of time defining and defending their approach, but this of course would be untenable. As will become clear, the normative papers in this thesis do not defend a detailed approach to the definition of health. The *prima facie* normativity in respect to others' health does not require a precise definition because health needs, as I will discuss them, are clear, and obligations in respect of our own health are clearly articulated in the context of individual lives, and the concept of health, evidenced by Lindsay's subjects, is part of this individual approach.

Whilst precise definitions are unnecessary for many discussions, it is useful to keep in mind the broad tension in understanding of health. My assumption about the 'official' government understanding is that despite their claims to the contrary, a relatively narrow approach is taken which focuses on a medical model and sees health gains in easily measurable terms of diseases and life expectancy. Extreme interpretations of this view are presented and critiqued by Skrabanek (1995) and Fitzgerald (2001), who see the medical profession as a willing partner in the enterprise of 'healthism',⁷ where health is valued for its own sake and the government regulates and coerces (as far as possible) what it considers to be healthy lifestyles. The term 'health fascism' is relatively commonplace, and not confined to

⁷ According to Skrabanek (1994, p.16), the Lalonde Report was the first healthist document.

the popular press (Fitzpatrick and Tinning, 2013, Lefever, 2012). I will discuss this more fully in terms of legal regulation in the next chapter and health promotion in Chapter 6, where I take a wider approach to health-threatening behaviour. Another way of addressing this tension is to claim that the ‘official’ position is that health is considered intrinsically good, the end of many public health policies, whereas my account relies on health being regarded as an instrumental good, being just one of many means to a wider and individually chosen good life. This tension is more important for the orthodox position than the alternative that I argue for because clear responsibilities follow from what might be considered a view about the ultimate value of something. If the supreme value of health is taken as a starting point for arguments and policies that follow, then positions arguing from a different view of what health is can simply be regarded as incommensurable and denied rather than engaged. The intrinsic goodness of health, narrowly defined, is accepted as self-evident.

Group cause and effect

Claims that certain behaviours are wrong because they cause ill health significantly simplify causal relationships. Each health threatening behaviour has its own relationship with its associated conditions, but its nature is dependent on many factors such that the simple statement that X causes Y, understood as an inevitable individual causal process is seldom appropriate, and yet this is the simple message contained within much health education material. Some habits, like tombstoning, can cause serious injury or death during a single episode. Others, like smoking, cause

cumulative harm. Drinking alcohol offers health benefits up to a certain level,⁸ and causes incremental cumulative harm only after a certain limit. Eating a ‘wrong’ diet causes some harm in some people, though the occasional packet of crisps results in nothing but pleasure. The diseases ‘caused’ by these habits are also caused by other factors or by none at all. It can be clearly said that a tombstoner’s injury was caused by his tombstoning but it cannot be said with the same certainty that a smoker’s heart attack was caused by his smoking. He may have suffered it anyway, along with many others who suffer heart attacks without ever touching a cigarette. Because of the lack of direct causation between habit and illness when we say that we are responsible for our health, we cannot fairly mean that we are held responsible for (just) having a disease. However, there clearly is a relationship between certain habits and certain conditions which can unequivocally be regarded as a disease, and so the concept of responsibility for health is often (but not always) more fruitfully conceived as being a responsibility to avoid behaviour that risks certain consequences.

Individual control and choice

The academic paper that introduced the thesis (Wardle *et al.*, 2008), the findings of which were ‘blithely dismissed’ by India Knight, reported empirical findings about the extent to which genetic factors contributed to obesity. These influences are causal at the group rather than individual level. India Knight is correct insofar as genetic influences can be overruled by personal behaviour in respect of diet. A genetic predisposition to obesity cannot lead to obesity in the context, for example, of a very low calorie diet, and so personal behaviour in this instance is a necessary

⁸ For example, Brien *at al.* (2011) correlated moderate alcohol consumption with improvements in biochemical markers, confirming the effect observed with population studies, and see Arranz *et al.* (2012) for a review.

condition for obesity. As Dougherty (1993) noted, similar genetic predispositions exert their influence on behaviour rather than metabolism influencing patterns of eating which cause obesity. Again it does not follow from the existence of these genetic predispositions that an individual affected will inevitably exhibit the behaviours that he is predisposed to; there is always the choice, however difficult, to overcome inclination to eat. Similar genetic and other biological influences which can be overridden can be seen elsewhere, for example in a predisposition to violence (Jaffe *et al.*, 2013). Genetic influences act both on behaviour and metabolism, but there are many other factors which exert influence over weight gain, including physiological factors and an obesogenic environment. The government foresight report (Butland *et al.*, 2007) details the factors in an incredibly complex diagram that lists over 100 connections, and yet India Knight's argument is true to the extent that obesity requires an individual lifting excess calories to his mouth, an act which if not under complete conscious control at all times, is capable of being of being so.

Western societies value personal autonomy and the choices that this allows, but this assumes and requires sufficient cognitive capacity in individuals. It does not require that agents choose rationally, only that the capacity for rational choice is present, recognised by the Mental Capacity Act 2005,⁹ which assesses procedure rather than outcome (Nicolson *et al.*, 2008), and includes as a criterion of assessment that '[...] the person is able to understand, retain, use and weigh up the information relevant to this decision' (Department for Constitutional affairs, 2007, p.41). The test is used to assess capacity to consent to medical and other procedures, and requires information to be presented in such a way that it can be understood by the decision maker.

⁹ And the Adults with Incapacity (Scotland) Act 2000.

The problem is that research has consistently shown that, as a species, humans are very bad at using calculations to assess risk. We are very poor at understanding the statistics used to inform us what our choices are (Gigerenzer, 2014; Gaissmaier and Gigerenzer, 2011), and in addition, words like “substantial” and “limited” are used, which describe but do not quantify risk. Risk, even low risk, has come to represent a harm in itself and what some regard as a harm (inebriation for example) is regarded by others as a benefit (Keane, 2009). We unconsciously use a range of psychological foibles to defend intuitive judgements and preferences demonstrating that we do not exhibit reflective decision making as perhaps we would like to think we do, and which supporters of the freedom model of responsibility assume. These foibles, though known about for some time, have assumed recent prominence with a number of popular books (for example, Kahneman 2011; Haidt, 2012). A relatively recent development which has accelerated during the writing of this thesis is the use of so-called nudge techniques which recognise the psychological foibles and utilises them to ‘nudge’ individuals to make choices that are judged (by the nudger) to be in their interests. The term ‘libertarian paternalism’ has been coined (Sunstein and Thaler, 2003) to describe this process; the ability of individuals to override the nudge and act on decisions taken outside the nudging frame allows its advocates to deny that it is coercive. Utilising insights from social psychology to manipulate individuals to act in a certain way has been a feature of health education and promotion for a number of years, and I will explore this in some detail in part II, especially chapter 6. These insights have also been used within the retailing and charity sectors for many years (Thaler and Sunstein, 2008).

The questions of behavioural, cognitive and neurosciences as well as other environmental factors suggest that the ability to act rationally is impeded in most people for most of the time. This is not so much a denial of moral agency as a series of empirical observations about how we act; moral responsibility is concerned with an *ability* to act on the basis of reasons and is undiminished by these observations (Sie and Wouters, 2010), supporting Levy's (2014) suggestion in relation to informed consent, that experts in reasoning should act as informed consent specialists, informing patients of their cognitive biases in an attempt to correct them.¹⁰ There remains something of a paradox in understanding of autonomy within professional health care which at once assumes capacity by requiring open information giving in consent and yet recognises its shortcomings by practicing restricted and manipulative information giving within health education and promotion. Levy's suggestions may help to reconcile this tension, but the point to be emphasised here is that individual control of behaviour and personal choice are complex and problematic, and though moral responsibility is retained despite these difficulties, meeting health-affecting obligations, even when they are recognised and acknowledged is nowhere near as easy as the freedom model and its proponents like India Knight, Edwina Currie and John Knowles assume.

Patients' duties

There is a 'modest' (English, 2005, p.139) and 'infrequent' (Iltis and Rasmussen, 2005) literature concerning the duties of patients, arriving at the nature of the obligation from a number of directions. Sider and Clements (1984), Draper and Sorrell (2002) and Resnik (2005, 2007) attempt in various degrees to ground an

¹⁰ In a response, Trout (2014) goes further and argues instead that we should bias patients to make the right decisions guided by their own values.

obligation to look after one's health in the Kantian notion of duty to oneself. Kant regarded the duties to self as so serious that if they were not met one is treating one's self merely as means (Kerstein, 2008). The duty to oneself is prior to duties for others (Paton, 1990). If the reasoning on this point is difficult, he regarded the conclusion as self-evident:

Animal immoderation in the enjoyment of food and drink is misuse of the means of nourishment; the capacity for the intelligent use of these means is weakened through such misuse. The vices under this heading are drunkenness and gluttony: when a man is drunk, he is simply like a beast, not to be treated as a human being; when he is gorged with food, he is temporarily incapacitated for activities which require adroitness and deliberation in the use of his powers. It is obvious that to put oneself in such a state is to violate a duty to oneself (Kant, 1994 [1797], p. 88).

This passage appears to regard the wrongness of drinking and eating too much in terms of the short term effects on the autonomous mind rather than the longer term effects that are of more contemporary concern. This long term health effect may be considered analogous to the categories of partial self-murder which are prohibited. In practice these duties to oneself are negative duties and offer reasons to avoid certain actions which may also be avoided for other reasons. The long term care of your body can be regarded as prudential or indirect duties to others, as, for example, when an airline pilot owes a duty to his passengers not to get drunk (Timmerman, 2006).

The notion of moderation is central to Aristotelian virtue ethics. The relevant virtue is temperance in regard to pleasures, the excess of which is licentiousness. Not all pleasures are susceptible to excess; those who gain their pleasure from music or art are regarded as neither temperate nor licentious. The virtue of temperance is concerned with 'such pleasures that are shared by animals too (which makes them

regarded as low and brutish). These are touch and taste' (Aristotle, 1955, p.79).

There is nothing wrong with seeking pleasure, but the

licentious display excess in every form. They enjoy some things that it is wrong to enjoy because they are odious; and where it is right to enjoy something, they enjoy it more than is right, or more than is normal [...]. Clearly, then, excess in respect of pleasures is licentiousness, and a culpable thing (Aristotle, 1955, p.78).

In simple modern terminology, Aristotelian morality appears to advocate moderation, though some pleasures seem to be regarded as 'odious' in themselves.

There is some circularity in this quotation; he seems to be arguing that it is wrong to enjoy wrong things, and he does not say what these 'pleasures' are, but it is amusing to speculate that among the contemporary targets of health promotion, smoking might be regarded as odious and always forbidden and blameworthy while drinking and eating are regarded as pleasures to be taken in moderation, because of their bad health related consequences:

Nobody would criticise a person who is blind by nature or as a result of disease or injury – he would more likely be an object of pity – but anyone would blame a person whose blindness is due to heavy drinking or some other self-indulgence (Aristotle, 1955, p.64).

Much of the literature about responsibility for health addresses the idea of obligation within the patient-professional relationship, partly in response to the imbalance between patients' rights and their responsibilities. There is clearly significant overlap between obligations for (just) health, and responsibilities within the patient-professional relationship, but there is also some conflation, and it is also the case that the rationale for the obligation is seldom fully developed. In 1847, the American Medical Association (AMA) published its first code of ethics, which included a section on the duties of the patient:

The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them. A failure in one particular may render an otherwise judicious treatment dangerous, and even fatal. This remark is equally applicable to diet, drink, and exercise (AMA, 1847, p.96).

It is an interesting document, illuminative of the social mores of the time, and yet the ‘obedience’ demanded is based on a jointly held enterprise recognised today by patient and physician: the health of the patient. The account that patients have an obligation to follow what were commonly referred to as ‘doctors orders’¹¹ is less seen, but still present in more recent literature. Meyer (1992) argues for a duty to engage in responsible self-care, and while noting that following the duty is obviously self-regarding, it is also a duty owed to others, including health care professionals because the professional has a ‘direct interest in the patient’s health’ (1992, p. 551). The interest is direct because it does not rely on the physician’s interest in advancing her career or knowledge, and the (*prima facie*) duties are based on prior autonomous agreement to the treatment or lifestyle choice. The obligation appears to be recast as a duty to adhere to agreements rather than to be anything more directly concerned with health, though Meyer also states that:

[t]he fact that a patient is too busy or too lazy to care for himself is an offence against the patient and the health care professional. This is an offence against the health care professional because in order to do his job well he needs patient cooperation (1992, p. 552).

The reason why the physician or nurse should be quite so offended is not clear; the same argument, based on task performance could equally be made, though less forcefully, against a home owner who undermines his landscape gardener by not keeping his weeds in check. Meyer’s version of obligation to the health care

¹¹ This term is still recognised in health care. For example women with heart failure in a Swedish study discussed feelings of guilt when failing to comply with ‘doctor’s orders’ (Burstrom *et al.*, 2012).

professional is doubly misplaced in a health care environment largely funded by the patient's own contributions,¹² directly or through insurance payments. In these systems there is an element of collective purpose, as the total health care costs are shared, to some extent, via insurance premiums. However, the notion of drawing more directly from pooled resources gives more pressing reasons for an obligation to maximise our own health (Gauthier, 2005; Evans, 2007).

Within a system of socialised health care, Evans (2007) argues for a 'duty' to uphold our own health as far as it is 'reasonably' open for him to do so. Additionally, there are obligations to make the patient-professional relationship and medical treatment as effective as possible and so maximise the opportunities for others to access jointly held resources. These include the duty to seek health care responsibly, be truthful during consultation, and a duty of 'compliance'. It is acknowledged that the duties that Evans argues for are unenforceable, but that this does not diminish their normative force, which is strong enough that taken together, 'their fulfilment is *prima facie* a condition of access to healthcare [...]' (2007, p.690). Woods (2007a) make a similar argument that the right of individuals to access health care must be 'premised upon a degree of personal responsibility' (p.722). Accepting that the common good argument is 'naïve', Woods draws on Rawls' (1971) notion of primary goods as the prerequisite of any life. Rawls published *A Theory of Justice* before the links between income and health had been developed, just before the rise of individually directed health promotion. Health is not recorded as a Rawlsian primary good,¹³ but Woods suggests that it should be regarded in this way – and that

¹² Civaner and Arda (2008) conclude that where health services are provided on an ability to pay, none of these duties can be properly be regarded as a patient responsibility.

¹³ Others have applied Rawls account of justice to health care. For example, see Bommier and Stecklov (2002).

‘therefore we all share a common interest in protecting, preserving and restoring health’ (p. 722). Thus the argument that we ought to care for our health so as not to draw on commonly held resources to restore it is extended to health itself, that is prior to the claiming of health care resources. We should act to maintain health not only so to avoid these resource claims but because it is a common good in itself.

In contrast to the Kantian and Aristotelian accounts, these are essentially contractarian accounts which recognise that the undoubted value of personal autonomy has been overemphasised within the relationship between individuals and the health care system. Arguments that we ought to care for our health are other-regarding to the extent that their normative force relies on avoiding drawing on health care resources so that they are available to others. In caring for our health, for whatever reason, by avoiding preventable disease, we are acting in others’ interest. We may also be acting in our own interest if we value health above other things. For many people and with respect to much health-affecting behaviour, our actions are both self and other-regarding in varying extents. My friends and especially my family are affected in many ways by my poor health: because they may be obliged to care for me, because I am less able to care for them, and simply because we are emotionally upset when we see those who we love suffer. These less tangible other-regarding reasons to look after my own health are less visible in the bioethics literature,¹⁴ and will be revisited in the papers in part II of the thesis.

It has also been claimed that there are responsibilities on individuals to behave in certain ways when they are sick. Writing in the early 1950s, Talcott Parsons

¹⁴ But see Gorovitz (1984) for a robust rebuttal of Sider and Clements (1984). His account grounds obligation in networks of human aspirations and relationships.

proposed a number of features of the sick role (Parsons, 1975). On his account the patient is not responsible for his illness, which is outside personal control and which requires outside support to cure him. He is obliged to try to get well, to seek required support, and then co-operate with caregivers. The sick role account was initially very popular and provoked a great deal of research, and despite being ‘abandoned’ by sociologists (Burnham, 2014), remains highly visible in text books (Williams, 2005; and see Clarke, 2010, for an example). The discourse of health replaced that of sickness, and as Burnham argues, sociologists were drawn into the ‘prevention crusade in which people were blamed for their own illnesses’ (2014, p.79). The responsibility to prevent illness represents an extension to Parson’s normative expectation of the sick (Greco, 1993, Varul, 2010), and the blamelessness is lost in it.

Since the literature on responsibility for health largely concerns patients’ duties in the context of professional health care, the final section of this chapter briefly discusses these duties from the point of view of the provider of these services. The UK has a highly developed socialised system of health care, often referred to as ‘the envy of the world.’¹⁵ Despite the growing realisation that the relationship between provider and consumer of health care was increasingly asymmetrical, official recognition of patients’ duties has only recently been developed.

Codes and declarations – the NHS Constitution

In England, the NHS Constitution, first published in 2009 and revised in 2013, sets out the rights and responsibilities that should characterise the relationships between

¹⁵ For example in the statement issued by the Secretary of State on the occasion of its 65th anniversary. <https://www.gov.uk/government/news/jeremy-hunt-celebrates-65-years-of-the-nhs>

the NHS and its patients. At over 4000 words and over 16 colourful pages, it is a lengthy document, and leaflets explaining the main features in a more accessible format are also produced. The document first sets out the principles and values of the NHS. Four sections addressed first to patients and then staff follow. The first is addressed to patients and the public and details what their rights are. At 5 pages it is the longest section, and is addressed to 'you', for example '**You have the right** to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority' (NHS, 2013a p.10, emphasis in original). The next section is headed 'Patients and the public – your responsibilities' and is reproduced below:

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Patients and the public - your responsibilities (NHS Constitution)

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.

Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.

Please treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.

Please provide accurate information about your health, condition and status.

Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

Please participate in important public health programmes such as vaccination.

Please ensure that those closest to you are aware of your wishes about organ donation.

Please give feedback – both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

There appears to be some confusion about the moral status of the clauses in the constitution. A link to this section on the NHS Choices website¹⁶ states that the constitution covers ‘what you can expect from the NHS, the promises the NHS makes to you, and what the NHS needs from you in return.’¹⁷ This suggests a contractual nature for the document, as though meeting the provision is required in order to exercise the rights. However, the actual clauses are written in the form of a series of requests, prefaced by the word ‘please’. It is difficult to see these individual requests as responsibilities at all, if the notion of obligation forms part of the concept. The initial version of the constitution had the same number of clauses but each was prefaced by the more normative ‘You should.’ The change from the normative ‘should’ to the requesting ‘please’ was explained as a ‘minor drafting change to use less paternalistic wording’ (DH, 2013b, p.19). This seems an idiosyncratic use of the concept paternalism as the previous normative expression does not constitute an interference with liberty, and many of the provisions are not directly concerned with the welfare of the patient.¹⁸ The proposal that formed the basis of the consultation (DH, 2012) did not include this change, and the government

¹⁶ <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

¹⁷ As I write this in July 2014, the wording of this section of the NHS choices website erroneously refers to the previous version of the constitution.

¹⁸ See for example Dworkin’s (2010) entry on Paternalism in the Stanford Encyclopaedia of Philosophy.

response did not elaborate further on whether respondents to the consultation objected to its previous tone. The change can be read as a weakening of the normative force of the responsibilities, which are consistent throughout despite their different objects. Patients are requested not to abuse staff (that is fulfil a legal prohibition), make the patient-professional relationship more efficient by providing accurate information, and also contribute to public health as well as their own by completing prescribed courses of treatment¹⁹ and by participating in vaccination.

The clause most pertinent for the subject matter of this thesis is the first, which was additionally amended following consultation. The previous version (DH, 2009a) stated that ‘Patients should recognise that they can make a significant contribution to their own, and their families’, good health and well-being, and take some personal responsibility for it’. This version is unclear as to what ‘some’ personal responsibility means with the new version being clearer and simpler, though the apparent strengthening of the responsibility is diluted by the change from ‘should’ to ‘please’.

The final two sections of the constitution cover NHS staff and are presented with mixed normativity. Commitments that the NHS has to its staff are set out alongside legal duties and normative expectations of staff. For example, ‘You have a duty to be honest and truthful in applying for a job and in carrying out that job’ describes a legal duty, whereas the nature of the relationship with patients is stated as a normative target: ‘You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to

¹⁹ This is of significant interest in light of growing concerns about antibiotic resistance as outlined by WHO (2014).

feedback and addressing concerns promptly and in a spirit of co-operation.’ It is not stated whether these duties are directed at health professionals or other staff. The duties, though written in a document intended for public consumption, go no further, for non-professionals, than can be expected to form part of the contract of employment. For health care professionals these duties form part of their professional codes of conduct, strengthened in many places by the stronger normative word, ‘must’.²⁰ The literature on patient’s duties was partly inspired by asymmetry within the relationships between patient and health care providers, personal and institutional, but on the analysis provided here, advocates of a reworking of these arrangements will need to look much further than the NHS constitution for a rebalancing,

Conclusion

In this chapter I have set out some general problems for the issue of personal responsibility for health and the environment in which the debates and health care practice is undertaken. The model of fully rational people always behaving rationally to maintain health as an intrinsic good has been revealed as being far from the way that people live their lives, and yet with some concessions, personal behaviour change remains the foundation of health promotion strategy in the western world. It is easy to conclude that it is a normative rather than an empirical model. But for many, health, widely understood, can be improved following change in behaviour, and so even those of us sceptical of much public health practice concede a role for supporting people to change their behaviour. And, since nearly all of us live within community ties of various sorts, drawing from common resources, it is indeed

²⁰ See for example the NMC Code (2008) Clause 52: You must give a constructive and honest response to anyone who complains about the care they have received.

sometimes the case that resources used on potentially avoidable treatment are denied to others. For these other-regarding reasons it is plausible to suggest a *prima facie* moral personal responsibility for health, even in the social environment that I have outlined, and I will return to this in part II of the thesis. Recognising that appeals to personal responsibility for health have not produced desired behaviour change, successive governments have used legal means increasingly robustly to regulate individuals' health-affecting behaviour, and these are the subject of the next chapter.

CHAPTER 3

Legal Context

This thesis is concerned with moral rather than legal responsibility for health but moral decisions are made in the context of a legal framework, and complete separation of moral and legal responsibility, in the cases that the thesis discusses, is only possible if moral decisions are taken in total social isolation, something that is neither possible or desirable for most people. I begin the chapter by identifying areas where law and morality differ, and discuss two necessary links between them; the claim that moral consideration is a necessary but not sufficient condition of legal regulation, and that there is a moral responsibility to obey the law. Using the example of potential legal enforcement of wearing a cycle helmet, it is suggested that moral and legal responsibility are often confusingly conflated. The remainder of the chapter discusses the regulation of smoking to illustrate and evaluate some measures utilised by the government to enforce its citizens to fulfil what it considers their moral responsibility.

Outright criminalisation is discussed in the light of the liberal presumption in western societies, and regulation short of criminalisation is discussed with reference to European Union (EU) regulation and the WHO Framework Convention on Tobacco Control (FCTC). Legal challenges by smokers at Rampton Hospital and The State Hospital, Carstairs to a *de facto* total ban on smoking are discussed in

some detail. Finally, the lawfulness of smokers being denied treatment for smoking related ailments is discussed, and I conclude that guidance and the law exclude this. Instances where individuals are required or asked to stop smoking before treatment seek justification from forward looking concerns about efficacy of treatment rather than backward looking concerns about desert.

Legal and moral responsibility

In questions both of wrongness and of consequence, there are significant differences between moral and legal understandings of responsibility. As Cane (2002, p.15) points out, 'law possesses institutional resources that morality lacks, and these enable it to answer detailed questions about responsibility'. Moral considerations alone can leave disputes about the wrongness of an act unresolved. There is disagreement about the ontological status of moral norms and values, whether it can be the case that it is *true* that something is morally wrong (Wedgewood, 2007, Mackie, 1990), and there is, for many, no external moral authority to settle questions about the general morality or a specific instance of something. In contrast, political and legal institutions, in making, applying and enforcing law, remove ambiguity in the final settlement. Disputes about the legality or otherwise of an act need not be settled contemporaneously, and this may be a source of frustration to someone contemplating undertaking such an act, but nevertheless an authoritative answer as to lawfulness will be forthcoming eventually. For example, public and professional attitudes in assessing arguments for and against euthanasia change over time even if the moral arguments themselves barely do (Emanuel, 1994), though periodic review in the UK and elsewhere changes the legal status of assisted dying through legislation, case law and prosecution policy.

Whether the prohibition or regulation of something is a matter for criminal or civil law, failure to observe legal responsibilities is subject to coercion in a way that moral responsibilities are not, except where these binary responsibilities coincide. A person undertaking an illegal act risks legal sanction as well as moral disapproval and in the case of, for example, smoking cannabis, this can involve fines and imprisonment.¹ He may also attract moral praise for breaking a law or defying a court order. Punishments are levied because smoking cannabis is illegal, not because the Judge thinks that it is immoral, though it has been suggested that on occasion Judges adopt definitions of legal terms so that they can defend their moral convictions, for example in the application for judicial review brought by the murderer Ian Brady, who sought removal of a feeding tube (Brazier, 2006).²

Moral considerations are important in debates concerning legal regulation in at least two respects. First, though it can be argued that some harm-causing immoral³ acts, for example marital infidelity, remain unregulated by law,⁴ ‘principles guiding legal regulation must include moral judgements’ (Greenawalt, 1995, p. 713). On this account, (im)morality is a necessary but not sufficient condition for legal regulation of one sort or another; even if the moral judgement is partial and/or contested, legal regulation requires moral justification.⁵ This is easier to see where the act threatens

¹ The Misuse of Drugs Act 1971 provides for penalties of up to five years imprisonment for possession of cannabis and up to 14 years imprisonment for supply.

² If true, it merely means that Judges are the same as everyone else for whom *post hoc* reasoning tends to confirm rather than challenge initial intuitive moral judgements (Haidt, 2012).

³ I mean that many people would consider this immoral.

⁴ Adultery remains illegal in a number of US states, though prosecution is rare. In New Hampshire, the Senate voted to decriminalise adultery on 19th February 2014, by 268 votes to 29. <http://legiscan.com/NH/bill/HB1125/2014> In Maryland, adultery is a misdemeanour punishable by a \$10 fine. <http://mgaleg.maryland.gov/webmg/frmStatutesText.aspx?article=gcr§ion=10-501&ext=html&session=2014RS&tab=subject5>

⁵ Similar arguments are presented in questions of whether proscribed acts should be legalised. We see this in arguments about the legalisation of drugs and also at the end of life, where it can be argued that

others' health, as in debates about prohibiting smoking in public places, and less visible where harm is predominantly to the individual's own health, for example the compulsory wearing of cycle helmets (Sheikh *et al.*, 2004 in favour, Hooper and Spicer, 2012 against). A significant assumption in this thesis is that lines of arguments like those supporting the view that we *ought* to wear a helmet when cycling are usually unarticulated, and to be clear, I mean a moral ought; that wearing a helmet when cycling is a moral obligation. Sheikh *et al.* (p. 263), for example, state that:

It is arguable that individuals have some sort of duty to their fellows of taking responsibility for their own health, that sometimes this duty is an enforceable one. Interestingly, in more 'libertarian' societies, such as the US and Australia, compulsory cycle helmet wearing is often a 'State' rather than a Federal law, in the interests of requiring individuals to be responsible for their health, since many of the severely injured will eventually need to use the State health safety net.

As I argued in the previous chapter, an argument that there is an obligation to fellow citizens so we do not use collective health care resources is common enough, but is directed (in US and Australia, anyway) at uninsured cyclists rather than all cyclists. But at least the argument is other-regarding, though in the previous paragraph they appeal to rationality in terms of self-interest as justification for proposing legal enforcement:

Our argument here is that, in the light of the evidence, most people would rationally choose to wear a helmet, and we would all allow that there are good social grounds for encouraging cycle helmet wearing. But equally, we know that doing what is in our own interest can be hard without external encouragement. We recommend legislation as a collectively autonomous choice in favour of one kind of external encouragement (Sheikh *et al.*, 2004, p. 263).

ethanasia is morally acceptable in certain cases but should remain illegal. Foot (1977) hints at this, and Gillet (1994) argues the point more directly.

A second consideration of the links between legal and moral responsibility travels the other way – from legal to moral considerations. The question is whether there is a moral obligation to obey the law. A behaviour being the subject of legal prohibition offers a reason in favour of avoiding it in the sense that if I undertake it (and get caught), sanctions follow. The reason is prudential and hypothetical, counting against smoking if I want to avoid a fine and a criminal record. A. John Simmons suggests that, in addition to this, ‘most of us living in reasonably just societies believe that there is a general moral duty to comply with the requirements of valid domestic law’ (2005, p.98). The empirical claim embedded in this statement is not supported by evidence (it is prefaced by the caveat ‘I think that it is likely true’) and is distinct from the moral claim (that we ought to obey the law) that he proceeds to reject. Further caveats ‘a reasonably just society’ and ‘valid domestic law’ suggest questions in application. Someone denying a moral obligation to follow what he regards as an unjust law could cite the very existence of this law to support his view that the society is not reasonably just; and the view that the ‘unjust’ law was enacted in the first place could question the validity of the system that enacted it. I assume that the descriptor ‘valid’ applies to the process of law making rather than individual outcomes. If the word ‘valid’ means laws I agree with then the argument would be circular; I have a moral duty to follow a law which proscribes something that I would not do anyway.

The statement that there is a moral obligation to obey the law is more usefully directed at those who do not agree with the specific legal provision. I would not count myself as one of the majority that Simmons assumes. If helmet wearing was legally required, I would comply in order to avoid prosecution rather than out of a

moral duty to follow the law.⁶ A less trivial example of the dilemma involved where moral and legal responsibility conflict is the issue of assisting suicide, which remains illegal in the UK. My suggestion, *pace* Simmons, is that individuals turning down a request from a loved one to assist with their suicide do so either because they think it is wrong, or that they fear prosecution. The suggestion that ‘most’, many or even some people would refuse a request just because it is illegal,⁷ separate to concerns of their moral view of the request or the potential of punishment is open to challenge. Jackson *et al.* (2012) note that many criminal policies assume compliance by the threat of sanctions for wrongdoers, but also that supporting evidence for this is derived almost exclusively from the US. Their study claimed to be the first of its kind in the UK, and found that individuals did regard obeying the law as a moral duty. However the examples that they used – buying stolen goods, illegally disposing of rubbish, vandalism, and shop lifting – are ‘everyday crimes’ (p. 1062) not representative of laws enacted to protect people’s health. Recent case law concerning the end of life is partly driven by the need to avoid prosecution. In the case recently rejected at the Supreme Court,⁸ it is noted⁹ that Mr Martin’s wife does not want any part of bringing about her husband’s death, but does not give a reason. It is reported¹⁰ however, that the earlier and influential case brought by Diane

⁶ Increased police presence is known to reduce speeding (Walter *et al.*, 2011). In a Norwegian study, drivers reported that increasing the likelihood of being caught would reduce speed more than steeper penalties (Ryeng, 2012).

⁷ Whilst assisting suicide remains illegal, the Crown Prosecution Service has issued guidelines about prosecuting decisions which mean that prosecution is unlikely in compassionate cases. See Mullock (2010) for a review.

⁸ *873R. (*on the application of Nicklinson*) v *Ministry of Justice*. [2013] EWCA Civ 961.

⁹ *873R. (*on the application of Nicklinson*) v *Ministry of Justice*. [2013] EWCA Civ 961. Paragraph 10.

¹⁰ *873R. (*on the application of Nicklinson*) v *Ministry of Justice*. [2013] EWCA Civ 961. Paragraph 158.

Pretty¹¹ was necessary because her husband, though willing to provide assistance to end her life, was anxious about the possible consequences of doing so.

Legal and moral responsibilities differ and yet are clearly connected, and often conflated. For example, the quotation from Sheikh *et al.* includes the statement ‘in the interests of requiring individuals to be responsible for their health’. If this means legally responsible the statement is tautologous, since it amounts to saying that it requires individuals to do what they are legally required to do, and so it seems more likely that they meant requiring individuals to be *morally* responsible for their health. But this is fallacious, as coercion is a feature of legal responsibility but not moral responsibility. If people do what they morally ought to do only because it is required to avoid a sanction, then they are not being responsible, or taking moral responsibility, not least because lack of liberty restricts their moral agency. If the individual takes the view that legal responsibility places a moral responsibility (to wear a cycle helmet), he still is not being responsible for his health because the obligation that he is meeting is to obey the law, not to wear the helmet. It may not even amount to the same thing; meeting a legal obligation may result in the wearing of a (just) legally acceptable helmet instead of a better one which he would choose in meeting a moral responsibility to protect his cranium.

The discussion illustrates the difficulty in separating legal from moral responsibility, and when legal regulation is being considered or enacted it is important to be clear about how moral arguments in respect of an act are different from moral arguments in respect of regulating the act. In the next chapter I will defend a philosophical

¹¹ *Pretty v the United Kingdom* (2002) 35 E.H.R.R. 1.

approach that emphasises the importance of acts, whereas legal prohibition tends to operate at the level of rules.¹² The thesis assumes that in many cases, arguments about regulation simply accept a conclusion about the wrongness of the acts in question rather than arguing for them but often, as in Sheikh *et al*'s paper, the questions are confusingly conflated. This thesis attempts, in part, to avoid this by concentrating, in the main, on moral questions concerning health-affecting behaviours, but as the threat of law is forever in the background it is useful to consider some methods of legal regulation. In the remainder of this chapter these issues will be introduced in relation to tobacco smoking, in particular, three questions: Should smoking be criminalised? Should there be regulation short of criminalisation? Can discrimination against smokers in deprioritising treatment be lawful?

Autonomy, legal paternalism and criminalisation

Bioethics, at least Anglo-American versions of it, is heavily influenced by the primacy of respect for autonomy (Gillon, 1993), evident in case law as well as codified, for example, in the Mental Capacity Act 2005. The law is quite clear, as far as medical treatment is concerned, that an adult and capacitous person's autonomously¹³ held wishes to refuse treatment cannot lawfully be overruled because treatment is considered by medical professionals to be in the interest of the

¹² I say tends to because it is possible to specify rules using terms like 'without reasonable excuse'.

¹³ In practice there is a range of understandings of autonomy and the situation is far more complex than I have presented it (See Coggon, 2007). In *Re T (adult refusal of treatment)* All ER 649, T needed an emergency caesarean section following a road accident. After a visit from her mother who was a devout Jehovah's Witness, she refused blood transfusion. Doctors treating her abided by this refusal even when she suffered internal bleeding, leading her father to ask the Court to allow a blood transfusion against her previous wishes. In granting the application, Donaldson LJ found that a combination of her injury, drugs, and pressure from her mother invalidated her consent because her refusal was not an autonomous decision.

patient, even if this refusal results in death.¹⁴ The term ‘paternalism’ is regarded as pejorative in the context of health care provision, though outright legal prohibition as far as treatment is concerned applies only to ‘hard paternalism’, that is when treatment is carried out against the wishes of a fully competent and informed patient. Health care professionals acting paternalistically in this manner are vulnerable to redress under both civil and criminal law (Brazier and Cave, 2011), and by professional bodies. ‘Soft paternalism’, by contrast, is characterised by decisions taken and treatment performed where there is a less than full understanding, allowing the claim at least to be offered that autonomy is not being overridden because the person is not fully autonomous (Feinberg, 1984).

It might be considered that the legal rejection of medical paternalism at the individual level is the result of an overarching legal principle, anti-paternalism, which disallows medical interference, and that this might be extended so that legal sanctions cannot be used to coerce autonomous individuals to refrain from undertaking something on the ground that it would harm them. The extent to which paternalism is considered illegitimate ground for *criminal* prohibition can be questioned. Even Mill would not allow a person to sell himself into slavery, arguing that ‘the principle of freedom cannot require that he should be free not to be free’ (1998 [1859], p.114), though prohibition in this case may take the form of rendering a contract unlawful rather than criminalising selling yourself. Successful

¹⁴ In a well-known case, doctors refused to disconnect a ventilator from a woman who had withdrawn consent, saying that death was preferable to her. She was found to have capacity, and so the continuation of treatment was an assault for which she was awarded nominal damages. Instead of ordering that the ventilator be switched off, Butler-Sloss LJ ordered that she be transferred to another hospital which would comply with her competent refusal. *B v An NHS Trust* [2002] EWHC 429 (Fam).

prosecution of individuals consenting in private to sexual violence¹⁵ also threatens the liberal presumption (Erin, 2007), though whether this is on paternalistic or moralistic grounds is questionable. The standard position against paternalism is that of John Stuart Mill in *On Liberty*, known as the ‘harm principle’:

[T]he only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral is not a sufficient warrant (Mill, 1998 [1859], p.14).

Mill’s famous claim underpins the position refined by Joel Feinberg in his exhaustive and authoritative account *The Moral Limits of the Criminal Law*. His version of the harm principle is more nuanced, offering good though not necessarily conclusive reasons for criminalisation of an act:

It is always a good reason in support of penal legislation that it would probably be effective in preventing (eliminating, reducing) harm to persons other than the actor (the one prohibited from acting) and there is probably no other means that is equally effective at no greater costs to other values (Feinberg, 1984, p.26).

Feinberg extends the grounds for criminal prohibition to preventing serious offence where there are no equally effective means, but concludes that these two reasons between them ‘exhaust the class of morally relevant reasons for criminal prohibitions’ (Feinberg, 1986, p.x). Though Feinberg wrote about the US rather than the UK, his work has resonance across the liberal democracies and, as Erin (2007) notes, has been cited by the Law Commission.¹⁶

However, the apparently simple principle is more complex in practical application. Two significant issues are the precise grounds on which coercion is justified and the

¹⁵ *R v Brown* [1993] 2 All ER 75 (HL).

¹⁶ Consent in the Criminal Law – A consultation paper published by the Law Commission (1995).

extent to which the law and legal process can be used to coerce behaviour,¹⁷ though these are as much political as jurisprudential matters. Feinberg (1984) refers to mixed and unmixed paternalism. Mixed paternalism is where a number of justifications for criminalisation can be advanced, only some of which are paternalistic. Putting aside the position that individuals arguing for criminalisation may be unable to articulate their real motivation (or it may not be believed), activities of the sort considered for criminalisation can cause a number of harms. Tobacco use (1) harms those who undertake the habit, but also (2) harms those who love them, or are supported or employed by them, and also (3) harms the rest of society because health care costs follow from treating tobacco-related illness. It might be argued that in consideration of criminalising anything, a modest variation of the doctrine of double effect is being utilised, where the bad effect of criminalisation (overriding autonomy) is outweighed, in the final defining criterion,¹⁸ by the overall reduction of harm in a utilitarian calculation (Smith, 2002). Similar calculations can be made for other health threatening behaviours such as taking illegal drugs, where harms for individual users might be more, though for fewer people. Wider harm resulting from criminal activity to pay for drugs might relate more to the addictive nature of the drug rather than directly harmful effects and differ between drugs.

In paradigm cases of criminal activity, it is clear that the state has an interest, on behalf of its citizens, to prohibit acts harmful to others and to punish perpetrators.

Regarding a person as a criminal and, for some crimes, depriving him of his liberty

¹⁷ This could mean coercing abstention (illegal drug use), or coercing compliance (seat belt wearing).

¹⁸ Webster (2013, p.1046), for example, gives the final criterion for legitimate application of the doctrine of double effect (DDE) as 'The good achieved must significantly outweigh in proportion the harm caused.' It has been argued that this weighing up undermines non-consequentialist claims for the DDE (Snelling, 2004).

are among the most serious sanctions that the state can justifiably level at an individual and in this respect at least it has been argued that criminalisation should be restricted to ‘prohibit behaviour that represents a serious wrong against an individual or against some fundamental social value or institution’ (Ashworth and Horder, 2013 p.1). Yet we have laws prohibiting the dropping of litter and other trivial matters which hardly deserve the opprobrium accompanying conviction for more serious offences. Justification for criminalisation should be sought in two dimensions (Ashworth and Horder, 2013); where deserved retribution is required, or because the very fact that something is criminalised offers a deterrent against wrongdoing. A case that smoking should simply be prohibited would likely rest on the second of these justifications.

If the question of criminalisation or regulation of tobacco is a consequentialist question, the harms and benefits resulting from criminalisation of tobacco must be compared with those resulting if the status quo is maintained (Ashworth and Horder, 2013). Considerations wider than just health status must be considered; a significant harm from criminalising smoking would be a sense that autonomous decision making, widely regarded as very valuable, is being overridden, and as Husak (1989) notes in relation to illicit drug-taking, benefits derived by users are rarely considered in calculations. I return to this point in more detail in Chapter 6. A lesser and yet still illiberal proposal is to make it illegal for any person born after a certain date to buy cigarettes, first proposed in Singapore in 2010 (Khoo *et al.*, 2010), but also considered in Tasmania, Finland and Guernsey (van der Eijk and Porter, 2013). In June 2014, the British Medical Association voted to lobby the UK government to change the law to implement this proposal (BMA, 2014).

There are anomalies within the criminal law. Tobacco use remains lawful, while cannabis use is illegal. Utilitarian calculations require evidence so that harms can be calculated and compared, and what evidence there is suggests that alcohol and tobacco, both legally available, are more harmful than cannabis and LSD, both of which are prohibited (Nutt *et al.*, 2007). According to an editorial in *The Lancet* (MacDonald and Das, 2006), the lack of appreciation of evidence by politicians has resulted in a classification system that ‘almost defies belief’ (p.559), and it is perhaps unsurprising that the principal author of the study into comparative harms, Professor David Nutt, was dismissed from his position as Chair of the Advisory Council on the Misuse of Drugs after criticising the reclassification of cannabis from class C to class B, reversing a decision taken five years previously. This decision, in effect increasing the penalties for cannabis use was justified, politically, on the ground that evidence was strengthening that cannabis causes schizophrenia, though it has been estimated that even for heavy users, over 1000 people would need to be prevented from using cannabis to prevent a single case (Hickman *et al.*, 2009).

These decisions demonstrate that questions of prohibition of drugs, including tobacco, are as much settled by the pragmatic concerns of electoral politics than by legal or political philosophy, influenced by millions of smoking voters and powerful commercial interests combining to ensure that there simply is not the political will to consider outright prohibition of smoking, or the manufacture or sale of tobacco products (West, 2006), not least because if a ban were enacted, it would be practically impossible to enforce. In this respect, reference is frequently made to prohibition of alcohol in the US between 1920 and 1933. Received wisdom is that this was a failure, though recent reappraisal has questioned this simplistic evaluation

(Blocker, 2006; Hall, 2010). Results were mixed and harms difficult to compare; the harm of reduced personal choice and lack of respect for the law cannot easily be compared with what might be considered public health benefits. Incidence of liver cirrhosis fell (Dills and Mirron, 2004), but alcohol related and total homicides increased (Asbridge and Weerasinghe, 2009). In 2004 the tiny Himalayan country of Bhutan became the only country to criminalise tobacco sale and use, but the ban was ineffective largely because of a flourishing black market, and was rescinded in 2009 (National Portal of Bhutan, no date).

Legal regulation short of criminalisation

The extent to which the harm principle can be used to justify legal regulation short of criminalisation presents similar problems. Here, Feinberg and Mill differ. Both argue that criminalisation cannot be justified paternalistically and Mill extends this argument to other legally coercive measures, including taxation, to reduce use, which he regarded as ‘differing only in degree from their entire prohibition’ (1998 [1859], p.111). Conversely, Feinberg does not object to taxation of tobacco, seeing the difference between taxation and prohibition as one of kind rather than degree, but also offers the justification that discouraging smoking benefits society in general, as well as smokers in particular (Feinberg, 1984). Taxation policies have been proposed as a ‘liberal egalitarian’ approach to holding people responsible for their health-affecting behaviour, addressing, to varying degrees, the cost of treatment required (Cappelen and Norheim, 2005).

WHO considers legislation to be ‘at the heart of effective tobacco control’ (Blanke and da Costa e Silva, 2004, p.15), and was the subject, in 2003, of the first WHO

international health treaty. The Framework Convention on Tobacco Control (FCTC)¹⁹ obliges signatory countries ‘to adopt or strengthen legislation addressing tobacco advertising, packaging, sales practices, smuggling, public smoking and more’ (Blanke and da Costa e Silva, 2004, p. 46). Significantly, an increase in the age at which cigarettes can be purchased, introduced in 2007, decreased smoking in 16 and 17 year olds by seven percentage points (Fidler and West, 2010), a proportional decrease of over 30% (DiFranza, 2010). At the time of the change of policy, the UK²⁰ was unusual in allowing young people aged 16 years to buy cigarettes, and arguments in favour of the change could draw upon considerations of children and young people as less than full moral agents.²¹ Inevitably, the success of the measure has led to speculation about increasing the age as far as 21²² (Fidler and West, 2010), though the arguments would have less force applied at legally unambiguous adults over 18 years old. Ahmad (2005) proposes a considerable health gain from the measure in the US, where significant reductions in alcohol related fatalities are claimed following an increase in the minimum legal drinking age to 21 (Carpenter and Dobkin, 2011).²³

The FCTC does not advocate or even mention an outright ban on smoking; its objective (Article 3) is ‘[...] to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke’ (WHO, 2003, p.5). Provisions in the

¹⁹ The Convention was signed by the UK government on 16th June 2003, ratified on 16th December 2004, and entered into force on 27th February 2005.

²⁰ The regulatory change applied to England, Scotland and Wales. Northern Ireland followed suit in 2008.

²¹ See Tiboris (2014) for a discussion on children and diminished moral responsibility.

²² On 19th November 2013, The Mayor of New York City signed into local law an amendment to the administrative code to increase the age at which cigarettes can be bought to 21.
<http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=664290&GUID=4223E26A-7F3F-4B7D-9E3A-0E3F7B850155&Options=ID|Text|&Search=cigarettes>

²³ The National Minimum Drinking Age Act 1984 reduced federal funding to states which allowed the purchase and public consumption of alcohol by those under 21. Precise arrangements vary between states.

convention intend to reduce both demand and supply. The language is far from forthright, Article 6 noting the

sovereign rights of the parties to determine and establish their taxation policies, each party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include [...]' (WHO, 2003, p. 8).

The lame provisions reflect its voluntary nature; signatory states are not bound by its provisions. The language is more directive in areas of reducing demand, such as using health warnings, prohibition of misleading promotion, regulation of the contents of tobacco products, and notably, banning smoking in public places, which can be justified non paternalistically. Like the question of outright criminalisation, the ban needs further detailed justification, since it imposes restrictions on smokers, and, it can be claimed, infringes their rights, though as Oriola (2009) demonstrates, no *legal* rights for unfettered smoking exist. Though it is accepted that second hand smoke causes ill health, there are dissenting interpretations of the evidence (Enstrom and Cabat, 2003, and for a subjective exploration see R. Harris, 2004). Bans on smoking have been introduced worldwide,²⁴ and initial evidence is that they have been effective in reducing environmental pollution, improving health (Meyers *et al.*, 2009), and contributing to a reduction in smoking prevalence (Gallus *et al.*, 2007, McNabola and Gill, 2009).

There is no EU legislation on workplace smoking bans, though following consultation in 2007, the European Commission produced a Council Recommendation calling on member states to adopt laws consistent with the FCTC

²⁴In the UK, workplace smoking was banned under the provisions of the Health Act, 2006, introduced with effect from 1st July 2007. The offense of smoking in a smoke-free place carries a fine of up to £200, and the offense of failing to prevent smoking in a smoke-free places carries a fine of up to £2,500.

(Commission of the European Communities, 2009). EU legislation to regulate tobacco use, predating and consistent with the FCTC, is contained principally within two directives. The Directive on Tobacco Products (2001) sets limits for tar and nicotine in cigarettes, requires warnings on packaging and bans the use of terms such as ‘light’ and ‘mild’. The Directive on Tobacco Advertising (2003) extended the ban on advertising for tobacco products, which had been banned on television since 1989.

If workplace smoking bans are justified by the harm principle, and shown also to be effective in reducing ill health, it is difficult to see why they should not be extended to private cars, especially when they contain children, as have been introduced in South Australia, Cyprus, and several American States (Stephenson, 2009; Freeman *et al.*, 2008). Public attitudes appear to favour such an extension (Thomson and Wilson, 2009). On 29th January 2014 the UK House of Lords passed (by 222 votes to 197) an enabling amendment to the Children and Families Bill, which allows,²⁵ but does not require, the Government to make it an offence ‘for any person who drives a private vehicle to fail to prevent smoking in the vehicle when a child or children are present.’²⁶ As some of their Noble Lords noted in the parliamentary debate, the arguments can be further extended to banning smoking in private homes that house children, though this would be difficult to enforce without compromising privacy (Nuffield Council on Bioethics, 2007). The Fostering network (2010) advocates a

²⁵ Government consultation to enact the provision started on 15th July 2014 and will close on 27th August 2014.

²⁶ Lords Hansard <http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/140129-0002.htm>

policy of banning smokers from fostering children under five, and though there is no national policy this has been adopted by some local authorities.²⁷

Though the supremacy of Mill's dictum has been challenged for a number of years, for example relating to the wearing of bicycle helmets as previously discussed, a number of fresh challenges has been, and continues to be, presented in relation to smoking and its legal status. The challenge does not concern whether people can lawfully smoke, but where and when they can be lawfully prevented from smoking. Where smoking is only permitted in a designated area, most smokers simply move to that area when they want to smoke, an option closed to some. NHS policy and smoking legislation combined at Rampton hospital to prevent patients from smoking at all, resulting in a legal challenge. As a case study in *de facto* prohibition of smoking, and the arguments used in justification, it is instructive to examine it in some detail.

The Rampton Smokers: A judicial and policy challenge to Mill

The Health Act 2006 introduced a number of changes to the NHS but it will be best known for changing forever the experiences of smokers in England and Wales.²⁸ From 1st July 2007, smoking was no longer permitted in public places and (in certain circumstances) places of work in those areas which are enclosed or substantially enclosed. Exemption regulations made under Statutory Instrument allowed smoking in designated rooms in certain categories of places including care homes, hospices

²⁷ For example the Leicestershire County Council policy states that 'Children under the age of five will not be placed with carers who smoke' http://www.leics.gov.uk/fostering_smoking_policy.pdf

²⁸ Smoking in public enclosed spaces had already been outlawed in Scotland under the provisions of the Smoking, Health and Social Care (Scotland) Act 2005 (with effect from 26th March 2006), and in Northern Ireland under the provisions of Smoking (Northern Ireland) Order 2006 (with effect from 30th April 2007).

and prisons (regulation 5). Mental health units were afforded temporary exemption under regulation 10, but this expired on 1st July 2008.

Prior to the legal ban, the NHS Trust running Rampton Hospital had introduced a policy that banned smoking for staff and patients except for individual exemptions on clinical grounds. This policy operated both inside and outside hospital owned buildings (including Rampton) and came into force from 31st March 2007. From this time until after the expiry of the temporary exemption, smoking was no longer allowed (but was lawful) inside the hospital. Following the expiry of the exemption regulations on 1st July 2008, smoking was unlawful inside the hospital. Throughout this period, smoking outside was permitted under the Trust policy in ‘very rare cases’, but this could not be enacted at Rampton as smokers were prohibited by security considerations from going outside.²⁹ Initially then, the Rampton smokers were prevented from smoking inside by NHS policy, and then by law. N sought judicial review of regulation 10 of the Smoke-Free (Exemption and vehicles) Regulations 2007 because it was only a temporary rather than a permanent exemption, while E sought judicial review of the Trust policy banning smoking at Rampton Hospital. B claimed that the Trust’s policy for exceptions had been applied unlawfully inflexibly. The High Court³⁰ refused and the case was heard in the Court of Appeal on 24th July 2009.

²⁹ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 17. B’s case was not heard at the Court of Appeal.

³⁰ *The Queen on the Application of G and Nottinghamshire healthcare NHS Trust* [2008] EWHC 0196 (Admin).

The appellants claimed that the European Convention on Human Rights (ECHR) had been breached, specifically articles 8 and 14. Article 8 (Right to respect for private life) states that:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The court first considered whether smoking was an activity protected under article 8(1). Clearly, the article does not simply mean that individuals are always allowed to do exactly as they please behind their own front door, and whilst accepting that Rampton was the appellants' home, arguments were presented about the precise nature of the home and the nature of the act (smoking). The majority conclusion concurred with the High Court: 'Article 8 does not protect a right to smoke in Rampton. The prohibition does not, in such an institution, have a sufficiently adverse effect on a patient's physical or moral integrity.'³¹

Judgement about the provisions of article 8(2) was not strictly necessary because justification of interference can only be relevant where article 8(1) is engaged, but the Court nevertheless offered views about whether it would have applied to the smoking ban at the Trust had they ruled otherwise on article 8(1). The majority verdict was that the intervention was justified. Article 14 of the ECHR provides that:

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour,

³¹ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 51.

language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

The appellants' claim under this article was that discrimination had occurred, under the category of 'other status', because the exemption regulations provided for an indefinite exemption for prisons, care homes and hospices, and only for a temporary exemption for mental health units like Rampton. Predictably perhaps, the majority judgement was that the Secretary of State had justified the position in light of the differences between various places covered by the exemption regulations. The judgement runs to 30 pages of complex legal argument and a full discussion lies outside the scope of this chapter.³² However, a number of points raised in the judgement are very relevant to continuing restrictions on smoking and illuminative of the relationship between legal and moral responsibility for health.

First is the movement away from policy aims that echo Mill's justified restriction on liberty only to prevent harm to others, and towards the prevention of self-regarding harm, narrowly defined. Justification of interference against an Article 8 right can be defended to protect the 'freedoms of others' but this other-regarding criterion is not needed to justify interference for the purpose of the protection of 'health or morals'. The judgement found that the smoking ban introduced at Rampton was necessary for the 'health of both the patients, which of course includes the appellants, and others.'³³ This necessity was not recognised in respect of the provision of designated smoking areas under exemption orders in prisons, care homes or hospices, and as Keene LJ noted in a dissenting judgement, neither was it accepted as necessary by

³² See Coggon (2009a, b) for detailed commentary.

³³ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 71.

the Welsh Assembly or Scottish Executive.³⁴ He additionally argued that the stated aim of the legislation was of ‘protecting people against the risks to health from second-hand smoke’,³⁵ and that the ban, after the expiry of the exemption order, was disproportionate to meet this legislative aim. On this basis, having accepted smoking as engaged by article 8(1), he regarded the ban a disproportionate under 8(2). The majority verdict, in contrast, justified the Trust’s ban in the ‘interest of ‘public health’,³⁶ as did the High Court³⁷ in noting that the removal of the exemption was justified because of the dangers both to smokers and those subject to second hand smoke. It is worthy of note that the Court of Appeal found that the ban was ‘required’ while the High Court merely regarded it as ‘justified’. The High Court³⁸ also reported that there is evidence of substantial health benefits arising from the ban, but this benefit must be to the smokers themselves. Evidence of health benefits to non-smokers is unlikely to have been derived from studying the banning of smoking in designated rooms,³⁹ but on the effect of stopping smoking more generally. The benefit is clearly to the smokers themselves and must be regarded as a paradigm case of ‘hard’ paternalistic intervention.

Second, it was noted in the judgement that the issue of whether Article 8 is engaged cannot be decided solely on the question of whether Rampton can be considered the appellants’ home, or whether smoking can be considered an activity central to a person’s identity or social interaction, but rather a conclusion can only be reached

³⁴ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 107.

³⁵ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 105.

³⁶ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 72.

³⁷ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 69.

³⁸ *The Queen on the Application of G and Nottinghamshire healthcare NHS Trust* [2008] EWHC 0196 (Admin). Paragraphs 126 and 127.

³⁹ The exemption regulations detailed strict criteria about ventilation and door closing mechanisms to prevent smoke escaping.

after consideration of all these factors.⁴⁰ The relationship between the nature of what is accepted to be a patient's home and the nature of the act that he wishes to pursue in it is such that 'the less the appellant can rely upon the nature of the place in which the activity is pursued, the more he must rely on the proximity of the activity to his personal identity or physical and moral integrity.'⁴¹ This sentence implies that the proximity of an activity to a person is an individual matter, different between people, and the policy allowed for flexibility in 'exceptional circumstances.'⁴² But the personal details of the appellants are not noted in the judgement, and do not appear to have been considered by the Court of Appeal.⁴³ The judgement noted that 'Difficult as it is to judge the importance of smoking to the integrity of a person's identity, it is not in our view, sufficiently close to qualify as an activity meriting the protection under article 8.'⁴⁴ This sentence implies that the judgement as to the personal value of smoking applies to everyone, independent of the nature of the place in which it is undertaken. Individual circumstances in habit and environment do not appear to have been considered, so when the judgement concluded that 'Article 8 does not protect a right to smoke in Rampton',⁴⁵ it might as well have just said that Article 8 does not protect a right to smoke.

The High Court considered whether the exemptions in the Trust policy were unlawful because no exceptions had been granted at Rampton. The policy in force at the time is detailed in the Court of Appeal judgement allowing some exceptions for

⁴⁰ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 37.

⁴¹ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 49.

⁴² Noted at Paragraph 15. The current policy at the Nottinghamshire Healthcare NHS Trust (2013) states that 'In circumstances where, by exception, the multi-disciplinary team permits an inpatient to choose to smoke, this must be formally recorded in the care plan.'

⁴³ There is more detail in the High Court judgement.

⁴⁴ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 49.

⁴⁵ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 51.

‘acute psychiatric state’ and ‘terminal illness’⁴⁶ which certainly appears to restrict opportunities for exemptions. The High Court only considered evidence from a consultant psychiatrist, who after noting the resentment felt by B, stated in a report that:

It would be very difficult to argue that giving up smoking by itself could have caused him to have these difficulties or that cessation of smoking is the critical factor causing him to experience psychological problems. I do not believe that permitting B to resume smoking will substantially moderate or end his current psychological problems.⁴⁷

The decision not to grant an exception has been settled by the consultant psychiatrist’s view of what happened *after* the decision was taken, and has been recast not as a decision to prevent him smoking, but rather as one of permitting him to restart. It is clear that despite the Court of Appeal stating that the proximity of an activity to an individual’s personal identity is material in deciding whether article 8(1) is engaged, the judgement considered smoking in a general sense.

Third, the judgment noted that the duty of care held by trusts towards its patients included a ‘duty to take reasonable steps to prevent patients causing themselves self-harm.’⁴⁸ A number of sources is cited in support of this, specifically Paragraph 30 of the Safety and Security in Ashworth, Broadmoor and Rampton Hospital Directions 2000, which requires that the ‘Trust risk assess each patient against a range of factors including whether the patient presents a high risk of [...] (b) committing suicide or self-harming.’⁴⁹

⁴⁶ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 16.

⁴⁷ *The Queen on the Application of G and Nottinghamshire healthcare NHS Trust* [2008] EWHC 0196 (Admin). Paragraph 133.

⁴⁸ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 62.

⁴⁹ http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_d/h/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4108402.pdf

The judgement accepts that smoking is covered under these directions, but there is no reason to believe that the directions quoted regard smoking in this manner. The word “smoking” does not appear in the directions or the guidance notes⁵⁰ that accompany them. The passage of tobacco into the hospital is restricted but only insofar as it is difficult to exclude the possibility of illicit drugs being hidden within, something that remains the case in the latest version of the directions and their accompanying guidance, published in 2011, two years after the judgement. In the directions, self-harm is considered alongside suicide, implying that it refers to more acute episodes of harm such as cutting, rather than the cumulative potential harm which characterises smoking. Smoking is a qualitatively different activity from suicide. Self-harm is a difficult concept because of the potential to include such a vast range of behaviours, but it would be an idiosyncratic understanding of the term that includes smoking. Recent quality standards from National Institute for Health and Care Excellence (NICE) (2013b) state that:

[t]he term self-harm is used in this quality standard to refer to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.

It would be difficult to regard smoking as falling within this definition as drinking lies outside it, and the Court of Appeal accepted parity between smoking and drinking: ‘We don’t think that there is any real distinction between banning alcohol and banning smoking at Rampton.’⁵¹ In a substantial article entitled ‘self-harm’ in the *Lancet*, Skegg (2005) does not mention smoking, but states that ‘other self-

⁵⁰http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4108505.pdf

⁵¹ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 71

harming behaviours that do not result in tissue damage (for example, exercising to hurt oneself or stopping medication with the intention of causing harm) fall beneath usual definitions of self-harm' (Skegg, 2005 p. 1472). While some authors do include smoking, this is restricted to where it is considered 'excessive', for example McAllister (2003, p. 179): 'More abstractly, self-harm can include excessive risk taking, excessive drinking, smoking or eating, starvation, unprotected sex with multiple partners, sado-masochism [...].'

Interpreting the directions cited to justify the Trust preventing smoking by regarding it as self-harm would be considered over-zealous extended to other places. Under common law, I am justified in using reasonable force to disarm an individual to prevent him from cutting himself, but this does not extend to me snatching a cigarette from his lips and extinguishing it, along with a large chunk of his liberty, under the heel of my shoe. And if common law justification extends to a duty so far as health professionals and organisations are concerned then the nature of patient-professional relationships will be irrevocably changed, perhaps most for nursing which has a duty for advocacy in its professional code (NMC, 2008).

The final area of interest is the role of debate and consultation in Parliament and outside about the status of mental health units within the exemption regulations. This is not so much a point of law, but of how the law came to be made, significant because of the processes inside Parliament but also because it was given some importance in the judgements. The initial position of the Department of Health was that mental health units would be afforded the same permanent exemption enjoyed by smokers in prisons, hospices and care homes, but this view changed following

consultation. The majority judgement in the Court of Appeal accepted that it would have been clear to the Secretary of State and Parliament, that if a person could not go outside to smoke, the smoke free legislation might have had the effect of prohibiting him from smoking at all.⁵² It was also noted that the exemption regulations were approved by both Houses of Parliament and scrutinised by the Joint Committee on Statutory Instruments.⁵³

Initially it appears that there is some democratic mandate for the change in exemption regulation which was to prove central in the legal case, but closer scrutiny reveals that it is not as clear as suggested. The report of the consultation states that 140 responses were received (not the 150 responses that the judgement states) and that 65% suggested that there should be no exemption or a time limited exemption. Only 20% agreed with an indefinite or broader exemption.⁵⁴ The explanatory note to the Joint Committee on Statutory Instruments⁵⁵ merely noted the change but did not explain it, possibly because the role of the Committee excludes a discussion on the merits of the provisions it scrutinises.⁵⁶ At a meeting of the Second Delegated Legislation Committee on 26th February 2007 the Minister, Caroline Flint, stated that the exemption regulations took account of the consultation, and that:

We deliberated over the issues surrounding mental health units for a considerable amount of time. However, I felt that it was right to come down

⁵² *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 75

⁵³ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 80.

⁵⁴ Responses from individuals and organisations are analysed together, and so just an additional 63 letters from individuals would have resulted in a majority of responses against changing the permanent exemption to a temporary one. The responses were discussed and reported by the High Court and reproduced as an appendix to the report from the Court of Appeal. *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 24

⁵⁵ http://www.legislation.gov.uk/ukxi/2007/765/pdfs/ukxiem_20070765_en.pdf

⁵⁶ The website of the JCSI states that ‘The JCSI does not assess the merits of any instrument or the underlying policy which is are (sic) the responsibility of other Parliamentary Committees.’
<http://www.parliament.uk/business/committees/committees-a-z/joint-select/statutory-instruments/role/>

on the side of moving the mental health sector away from an exemption as soon as possible.⁵⁷

The next day, without division or debate, the draft Smoke-free (Exemptions and Vehicles) Regulations 2007 were approved in House of Commons. Five motions, covering terrorism, public health and children were taken together.⁵⁸ The same day in the House of Lords Grand Chamber, Baroness Royal of Blaisdon moved, ‘that the Grand Committee do report to the House that it has considered the Smoke-free (Exemptions and Vehicles) Regulations 2007’. Again, there was no debate, and nor was there when the House of Lords agreed to the regulations on 6th March.⁵⁹ Had any of the legislators read the document outlining the responses to the consultation (DH, 2006) they would have been aware of a footnote (p.13), inserted in response to the Mental Health Commission’s concerns that patients detained under the Mental Health Act should not be deprived of the right to smoke. It states that:

It is important to note that under smoke-free legislation, no individual is being deprived of any right to smoke. The laws deal with smoking in enclosed and substantially enclosed places, not the right to smoke.

The Judgement noted⁶⁰ that the prohibition of smoking outside is not a consequence of the legislation but of the trust’s policy, a fact, I suspect, peripheral to the resentment felt by the smokers whose abstinence was enforced by a combination of the two. A review of the documents and records does not support the view that the Secretary of State and the members of the Houses of Commons and Lords were aware of the consequences for the smokers at Rampton of the change to a temporary exemption, and it is difficult to see how there is any democratic mandate, as was claimed in the judgement, for the measure.

⁵⁷ <http://www.publications.parliament.uk/pa/cm200607/cmgeneral/deleg2/070226/70226s01.htm>

⁵⁸ <http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070227/debtext/70227-0023.htm>

⁵⁹ <http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70306-0002.htm>

⁶⁰ *R (N) v The Secretary of State for Health*. [2009] EWCA Civ 795. Paragraph 75.

I have identified four causes of concern that indicate a strengthening of prohibition of smoking: the emphasis on paternalistic self-regarding reasons for enforcement, the move from individual to more general consideration of human rights, judicial and policy acceptance of smoking as self-harm contrary to medical conceptualisation, and finally judicial misrepresentation of the democratic process.

Four years after the Rampton judgement, a similar case came before Lord Stewart in the Court of Session in Scotland,⁶¹ seeking judicial review of a decision by the State Hospitals Board to ban smoking, inside and outside. The claimant, a man with schizophrenia, who had been detained for 18 years following some low grade disorder offences for which he might have been imprisoned for no more than a few months, claimed that the ban breached the EHCR, especially article 8, which had proved pivotal in the earlier English case. In this case the EHCR was found to have been breached. In fact the Judge reached the decision with some reluctance:

Insofar as I have allowed the petitioner's application on the merits I have done so with a degree of reluctance. It is a perfectly reasonable proposition, given contemporary understanding about the effects of tobacco smoking, that patients in a hospital should not be permitted to smoke; and I have no cause to doubt that the respondents - who have a difficult job to do on behalf of the wider community - have throughout been acting in what they genuinely see as the best interests of their patients.⁶²

This can be read as against the Millian harm principle. Nevertheless his view, *pace* the Court of Appeal, but in agreement, largely, with the dissenting view of Keene LJ there, was that article 8(1) was engaged, and that the prohibition could not be justified under article 8(2). In a sentence which seems destined to be much quoted he said that:

⁶¹ *C M v The State Hospitals Board for Scotland*. 2013 WL 4411375.

⁶² *C M v The State Hospitals Board for Scotland*. 2013 WL 4411375. Paragraph 5

Article 8(2) ECHR authorises interventions which are “necessary in a democratic society [...] for the protection of health or morals”: it is not a warrant for lifestyle fascism.⁶³

Again noting his reluctance, Lord Stewart came to the view that ‘the decision to compel the petitioner to stop smoking was flawed in every possible way.’⁶⁴ However, it would be unwise for those opposing blanket bans of smoking in hospitals and elsewhere to regard this as an unequivocal fillip for their cause. Not only was the Judge at pains repeatedly to note his reluctance to find for the claimant, he also declined to rule that the smoke free policy was unlawful; it was unlawful only insofar ‘that it affected the petitioner’.⁶⁵ The Scottish Court has taken more care than the English Court of Appeal to apply the EHCR to the individual, and though it is clear that Lord Stewart’s moral inclination is supportive of the English decision, he has been diligent in applying its provisions very carefully to the individual case before him.

England was the last of the home nations to adopt a smoking ban in public places. Its clear justification was the protection of people from the secondary effects of other people’s smoking. However, in parliamentary and judicial action, England has taken up the cause of self-regarding paternalistic smoking bans with greater vigour than Wales, Scotland and Northern Ireland, and courts and public bodies, as I have demonstrated, have been ready to cast aside Mill’s liberal dictum and use sophistical arguments in pursuit of stopping people smoking for their own good.

⁶³ *C M v The State Hospitals Board for Scotland*. 2013 WL 4411375. Paragraph 52

⁶⁴ *C M v The State Hospitals Board for Scotland*. 2013 WL 4411375. Paragraph 124

⁶⁵ *C M v The State Hospitals Board for Scotland*. 2013 WL 4411375. Paragraph 6

Lawful consequences of smoking: denying treatment

I will argue in Chapters 5 and 8 that responsibility is as much about the response to those who fail to meet their obligations as it is about the obligations themselves.⁶⁶ In an obvious sense, for those breaking the law, for example in smoking in a public place, penalties are set out in legislation. Terms of imprisonment can be handed down for possession of some illegal drugs. But as we have seen, the prospect of criminalising smoking is slim, and so these sorts of penalties do not apply. This is not to say that there are no liabilities attached to smoking because it is not prohibited; extra taxes can be regarded in this light, a sort of liability blame according to Martin's (2001) account. Other forms of liability can accrue from smoking, and while these cannot be said to be part of codified law, they must at least be lawful. Of significance for smokers is the suggestion that they should be regarded differently if they become ill with a smoking-related disease, specifically in the suggestion that they can be given a lower priority than others for medical treatment, or even denied treatment altogether. The question of whether smokers should be offered coronary artery bypass grafting was the subject of debate in medical journals some time ago (Underwood and Bailey, 1993; Shiu, 1993), and has periodically resurfaced as a public debate ever since in slightly different guises.⁶⁷ The suggestion of denying treatment to those who caused their disease is undoubtedly intuitively attractive to some (Samuels, 2006), but it has become a serious suggestion because of the financial restrictions placed on a publicly funded health care system. Is denial of treatment lawful?

⁶⁶ Tadros (2005, p.24) notes the obvious etymological connection between responsibility and the idea of a response.

⁶⁷ For example, it was reported that a Primary Care Trust was 'asking' patients to give up smoking before elective surgery, while stressing that the final decision rests with clinicians. See <http://news.bbc.co.uk/1/hi/england/leicestershire/6718439.stm> Another trust reportedly reversed a decision not to treat obese patients until they had lost weight. <http://news.bbc.co.uk/1/hi/england/leicestershire/6718439.stm>

Syrett (2007) noted that there is a paucity of case law relating to the allocation of scarce resources. The usual mechanism is application for judicial review of rationing decisions (Syrett, 2004), and these are seldom successful, partly because allocation decisions of this sort have been considered non-justiciable (King, 2007). In the case of child B, whose father challenged the decision to deny his daughter expensive and probably ineffective treatment for leukaemia, Sir Thomas Bingham MR put it like this:

Difficult and agonising judgements have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgement which a court can make.⁶⁸

Though the doctrine of non-justifiability was considered to be under threat from the ECHR, there was no increase in successful applications, which remain rare (O’Sullivan, 1998). There have been exceptions, but these have been related more to the way in which decisions have been made rather than the decision itself. West Lancashire Health Authority denied patients gender reassignment surgery but had what amounted to a blanket policy that this would not be provided and failed to evaluate medical evidence that the patients’ condition was an illness rather than a lifestyle choice. The Court of Appeal⁶⁹ found for the patients.

As drug therapy has become more expensive, so more guidance has been produced by NICE for local funders⁷⁰ about whether particular drugs should be funded. Where drugs have not been found to offer cost effectiveness and therefore have not been funded, provision can be made in individual cases based on ‘exceptionality’. This

⁶⁸ R v Cambridge Health Authority ex parte B [1995] 2 All ER 129 (CA).

⁶⁹ [2000] R v North West Lancashire Health Authority, ex parte A.D.G. 1 WLR 977, CA .

⁷⁰ Prior to 31st March 2013 these local organisations were Primary Care Trusts (PCTs). Following implementation of the Health and Social care Act 2012, their function was taken over by Clinical Commissioning Groups (CCGs).

has proved an elusive concept (Ford, 2012) in practical application, and five cancer patients have been successful in challenging decisions. Ann Marie Rogers successfully challenged a decision by Swindon PCT to deny Herceptin to treat breast cancer. The Trust, after claiming that the cost of the treatment was not considered in the decision, could not find a rational basis on which the decision was taken.⁷¹

In these cases justification has not been attempted on the grounds that the patients were in some way to blame for their illness. One reason why there has been no challenge is that despite occasionally emotive headlines, it is unlikely that any resource decision would be taken on these grounds. In what was claimed at the time to be the first application for judicial review of a decision concerning resource allocation, Mrs Harriott⁷² claimed that she had been refused infertility treatment because previous work as a prostitute resulted in her rejection by social services as a foster mother. Ruling against the applicant, Schiemann J nevertheless made it clear that refusal of treatment on non-medical grounds could be reviewed by the court (Brazier and Cave, 2011), and this clarity makes it unlikely that any resource allocation decision would be defended on non-medical, backward looking ground grounds, that is, on the basis of desert. NICE guidelines state that:

NICE should not produce guidance that results in care being denied to patients with conditions that are, or may have been, dependent on their behaviour. However, if the behaviour is likely to continue and can make a treatment less clinically effective or cost effective, then it may be appropriate to take this into account (NICE, 2008⁷³ p. 25).

The relevant principle is:

⁷¹ [2000] R v Swindon NHS Primary Care Trust. 1 EWCA Civ 392

⁷² [1988] R v Ethical Committee of St Mary's Hospital ex parte Harriott 1 FLR 512

⁷³ This guidance is currently being revised. It predates the Equality Act 2010, and The Act's requirements now govern NICE's approach to applying social value principles when considering legally protected groups, though the Act doesn't have anything to say about treatment being denied for behaviour caused illness. See also Shah *et al.* (2013).

NICE can recommend that use of an intervention is restricted to a particular group of people within the population (for example, people under or over a certain age, or women only), but only in certain circumstances. There must be clear evidence about the increased effectiveness of the intervention in this subgroup or other reasons relating to fairness for society as a whole, or a legal requirement to act in this way (NICE 2008 p. 25 principle 7).⁷⁴

It is unclear how the criterion for fairness would operate, but any decision using this for justification would almost certainly be challenged. NICE guidance and individual funding authorities make clear that where smokers are prioritised lower than non-smokers it is because smoking results in more complications and longer hospitalisation, decreasing the capacity for benefit and increasing cost. That is, difference in treatments look forward for their justification. If treatment is prioritised on clinical need, and need is understood in terms of capacity to benefit, smokers need treatment less.⁷⁵ The decision, though clearly involving rationing, can be cast as one of clinical rather than desert consideration, and if requiring patients to stop smoking prior to surgery is seen as unjustifiably paternalistic, like the imposition of legal regulation it can be regarded as mixed, offering wider benefits. In political debate the distinction appears less distinct. In an influential book, *The Big Society*, Jesse Norman MP states (without evidence) that ‘The NHS increasingly looks at “lifestyle” factors such as obesity and smoking in deciding whether a given treatment is available. These trends can only continue’ (Norman, 2010, p.35). A King’s Fund report about health care rationing (Klein and Maybin, 2012) barely mentions the possibility of rationing by desert, and Medical Codes of Practice also outlaw denial of treatment based on lifestyle choices. I return to this issue in a little more detail in Chapter 8.

⁷⁴ An interesting comparison can be made here with the UNESCO Universal Declaration on Bioethics and Human Rights, which states, at article 3.2 that ‘The interests and welfare of the individual should have priority over the sole interest of science or society.’

⁷⁵ See Syrett (2007) for a discussion on the definition of need so far as it concerns health care rationing.

Conclusion

Using criminal and civil law to identify and enforce individual responsibilities in regard of health threatening behaviour is a blunt and unwieldy liberty threatening instrument. That the current position appears internally inconsistent is largely the result of political considerations, where reasoning is not required to the same extent as might be expected if a coherent set of principles establishing exactly how essentially utilitarian calculations are applied. However, it is the case that worldwide legal regulation of tobacco and other harmful substances and behaviours has extended in recent years, and that this is likely to continue, to the overall benefit of public health, and at the expense of individual liberties. A predominantly publicly provided health system may flounder in an uncertain fiscal environment unless public expectations are trimmed, and as difficult rationing decisions become more common, it is to be expected that legal challenges and scrutiny will become more frequent, and hoped that this will clarify the lawful consequences for individuals contributing, by their actions, to their poor health. If the supremacy of personal autonomy appears to be under increasing challenge (Gauthier, 2000; Walker, 2008), there is also a line that cannot be crossed in liberal societies. And though it might be argued that the line is receding somewhat, the challenge for those who advocate using the law to improve the nation's health is to advance legal regulation as close to the line as possible. In the next chapter I move from consideration of the legal background to provide theoretical and procedural underpinning for the moral analyses that will be developed in more detail in Part II of this thesis.

CHAPTER 4

Philosophical Approaches

The purpose of this chapter is to set out and defend philosophical approaches to the thesis linking the papers into a single coherent account and filling the theoretical lacunae left by the publication process. The papers in the thesis can be considered to consist of a combination of analytical and normative philosophy, and the chapter considers these approaches in turn. Necessary methodological detail for the analytical papers is contained within them, and so discussion here is restricted to the difficulties of using documentary sources to illustrate points throughout the thesis. The bulk of the chapter will consider the normative approaches used. I first consider the role of philosophical bioethics in public debates, and in rejecting the role of philosopher as moral expert I nevertheless defend the essentially rationalist approach taken. In discussing the application of moral theories generally and specifically within bioethics, I argue that application of moral theory is problematic and that in practice, application of this or that single moral theory may be illuminating and interesting but is seldom satisfactory as an action guide. Various accounts of moves to de-emphasise, modify or amalgamate orthodox moral theories are briefly introduced, and I argue that a theoretical approach remains of interest and value, especially so where the prospect of consensus is lacking.

Deductive and inductive approaches are then introduced. In choosing a broad form of two level utilitarianism as the principal normative basis of the papers it is acknowledged that final justification for the choice is inevitably question begging, but I offer normative and empirical reasons for suggesting that it is a plausible moral theory capable of being used widely. I then proceed to explain my use of case studies and analogies in the papers and their use within inductive argument.

Analytical approach

Where they are significant, analytical approaches and critiques of established methods are detailed within the papers, notably the first, which critiques the method of concept analysis. Many of the analytical points made in the thesis refer to various forms of documents and other public output, including policy documents, professional codes of conduct, health promotion material, television advertisements, social media sites and news coverage. As presented here the materials are not the focus of analysis; the papers do not intend to offer an analysis, for example, of how television advertisements present the moral status of blood donation. This approach would call for a more detailed examination of how advertisements came to be made and presented, including perhaps details of when and how often they were screened, and an evaluation of their effectiveness both in representing the chosen moral position and in recruiting blood donors. Similar points can be made about analysis of policy documents. The papers use the materials more loosely to illustrate points made and they cannot be said to be following any particular method of documentary or discourse analysis (Abbott *et al.*, 2004).

The use of these materials calls for some caution, but room and focus within the published papers rarely allows this to be detailed. It is easy to assume that documents and other materials mean *exactly* what they say when subjecting them to detailed analysis more appropriate to academic papers where the use of language can be taken to be measured and precise. This would perhaps be a level of scrutiny too far; a scrutiny that the documents were not written to be able to withstand. However, the documents were written to be read by *someone*, their intended audience if not academics, and they must mean *something*, but it would involve a large amount of second guessing and supposition or perhaps interrogation of the usually anonymous authors to get to the precise meaning. In some cases I maintain that meaning, in the form of action guidance, is very difficult to discern from documents, and this is discussed in more detail in relation to health promotion in Chapter 6. In other cases, loose language has the potential to confuse intended readers and this is seen even in quasi-legal standard documents from health care profession regulators. For example, the Standards for Medicines Management published by the Nursing and Midwifery Council (NMC) states that ‘Students must never administer or supply medicinal products without *direct* supervision’, and then proceeds (on the same page) to state that ‘As students progress through their training, their supervision may become increasingly *indirect* [...]’ (NMC, 2007, p.33; Fullbrook-Scanlon, 2010. Emphasis added). Similar NMC documents relating to educational standards state that nursing practice both ‘must’ and ‘should’ be based on evidence. (NMC, 2010; Snelling, 2013c). These two examples are regulatory, action requiring rather than action guiding, but are self-contradictory and ambiguous and it is difficult to believe that the authors intended them to be understood in that light.

My interpretation of documentary and other sources used in analyses presented make no general assumptions about their literal meaning or their intention or effect and it is acknowledged that their nature is such that they can present a partial and superficial representation of the 'reality they purport to describe' (Abbott *et al.*, 2004, p.260). All that can be said about their use in the papers, without detailed methodological justification which would be required were they the focus of the analyses, is that I consider that the inferences are well drawn and explained and thus open to, and inviting of, critique.

Normative approach: bioethics and public discussion

This thesis considers personal responsibility for health; its meaning, extent and consequences. Each of these areas inhabits a slightly different moral environment, though common to all is morality in the general sense, defined by Gert (2005, p.14) as:

an informal public system applying to all rational persons, governing behaviour that affects others, and includes what are commonly known as the moral rules ideals and virtues and has the lessening of evil or harm as its goal.

I take it that morality resides in the effects that actions have on other people. Part of the challenge of enquiry in this area is a tendency within bioethics to regard health related decisions as being solely within the domain of the individual, with personal choice of health related behaviours being maximally considered in the light of consequences for the individual, and for others only minimally or not at all. In Anglo-American bioethics, respect for autonomy is frequently presented as the overriding bioethical principle¹ (Gillon, 2003), and it is easy to regard personal

¹ Though not by Beauchamp and Childress.

choices in respect of our own and others' health simply as following the principle. On this account personal choices might even be considered outside morality altogether with views to the contrary being disparaged as paternalistic or, even worse, moralistic (Driver, 2005).

In this general sense morality does not only provide a guide for an agent's own behaviour but rather a guide that rational persons suggest that others also should follow: 'We want people to believe us *and* we want them to change their behaviour as a result' (Brassington, 2007a, p.1 emphasis in original). Implied by a general (philosophical) argument that something is morally obligatory is the normative expectation that I ought to do it, and what's more that others in similar situations ought to do it as well. There should be a direct link, that is, between an analysis of the moral status of something and real life engagement with moral agents, and there are at least two possible ways to do this.

Public discussion (1): moral expertise

The first is for the moral philosopher or other authority to arrive at a considered position and then to manipulate or otherwise persuade others to follow it. David Hume identified two versions of philosophy, the easy and the abstruse, and the easy version appears to present the philosopher as moral expert (Archard, 2011,² Priaulx, 2013), seeking to 'bend our hearts to the love of probity and true honour (Hume, 2007 [1748], p.5). The more abstruse philosopher seeks a more detailed and objective analysis 'though their speculations seem abstract, and even unintelligible to common readers' (p.4). Contemporary adherents of Hume's 'easy' philosophy are

² Archard (2011) says that Peter Singer is a notable exception to the view that philosophers are not moral experts.

likely to look to insights from psychology to ‘allur[e] us into the paths of virtue...direct[ing] our steps in these paths.’ (p.5). Notable in this regard is the book *Nudge* by Thaler and Sunstein (2008) which has been enthusiastically adopted by the UK Government in public health and other policies.³

There is a number of arguments against the moral expertise approach; two are particularly relevant to the philosophical approach of this thesis. The first is that moral philosophers⁴ are no better than the rest of us in formulating and then following moral judgements and rules. Dickenson (2000) identified value differences between bioethicists and professional health care practitioners, and Schwitzgebel and Rust (2009, 2014) have demonstrated that the moral behaviour of university teachers of ethics is broadly no better than their non-philosophical peers. In Chapters 6 and 7, I argue that there are obligations to our own and others’ health but they are not presented by my claiming expertise and then seeking to persuade, cajole, manipulate or coerce the public to follow my injunctions on the ground that I possess moral expertise. My normative conclusions largely stand in opposition to established views which emphasise prescribable and proscribable health-affecting acts rather than processes, which I will discuss in chapter 6.

A second argument opposes this sort of approach as being paternalist, such as the libertarian paternalism of Sunstein and Thaler’s (2003) paper from which the book *Nudge* was developed. Paternalism applied to individual patients within professional health care is not generally supported in the UK, though the approach within collective public health is more prevalent and apparently more acceptable. I cannot

³ There is a behavioural insight team inside the Cabinet Office (2010, 2011). See Yeung (2012) and Quigley (2013) for further discussion.

⁴ The same point applies to other groups tempted to tell us what to do.

discuss this in detail here, but what I mean is that public health measures such as water fluoridation are advocated and lawfully implemented whereas a similar lack of consent for ingestion of a therapeutic substance by an individual patient would not be allowed outside specific mental health treatment legislation.⁵ Mitchell (2005) suggests that libertarian paternalism, which uses the framing of messages so that they are more likely to be accepted, relies on the ‘cognitive limitation’ (p.1245) of the libertarian, and that therefore, ‘it is often wise to make intuitively appealing arguments rather than drab, analytical arguments when trying to persuade others’ (p.1277). The challenge for anyone trying to discuss bioethics with the public, but not resorting to paternalism, is to avoid making the analytical arguments drab. That is what I have tried to do.

Public discussion (2): arguments

Paternalistic imposition or manipulation of values or conclusions is difficult in a number of ways, but this leaves largely unresolved the problem of how to engage in discussion with the public about both policies and individual choices which require philosophical thinking. Real variations in opinion and behaviour can result from differences between or within moral theories which can best be considered esoteric and probably irrelevant by many people thinking about their own and others’ moral behaviour. But if Brassington’s observation about the purpose of moral debate is correct, then engaging forms of public discussion are needed. This can be achieved in a number of ways, through independent bodies such as the Nuffield Council on Bioethics⁶ as well as by regulators, like the Human Fertilisation and Embryology

⁵ See Cross and Carton (2003) for a critical review of water fluoridation.

⁶ The Council’s terms of references require that it ‘...make arrangements for examining and reporting on such questions with a view to promoting public understanding and discussion.’ (Nuffield Council on Bioethics, 2013).

Authority (Moore, 2010) who also aim to increase public understanding.⁷ An important distinction between these bodies and ‘official’ health promoting public discussion and persuasion is that these bodies are not necessarily arguing *for* anything, but aiming to educate and to inform. This is not to say that public discussion about ethical issues in general as well as bioethics generally cannot or should not argue for something, but that if a particular normative stance is taken, based on theoretical lines of reasoning, then the arguments should be couched in such a way as to make them accessible. This is especially the case where the aim of the normative stance is to convince people to alter their behaviour, based on an understanding of the arguments rather than simply their outcomes. It is the difference between persuading people to stop smoking by emotional means using graphic imagery (Hume’s easy philosopher) and helping them see the arguments why first of all smoking is a moral matter and then by helping them work out for themselves whether it is something that, all things considered, they ought not to do (Hume’s abstruse philosopher). If this is the case, Brassington’s suggestion is more usefully directed at the process of moral thinking rather than its outcome, and I shall explore this in more detail in Chapter 6.

A further way that the normative arguments attempt to relate to everyday life is in occasional references to common morality, a highly nuanced construction with both normative and empirical elements. For a concept rooted in the belief that there are universal values, there seems to be considerable disagreement about their scope. Beauchamp and Childress (2013) whose principles of biomedical ethics is probably

⁷ The HFEA (2013) strives to ‘inform patient choice, securely hold personal data, and maximise public understanding (of available and developing treatments, embryology research, and the HFEA and its role)’.

the most influential bioethical book of the last generation⁸ defend duties grounded from common morality, whereas the author of a popular and extensive theory, Bernhard Gert (2008) denies any positive duties from common morality, regarding its role as the lesser and negative avoidance of rule violation.⁹ Terms relating in various ways to pretheoretical morality include common morality (Beauchamp and Childress, 2013; Gert, 2004), common-sense¹⁰ morality (Slote, 1974; Hooker, 2000a; Portmore, 1998, 2011), and ordinary morality (Kagan, 1989; Rajczi, 2009). Common morality can refer to universal values (Bok, 2002), and also intuitively held processes of deliberation (Sidgwick, 1907, and see Greene, 2013 on the empirical evidence on how we think morally). The papers in the thesis refer to common morality as part of an attempt to narrow the theory-practice gap in practical ethics, usually in an attempt to ameliorate the strict injunctions of moral theory, and in doing so I intend to simplify things rather than follow any particular account.

Rationality as the basis of the philosophical approach

This thesis addresses normative questions concerning responsibility for health, that is, what are our obligations in respect of our own and others' health? The answers to these normative questions can be arrived in a number of ways. In addressing the genetic challenge, Matti Häyry (2010) identifies three approaches to bioethics. The first, exemplified by John Harris and Jonathon Glover, emphasises transparent and clearly rational arguments. The second approach, typified by Leon Kass and Michael Sandel, proceeds from a position opposed to analytical philosophy, and regards

⁸ Now in its seventh edition, it first appeared in 1977. The principles are also afforded a degree of official recognition in 'Social Value Judgements: principles for the development of NICE guidance' (NICE, 2008). 'These so-called 'four principles' have been adopted by NICE because they provide a simple, accessible, and culturally neutral approach that encompasses most of the moral issues that arise in healthcare' (NICE, 2008, p.8).

⁹ See Arras (2009) for a discussion.

¹⁰ With and without the hyphen.

moral problems to require holistic examination including appeals to emotional responses. The third approach, as proposed by Jürgen Habermas and Ronald Green sits between the outlying two. Häyry's principal justification for the view that none of these approaches alone is sufficient is that there is considerable support for all of them, and so a single position, however convincingly argued and presented, simply will not be accepted by everyone. He proposes a nonconfrontational notion of rationality:

A decision is rational insofar as it is based on beliefs that form a coherent whole and are consistent with how things are in the world; and is aimed at optimising the immediate or long-term entities that matter (Häyry, 2010, p.43).

On the face of it, this nonconfrontational approach is uncontroversial, but there is a danger that it can be taken to imply a dichotomy between rational and non-rational. Häyry doesn't intend this, and in elaborating on the elements of his proposal he talks of rationality being neither black nor white but in shades of grey. The irrational end of the spectrum can be found where decisions are based on beliefs that have '*no regard to how things are in the world around us*' (2010, p.45. Italics in original), and this, Häyry claims, is very rarely the case in bioethical disputes. This can be taken to mean that outside these rare cases, disputes or opinions are rational to some extent, and so a rational analysis is nearly always of direct interest. Häyry's clarification referred to bioethical disputes, and it is probably true when applied to disputes within the academic discipline of bioethics, that is between bioethicists. It is difficult to argue with Häyry when he says that 'very few philosophical ethicists would like to be labelled as "irrational" [...]' (2010, p.43).

It might not be quite so simple where the discussion (let us say this instead of dispute) is between ethicists and members of the public. As I discussed in Chapter 2, empirical evidence suggests¹¹ that it is over-simplistic to suggest that individuals behave on the sole basis of rationality, independent of all other factors that influence behaviour, but nor does it mean that all decisions are made irrationally. I do not propose to attempt an answer to the question of whether all individuals can make rational behaviour choices. Some people are capable of and willing to make decisions based on rationality and some are not. Others, I suspect, are capable but unwilling, still others willing but incapable. It is known that ethical decisions are arrived at (sometimes) through non rational and emotional processes (Rogerson *et al.*, 2011; Haidt, 2012), an observation that contributed to Gilligan's (1982) critique of Kohlberg's research on moral development and the development of feminist care ethics (Kuhse, 1997).¹²

Despite the shortcomings of rationality as the basis for moral thinking, and especially its apparent lack of universal appeal, I will largely be taking a rational approach to the normative questions presented, and not only arguing that there are obligations in respect of our own and others' health, but that these can be decided using a largely rational decision making process. In light of the shortcomings it might be suggested that this is a doomed enterprise, but there are good reasons for not only wanting to persist with it, but also for arguing that it has value. Some, if not all, people will engage rationally, and more importantly, it does not follow from observations that many people do not appear to make fully rational decisions about their health-affecting behaviour that all rationality is absent from consideration, or

¹¹ See Greene (2013) for a recent and accessible overview.

¹² See You *et al.* (2011) for a meta-analysis of the difference in moral sensitivity between men and women. They found wide variation and an average effect size of 0.25.

that it ought to be. There is no objective external measure of an irrational decision, and the requirement to allow people to make what others may regard as unwise (and possibly irrational¹³) decisions is legally protected, for example in the Mental Capacity Act 2005, where the test is on the process and ability of decision making rather than its outcome. A further argument in favour of the value of rationality is that it is part of the utilitarian process: an acceptance that morality ought to be directed at increasing welfare requires some sort of calculation and this requires both evidence and rationality, but it is important that these are grounded so far as is possible in people's real lives and experiences¹⁴ if the processes that I will be arguing for have a genuine chance of influencing behaviour. This experience will involve emotional attachments and elements of behaviour that others may regard as irrational. However, as is also suggested in the realm of clinical decision making, emotions fulfil a role not necessarily antithetical to objective reasoning (Marcum, 2013). Hayry's understanding of rationality sets a low bar and is capable of also including emotions that inevitably characterise the interpersonal relationships that will form the backdrop of my normative analysis. My analysis is rational to the extent that even accepting an emotional element, most individuals remain capable of acting on the basis of reasons, and are held to account, at least in law, on this basis.

Juthe (2005) suggests four different types of arguments; deductive, inductive, abductive and analogy. In biomedical ethics the first two arguments have been discussed, influentially, by Beauchamp and Childress, as top-down (deductive) and bottom-up (inductive). The thesis uses both, as well as a case study and analogy.

¹³ Stauch (1995) makes the distinction between non rational and irrational.

¹⁴ See Russell Hardin's (1988) *Morality within the Limits of Reason*.

Deductive arguments: moral theory

A problem for any deductive approach to ethics is determining the starting point, what the theory is and what it requires, exactly. Not only are original texts of standard moral theories interpreted and reinterpreted, they were written in distant times. Sterba's (2005) book *The Triumph of Practice over Theory in Ethics* begins with modern critiques of Aristotle's slaves, Kant's racism, and Mill's colonialism, and the theories themselves have forked repeatedly through the centuries resembling not so much single accounts, as upturned trees whose distal branches, though connected to a unifying methodological trunk, now grow in quite different directions. For utilitarianism, acts or rules can be used as the level of calculation and differences in what, exactly, should be maximised and how may result in contradictory action-guiding calculations all of which could claim to be 'utilitarian.'

The tenets of utilitarianism and Kantianism appear in fundamental opposition yet there are authoritative accounts which claim theoretical foundations for health care ethics from each. Häyry (2007, p.60) claims that 'some elements of utilitarianism are taken for granted in today's health policies and medical ethics', especially perhaps in regard to justice: 'In one sense all approaches to justice in health-care provision are utilitarian' (Häyry, 2002, p.53). Heubel and Biller-Andorno (2005, p.5) claim that 'in modern medical ethics the influence of Kantian moral theory is obvious.' Contemporary nursing ethics has a strong Aristotelian and care ethics pedigree (Armstrong, 2007; Sellman, 2011), and professional codes of ethics¹⁵ are themselves based on both rule utilitarian and Kantian frameworks (L'Etang, 1992; Starr,

¹⁵ The extent to which codes of ethics reflect morality is questionable, and nursing codes of practice have been accused of being unethical (See Pattison, 2001; Pattison and Wainwright, 2010).

1983)¹⁶. Hämäläinen (2009) suggests that moral theories enrich each other and there are also in the literature many attempts at reconciling or combining traditional moral theories. Sterba (2005), for example combines Kantian and Aristotelian approaches in opposition to utilitarianism. From nursing ethics, Paley (2002) offers an interpretation of Kant compatible with the ethics of care, Hare (1997) and Ridge (2009) offer partial reconciliation between Kantianism and consequentialism, and Alexander (2008) argues that nearly all deontologists' views collapse into consequentialism at and beyond a certain threshold.¹⁷ Finally, Driver (2001) offers an account combining virtue ethics with consequentialism. In short, every standard moral theory is apparently capable of being combined with each of the others.

For Sterba (2005, p. 28), 'morality as compromise' is situated at some point on the spectrum between egoism and altruism, borrowing from both, with the weighting depending on the quality and strength of the reasons for acting in your own or in others' interests. In formulating this approach, and particularly in its response to egoism, Sterba accepts that it leans more heavily towards a Kantian understanding of obligation, though goes on to recast the principal argument into an Aristotelian framework. Ultimately his position, stated right at the beginning of his book, is that:

[t]he traditional theories of ethics, be they Aristotelian, Kantian, Millian, or whatever, have come to be revised and reformed in such a way that at least in their most morally defensible formulations they no longer differ in the practical requirements they endorse (Sterba, 2005, p.1).

Though the meaning seems straightforward, an immediate question is raised by what is meant by 'most morally defensible formulations' of moral theories. A compromise

¹⁶ These cited examples are from Business ethics, but the arguments can be transferred to health care ethics.

¹⁷ 'A threshold deontologist is one who believes that certain acts cannot be justified by their consequences unless those consequences reach or surpass some threshold point of compellingness'. Almost all deontologists admit to being threshold deontologists (Alexander, 2008, p.85).

position which does not recognise the supremacy of moral theory is extended to bioethics by Durante (2009) who suggests that those arguing from one particular theory pay insufficient attention to cultural differences and the moral diversity that characterises modern society. These differences seem especially difficult when the moral position taken is from religious conviction, whose adherents often regard fundamental principles as absolute truths rather than reasoned preferences.¹⁸ If these principles preclude meaningful discussion on matters where different viewpoints fundamentally conflict, in for example, the moral status of the human embryo, they also provide areas where consensus and/or compromise is possible, in for example the methodology of clinical pragmatism (Fins *et al.*, 1997).

Many ethical problems in health care have solutions that are the same whichever theory (if any) is used, even if the underlying principles or methodologies conflict, and this is a clear feature and claimed advantage of a popular method of ethical analysis in healthcare. Principlism, most clearly associated with the work of Beauchamp and Childress, argues that its titular principles can be derived from all of the major moral theories. In moving from the specific to the general, ultimate justification might be required from a moral theory, but most questions can be settled by reference to lower order principles and rules, founded in common morality and rendering overly theoretical approaches superfluous. Supporters and critics of principlism have engaged in vociferous exchanges for a generation, and as far as the de-emphasis of moral theory is concerned, a significant critique (Clouser and Gert, 1990) is that following and respecting the principle of respect for autonomy may

¹⁸ For an interesting discussion on the role of religion in bioethics see Stempsey (2011). He argues that despite its roots in theology, bioethics as a discipline has marginalised religious considerations, and offers some areas, including solidarity and dignity where a renewed religious viewpoint may enrich bioethical debate.

lead to defensible action, but agents following the principle will not know *why* respecting autonomy is generally a good thing, and this means that exceptions to the principle, or giving priority to other principles in certain circumstances may present problems in justification.

I have briefly sketched some methods employed in response to the inadequacy of utilising a single moral theory; that in practice moral theories often require the same things, and that there is room for compromise and reconciliation between competing theories. Additionally the observation that often more than one position is ethically justified, and that there must be room in an account of morality for ‘the possibility of progress’ (Scanlon, 1992, p.6) and changing our mind argue against the adoption of a single moral theory. However, there at least two reasons for wanting to persist with some sort of theoretical account. First, notwithstanding that agreement is often possible, it is not always possible, and the greater the possible divergence between theoretical positions in specific application, the greater the need for a theoretical justification. This can make reconciliation problematic, leading to the second point; that some sort of theoretical justification is required if we are to avoid falling into the capricious territory of intuitionism¹⁹ and moral relativism.

Philosophical approach: broad dual level utilitarianism

The thesis will take a broad form of dual level utilitarianism as its principal theoretical basis. In support of this I offer empirical and normative justification, though these are tentative and imprecise, and it is acknowledged that the influences of moral decision making are many and varied. The thesis does not consider the

¹⁹ Despite its central place in the method of reflective equilibrium, empirical research in psychology and the neurosciences led Singer (2005) to question the influential role that intuition has in ethical decision making.

place of religion, gender, occupation, religiosity or any other factor in influencing how individuals make ethical decisions even though, for many, these considerations are decisive. Much of the empirical research on moral reasoning is undertaken in specific fields, for example in business ethics²⁰ and health care ethics (for example Goethels *et al.*, 2013, Deshpande, 2009) which are not immediately transferable to a wider population, for a number of reasons including the nature and frequency of ethical decisions in professional practice, the presence of ethics in professional curricula, professional accountability, the use of influential codes of conduct and the development of models of ethical decision making (Park, 2012).

Empirical justification

Utilitarianism can be seen throughout bioethics. The move towards an evidence base for health care requires an assessment of the consequences of interventions, and if there could also be a Kantian response to this at the level of individual patients, the utilitarian foundation is more secure at the institutional level of socialised health care, for example in statements of purpose of the NHS, and in resource allocation. The NHS constitution in England (DH, 2013b, p.4) states as one of its principles that ‘The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources.’ Funding allocation by use of Quality Adjusted Life Years (QALYs) is an attempt to get the most benefit for each health care pound spent, and in many features this is close to institutionalised utilitarianism – even though serious concerns are raised in relation to its fairness in regard to particular illnesses.²¹

²⁰ For detailed reviews of the literature from 1996-2003 see O’Fallon and Butterfield (2005), and from 2004-2011, see Craft (2012).

²¹ See, for example, Garau *et al.* (2011) in relation to the difficulties in using QALYs in cancer.

Perhaps the most famous thought experiment in ethics is the trolley problem, first posed by Philippa Foot in 1967.²² In the first version, a runaway trolley is hurtling uncontrolled down a track towards five people who cannot escape and who will inevitably be killed if the trolley continues unchecked. However, the trolley will pass a side track before hitting the five men, but there is a single person on this track who will be killed if the trolley is diverted. An onlooker stands by a switch. If he does nothing, five will die; if he diverts the trolley along the side track, one will die. What should he do? In a second version there is no switch and no possibility of diversion but there is a fat²³ man standing by the track. His weight is such that if he was on the track the trolley would be stopped, saving the five but at the expense of his own life. An onlooker stands behind him as the trolley approaches. Should he push the fat man onto the track? Academically undertaken tests and large scale media experiments consistently show that about 80% are in favour of diverting the train, but only a quarter would push the fat man onto the track (Edmunds, 2014). Further nuanced versions of the original have been developed, some of which suggest caution in their use (Rai and Hoyloak, 2010), and the consistent findings suggest that subjects use utilitarian reasoning but only up to a point.²⁴

Lanteri *et al.* (2008) suggest that individuals rationalise intuitive decisions retrospectively, and in their study on the trolley problem more people indicated that flicking the switch and pushing the fat man were permissible rather than obligatory, a position difficult to reconcile with most forms of utilitarianism. Experiments concern individual cases of moral judgement, but not morality in any general sense

²² For an excellent and accessible discussion see Edmunds (2014).

²³ More recent versions use the more inclusive device of an onlooker wearing a backpack (Greene, 2013).

²⁴ It is worthy of note that the trolley problem was introduced in a paper about the doctrine of double effect, but it has become frequently useful for teasing out reasoning involved in ethical decisions.

(Abend, 2013), and are as likely to identify incoherence of our intuitions as any clear pattern of moral decision making (Nelkin, 2007). It is important to keep in mind Hume's famous observation that you cannot derive an ought from an is, but nevertheless the empirical findings about how individuals make decisions are useful in the sense that they provide evidence that normative positions based on utilitarian calculations are unlikely to be rejected as hopelessly implausible.

Normative justification

Normatively, choosing a utilitarian approach over its rivals inevitably begs the question. Arguments that conclude that it is superior to its rivals assume the features that define it. Gert (2005) argues that right at the very beginning of *Utilitarianism*, Mill conflates the greatest good (*summum bonum*) with morality. There can be no justification for this, the principle standing at the pinnacle of a system where specific moral rules and principles are justified with reference to more general ones. At this level an argument in support of the *summum bonum* becomes merely an assertion, a first order principle which is both exceptionless (Schneewind, 2009), and incapable of further justification apart from what can be rather bemused statements such as from Takala (2003, p. 448): 'I cannot understand why these simple general ideas do not appeal to everybody'. As Murphy (1994, p.205) states in relation to ultimate principles, 'you pay your money and you take your choice.'

A preference for utilitarianism must accept that there are critiques of the theory in general and more specifically in its bioethical application. General problems include that in practice calculations are too difficult (Streumer, 2003), that they require too much of agents (Mulgan, 2001), do not account for supererogatory acts within a self-

other asymmetry (Slote, 1975) and often offer counterintuitive solutions based on valuing collective rather than individual rights. It is this latter point that lead Takala (2003) to observe that utilitarianism has a bad reputation in bioethics, but this is based on what might be considered thoroughgoing accounts, outside Sterba's view of what might count as a 'morally defensible formulation.' It may be that at root of what many find objectionable about the bioutilitarianism that Takala criticises are ontological assumptions, about personhood for example, rather than the first order principle that welfare, however construed, be maximised. Alternatively, it might be the consequentialist²⁵ view that consequences are the *only* morally relevant consideration which not only makes it unpalatable to many, but also impracticable when superimposed on the law and rules such as codes of conduct which must be followed by professionals. An understanding that consequences can count, *inter alia*, under the general rubric of 'broad utilitarianism' can be further criticised on the grounds of imprecision, and of multiple interpretations.

Arguments presented in the normative papers, can be considered to be 'broadly' consequentialist,²⁶ but the level of precision is in need of some explanation. I have suggested that detailed deductive application of a precise version of a moral theory is not a satisfactory method of discussion with the public about the morality of their health-affecting behaviour, even if it is used to arrive at a normative position. However, too broad a version of the moral theory risks not fulfilling its function at all. There is a number of considerations about the nature of the theory that are stated or implied in the papers which require more detail.

²⁵ It is standard to regard utilitarianism as a form of consequentialism, though Foot (1985) regards consequentialism as what is most wrong about utilitarianism and Jacobson (2008) argues that utilitarianism is not consequentialist. I return to this point in chapter 6.

²⁶ John Harris, one of the utilitarians taken to task by Takala (2003), refers to himself as 'broadly consequentialist' (Harris 2004, p. 177).

How and what to calculate

Any version of utilitarianism will need to address at some length what must be maximised and how it is calculated, not least because the difficulties with these calculations constitute influential objections to utilitarianism as a practical everyday morality. In cases like the trolley scenarios the calculations appear simple; five lives against one. Other versions of the trolley dilemma could be advanced so that some self-sacrifice (apart from the unpleasantness of having to decide) is needed, or that the one person whom most people would sacrifice is a daughter or favoured friend, and these would likely conclude with different results.²⁷ Jacobson states that:

The failure of the standard interpretation of Mill to account for his sentimentalism has led to a profound misreading of his moral theory, which makes Mill out to be a predecessor of the most fashionable view in the neighborhood of utilitarianism: namely, multilevel maximizing act-consequentialism (2008, p.160).

I offer this as an example of moral philosophy as an academic puzzle rather than a credible action guide for those who are thoughtful but perhaps not philosophical in outlook or education. Jacobson mentions the ‘most fashionable’ type of utilitarianism, but as any daughter will confirm, fashion is transitory, bordering on the random, and so we can expect this position, assuming that it is justifiable, to change over time. In everyday life we know what it is to say that this or that option goes better, all things considered, though we may struggle to say exactly what has been maximised or how the calculations have been undertaken or what, exactly, has been considered. Objections to the requirements that we ought to seek maximisation, and that this requires detailed calculations and comparisons can both be met by the notion of satisficing utilitarianism, whereby options which produce *enough* utility

²⁷ Kagan (1989) for example notes that ordinary morality forbids violating special obligations to family or professional duties even if better consequences follow, all things considered.

rather than *most* utility are allowed.²⁸ This might allow individuals to say that a calculation has been done whereas what has really been undertaken is to prioritise individual enjoyment over harms to everyone else, but this is a problem for all utilitarian justification, and can be addressed in how individuals are held to account for their decisions. I discuss this in chapter 8. There is some empirical support for the view that we are intuitively biased in our own favour (Greene, 2013) and in any case the calculations are so subjective that external disinterested review simply is not possible, so the most that can be required of any theoretical account is to argue that people ought to make a calculation, that it should be as inclusive and unbiased as possible and that they should be able to defend their choice of maximised or satisfied property.

Act or rule?

Utilitarianism in its classical formulation regards calculations for each act as necessary so that aggregate utility is maximised, whereas recognising difficulties in calculations, rule utilitarians formulated rules which maximise utility if followed. Both forms attract serious objections. Act utilitarianism requires implausibly detailed calculations for every moral act, but perhaps more tellingly, it requires agents to perform acts which intuitively individuals think are wrong, like pushing the fat man in front of the trolley. So even if threshold deontologists (Alexander, 2008) may find it necessary to kill one innocent man to save a city, this would be done with acceptance that it is a wrong act and only because a very high threshold for benefit is reached. Act utilitarianism, in its thoroughgoing form, would not see this as a wrong but justified act, but a correct act *required*, at much lower levels of benefit. Portmore

²⁸ See Jenkins and Nolan (2010), and Bradley (2006) for a critique.

(2011) suggests that a murder must be committed if it produces single utile (the smallest unit of utility) more than alternative course of action. Most people would find this counter-intuitive and using any form of reflective equilibrium would result in the theory being rejected. To counter this it has been suggested (Lopez *et al.*, 2009) that deontological side constraints should restrict the choices available, and in contemporary forms of act utilitarianism, genuinely action guiding in a particular society, professional codes of conduct and the law²⁹ may perform this role. This discussion shows once more the difficulty in applying a single moral theory. In different ways, deontology and utilitarianism are combined, with each theory addressing a fault in the other.

Rule utilitarianism was developed in response to this quandary, and yet it brings its own set of problems. Principally, an agent may find himself obtaining less utility by following the rule than by calculating utility for an act. It does not follow from a claim that we would be hard pushed to calculate utility for all acts that morality allows that we calculate none. So a rule, widely accepted, that more utility is obtained if people do not lie to each other, would not apply where someone clearly bent on murder asks if you know the whereabouts of his intended victim. The rule utilitarian forsakes either his chosen theory or maximising utility; or he could specify the rule ever further, in which case rule utilitarianism eventually collapses into act utilitarianism. This level of analysis causes some problems with health-affecting acts because some behaviour, like tombstoning, damages health as the result of a single act, while others, like smoking, damage health over time. Health promotion is

²⁹ I say may because accepting the punishments that the law hands down may also simply form part of the calculations.

generally a rule based enterprise which occasionally considers individual acts. I discuss this further in chapter 6.

R.M. Hare's dual level account

R.M.Hare proposed a dual level account in his book *Moral Thinking*,³⁰ offering a solution to the debate between act and rule versions of utilitarianism. In everyday morality we can be guided by the first level of moral thinking consisting of intuitive rules, formed by experiences and moral emotions, constituting a form of rule utilitarianism. These *prima facie* rules are selected by the second level of critical thinking which is also required when the intuitive principles conflict. This level of thinking, when required, can operate at the level of acts, and the developed account combines the features of act and rule utilitarianism. The principles themselves 'have to be selected by critical thinking; if not by our own critical thinking, by that of people whom we trust to be able to do it' (Hare, 1981, p.47). I take this assistance by a trusted other to concern the selection and refinement of the *prima facie* rules rather than their application in a calculation of the utility of a particular act as this will likely involve some careful weighting of preferences known only to the actor. There is potentially some confusion as to the extent to which the *prima facie* rules need to be universalisable. If they are universal rules then the formulation will be of the sort that 'people shouldn't smoke', whereas an individual is perhaps more likely to refer to an intuitive and specific rule that he shouldn't smoke, or perhaps, recognizing that this is problematic for utilitarianism, that 'he is permitted to smoke.'

³⁰ The account can be seen in earlier papers. For example Hare (1975).

The account of moral responsibility for health that will be proposed in Chapter 6 emphasises obligations in terms of process rather than outcomes, without prescribing exactly what the process ought to be. My suggestion is that it be broadly utilitarian for the reasons that I have offered, and the discussion about acts and rules is required principally because I will be characterising and critiquing health promotion as health maximising rule utilitarianism. My proposal stands in opposition to this, and for practical purposes it does not really matter at the critical level whether the agent specifies universal rules so that they apply to him, or takes an outright act-utilitarian approach. Hare's critical level equates act utilitarian calculations with that kind of rule utilitarianism 'which allows its rules to be of unlimited specificity and which therefore is not distinguishable from act utilitarianism (1981, p.43). Rather than tortuous reasoning about acts and rules, what is needed is the moral sensitivity to see that health-affecting behaviours as undertaken within a considered version of the good life are instances which often cannot be settled simply by following a rule, and must also include an awareness of how one's actions affects others. This sensitivity forms part of many models of ethical decision making and can itself be developed and refined by critical reflection (Park, 2012). Critical thinking is required at *some* level of specification in order to meet the responsibility of health that I will propose.

A dual level model might be considered complex but it is consistent with the way that our moral decision making is undertaken within professional health care³¹ and more generally, empirical research undertaken long after Hare's work appeared lends some support. Much research uses case studies presenting dilemmas like the trolley problem, and claims to show that initial judgements tend to be deontological while

³¹ For example, decisions about breaking confidentiality require reasoning at the level of each act, and the general public interest in maintaining the presumption of confidentiality, that is the maintenance of the rule. (DH, 2003a, p.34).

later, more considered judgements tend to be utilitarian (Suter and Hertwig, 2011). So for the trolley problem, an initial reluctance to divert is countermanded by later thought which typically requires diversion but not pushing the fat man. A problem with research using these sorts of dilemmas is that the subjects are often presented with a binary choice with the assumption that an initial reluctance to kill an innocent person represents a deontological judgement. However, it is possible that the reasoning resulting in this choice is rule utilitarian rather than deontological, and it cannot be assumed that an initial intuitive choice is in *favour* of (what is interpreted as) deontological rather than a *rejection* of the act utilitarian option (Conway and Gawronski, 2013). Other studies have presented the initial response as ‘intuitive’ rather than deontological (Feinberg *et al.*, 2012), consistent with Hare’s normative theory. The picture is of course much more complex than this and so it is not claimed that the evidence demonstrates that Hare’s theory is utilised in practice as he presented it, but it adds to the evidence presented earlier suggesting not only the plausibility of utilitarian thinking generally, but also the dual level version of it.

I am aware that the discussion on the details of the theory that I propose to utilise plays somewhat fast and loose with the requirement for coherence in a theoretical account, and that it might be suspected that I am moulding the account so that it fits my lower level analyses. I offer three defences to this suggested critique. First, that adapting the account so that it fits lower level analyses is what the process of reflective equilibrium requires of us where there is conflict. Second, the account could be developed and nuanced further, but that would turn it into a thesis about theoretical underpinning of health-affecting behaviour, and so the challenge is to provide sufficient detail so that the lower level analyses can have some external

justification without overloading the reader or the moral agent with extraneous detail. Third, and most important, a fully developed theory that agents ought to make this calculation and do it in the way that I stipulate would simply make detailed prescriptions about process amounting to the same patronising claim for moral expertise which was rejected insofar as it applied to outcomes. My chosen deductive approach then can be described as broadly utilitarian, but the real normative thrust is to argue that obligations for our own and others' health do exist and therefore need to be identified. My justification for explaining what they are and how they should be calculated is a plausible place to start a discussion – but it is for individuals and those affected by their behaviour to agree the extent of the obligations and what the response should be should they fail to be delivered.

Inductive arguments: case studies and analogies

The normative sections of the thesis use examples as a narrative rather than argumentative focus. Responsibilities for others' health are exemplified by blood donation, and arguments for responsibility for our own health use the example of tombstoning, and in particular a specific tombstoning accident. Case studies are a popular method of argumentation in bioethics but care must be taken to be clear about their exact purpose. They can for example be used as a sort of abbreviated inductive argument, of the sort 'A did x which is commonly judged as a good action; therefore a general maxim prescribing x is a good maxim' (Spranzi 2012, p.483). It would be safe to suggest that this is the sort of reasoning encouraged by the makers of television advertisements promoting blood and organ donation such as those discussed in chapter 7 which use appealing stories, fictional and factual, as

normative narratives.³² Similar reasoning can be seen in the news and promotional videos used to discourage jumping from seaside piers. Even though the normative papers in the thesis use the examples in the titles, the reasoning does not proceed overtly from them to the supposed general maxim. Deductive arguments are offered with the examples as the conclusion. The papers are presented in this form because examples are more likely to be engaging for the reader than an abstract philosophical argument. The most that can be said, inductively speaking, for the examples is that they are also capable of forming part of the process of reflective equilibrium whereby theoretical applications are applied and tested against their practical conclusions. If these conclusions are at odds with our considered intuitions then the theory can be amended to accommodate them. Only in this way can the case studies be considered the start of an inductive process, albeit an iterative and explanatory one that has concluded before academic papers have been drafted.

I have argued that I have used the stories as examples of applications of deductive reasoning from an identified and partially developed moral theory but examples like this are clearly capable of being used as steps in more formal inferential reasoning. The problem of detail at which I hinted in the discussion about moral theory also applies here. I noted in the introductory chapter that theoretical justification is seldom detailed in academic papers in the bioethical literature, and this is arguably truer for inductive processes than for deductive ones, and it is especially pertinent in discussion with a population who live their lives perfectly well without being encumbered with concern about whether the stories played out on their television sets are examples, parables, metaphors or analogies, and the precise way in which

³² See Charon and Montello (2002) on the role of narrative in medical ethics.

the conclusions that they are being invited to agree with and act upon (I ought to register as a blood donor; I ought not jump off a pier into shallow water) form part of a sequence of logical reasoning. Too much detail about analogies and case studies presented would probably be a disincentive to engage with them, acting against the emotional impact which is a strong reason for their use (Spranzi, 2012). However, as Trudy Govier (1989) points out these sorts of arguments are also capable of being dismissed as being merely rhetorical,³³ and this might be expected if the analogy or metaphor is too outlandish and/or where the domains of reality between the similar examples are distant (Kienpointer, 2012). If ‘reasoning from analogy is an extremely controversial and complex form of reasoning’ (Macagno and Walton, 2009, p.179), it must also be simple and emotionally engaging.

The main analogy in the normative papers is between tombstoning and other health-affecting behaviours. Even though the thesis as a whole relies on deductive reasoning, the point and value of this individual paper would be much diminished if the analogy is obviously false. Following a move from the case study to tombstoning in general, the argument can be presented in these terms:

1. Tombstoning can be enjoyable but can also cause harm to the tombstoner and others, directly and indirectly.
2. The potential harm is insufficient to render it always morally forbidden because the risk of harm is balanced by it being an enjoyable experience.

³³ I offer as an example the use of the example of a patient drinking water from a flower vase which was discussed in Robert Francis QC’s recent enquiries into failings at a NHS hospital. Francis found no evidence that the episode occurred. The case is still being used, shorn of its relevant detail in political debate. For example in prime Minister’s Questions on 6th November 2013 the Prime Minister shouted that ‘I am not going to take lectures from a Government who saw patients drinking out of flower vases.’ Hansard (2013, at column 243) reports the final word as being [interrupted] (Hansard (2013) but it is clearly audible on the BBC video clip (BBC, 2013). <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131106/debtext/131106-0001.htm> (last accessed 26th November 2013)

3. The moral status of each act of tombstoning requires an analysis of risks and harms.
4. Individuals ought to consider tombstoning in light of its enjoyment and the effects on themselves and those around them.
5. Smoking [for example] is like tombstoning in important respects.
6. Therefore individuals ought to consider smoking in light of its enjoyment and the effects on themselves and those around them.

The argument is presented as applying to smoking but it can also be applied to other instances of health-affecting behaviour, so that it can be inferred that:

Individuals ought to consider their health-affecting behaviour in light of its enjoyment and the effects on themselves and those around them.

This is a similar conclusion to one arrived at following a deductive utilitarian process using the moral theories and processes discussed earlier, and the equivalence is the basis of a claim that reflective equilibrium has been secured. The inductive argument is only sound to the extent that the normative duties of reflection required by the conclusion of 'consideration' of tombstoning can be reasonably inferred from the examples as presented, and can only be transferred more widely to the extent that other health-affecting behaviours are similar. Similarities and differences between smoking and tombstoning can be represented on the table on the following page.

Feature	Tombstoning	Smoking
Enjoyment	Yes	Yes, but also simply habitual.
Preparation	Can require travel to pier	Not much – going to the shop
Stratification	Yes	Perhaps. Evidence unclear.
Harm to self	Single episode	Almost exclusively cumulative
Harm to others	Mainly indirect (but can be direct)	Mainly indirect (but also direct)
Addictive	Possibly to some extent.	Yes

Table 1 – Similarities between tombstoning and smoking.

The list is illustrative rather than exhaustive. The features ‘enjoyment’ and ‘requires preparation’, refer to the way in which the act of smoking a cigarette or tombstoning can properly be subject to considered calculation. Smoking a cigarette can be performed as an unreflective act requiring no preparation whereas tombstoning requires at least a decision, reflective or otherwise, to jump, and often (but not always) needs preliminary decisions to go to the pier or cliff. Stratification refers to the possibility of minimising harm; tombstoners can minimise their risk of harm by being properly equipped and prepared (following advice from the Royal National Lifeboat Institution) and though it seems plausible that the harm caused by smoking has a correlative relationship with the amount of cigarettes consumed, ‘official’ advice concentrates very firmly on cessation rather than reduction.³⁴ Both pastimes potentially harm their devotees though the incidence and mechanism are different.

³⁴ Early data confirmed for example that the risk of lung cancer increases with the number of cigarettes smoked (Doll and Peto, 1978). However, Secondary prevention of airway disease is barely improved with reduction rather than cessation (Godtfredsen *et al.*, 2002a, b). A Cochrane review concluded that it is uncertain how much health benefit there is from cutting down (Stead and Lancaster, 2007).

More smokers than tombstoners suffer ill health; for smokers it is mainly cumulative whereas for tombstoners it is mainly as the result of a single incidence. There are direct harms to others from the habits. For smoking these include illness and irritation caused by second hand smoke and injuries caused by smoking related fires, and for tombstoning, injuries inflicted on fellow tombstoners by jumping on top of them. Indirect harms, that is setbacks to interests and emotional distress to the friends and families of injured or diseased smokers and tombstoners are similar. Addiction is relevant to the analysis because it impairs autonomy and agency which are required for (full) moral responsibility. Smoking is clearly addictive, tombstoning is not.³⁵

It is not suggested that there is a calculus or rubric to settle the question of whether, or to what extent the analogies are valid or meaningful. Argument by analogy, despite its formal expressions, is an inexact process, most effective when used, as in this thesis, together with other kinds of arguments (Kienpointner, 2012). The most important question is how persuasive they are; as presented here, I find them persuasive but their success as arguments if not as motivators for change, is a question for readers rather than the writer.

Conclusion

This chapter has detailed the philosophical approaches taken in the remainder of the thesis and has aimed to complete the theoretical picture left unfinished by the papers which form the original contribution to knowledge of the thesis. I will revisit theoretical issues within the papers where necessary. In sketching theoretical

³⁵ The range of activities which can be regarded as addictive continues to expand. Recent evidence claims sunbathing as an addiction (Fell *et al.*, 2014)

approaches that I claim have sufficient empirical and normative justification I hope to have steered into the middle ground between an unwieldy, theory driven academic puzzle on the one hand and unreflective, capricious and potentially self-interested emotionality of the other, and to have used case studies and analogies in ways that illuminate rather than manipulate. Greene (2013) argues that, fundamentally, utilitarianism is not just a decision making procedure, but is concerned with what matters most, what is worth valuing and for what reasons, and I offer this as a good aspiration for the papers that follow, taken together. I am not arguing that here is a moral theory that I approve of, and that you ought to follow it. Instead what the papers boil down to is saying that here is an account that I think that you will recognise, and which offers you a way of working out what your obligations are in respect of your health and other people's health. It is a process that you may care to follow, but if you think about it and decide it's not for you, than at least you will have thought, hopefully, about what's worth valuing and what you ought to do to protect it. I will return to this and what it means for professional health care in the final chapter of the thesis, but for now, the introductory section is complete. In Part II of the thesis I offer analyses of responsibility for health and blame, and normative accounts of our obligations in respect of our own and other's health, all of which have been published in peer-reviewed academic journals.

Part II: Published Papers.

CHAPTER 5

Saying something interesting about responsibility for health

Abstract

The concept of responsibility for health is a significant feature of health discourse and public health policy, but application of the concept is poorly understood. This paper offers an analysis of the concept in two ways. Following an examination of the use of the word 'responsibility' in the nursing and wider health literature using three examples, the concept of 'responsibility for health' as fulfilling a social function is discussed with reference to policy documents from the United Kingdom. The philosophical literature on moral responsibility is introduced, and in considering two versions, reactive attitudes and accountability, it is argued that in application both can be regarded, though with different emphasis, as being constituted in three parts: (i) a responsible agent (ii) having obligations (responsibilities) and (iii) being susceptible to being held responsible (that is blamed) if he fails to meet them. The three stage model is consistent with the examples of the word responsibility in use, but application to the social function model causes a number of problems for health care practice, especially for the reactive attitudes account. Apart from considerable problems in stating what exactly the obligations are and how they can be justified; and how blame might justly be apportioned and by whom, the very ideas of obligation and blame are in conflict with health care systems and professional nursing practice which have foundations deeply embedded in the notion of the supremacy of personal autonomy. It is concluded that current application of the concept of responsibility for health is conceptually incoherent, and if it is to retain its place in health policy and discourse, urgent remedy is required.

Note on text

The text of the four published papers that form Part II of the thesis is the same as the publisher's pdf versions which can be found in in the appendix. There are some very minor differences in headings made by publisher's copy editors, and a small number of references have been changed for consistency.

Introduction

It cannot be said that the issue of responsibility for health is new (Reiser, 1985), but current fiscal uncertainty, technological advances, and the unrelenting increase in the prevalence and incidence of illnesses related to lifestyle combine to give the issue renewed significance. Despite this, there is little in the nursing literature about what the concept of ‘responsibility for health’ consists of, and why it is so important and so difficult. The simple aim of this paper, following Paley (1996), is to ‘say something interesting’ about responsibility for health. I offer two analyses of ‘responsibility’ as applied to professional health care. First, I discuss examples of the use of the word ‘responsibility’ found in the nursing and broader literature. Second I consider the concept of ‘responsibility for health’ as fulfilling a social function. I then turn to the philosophical literature on moral responsibility, and in considering two versions, reactive attitudes and accountability, argue that in application both can be regarded, though with different emphasis, as being constituted in three parts: (i) a responsible agent (ii) having obligations (responsibilities) and (iii) being susceptible to being held responsible (that is blamed) if he fails to meet them. The three stage model is consistent with the examples in use, but application to the social function model causes a number of problems, especially for the reactive attitudes account. Apart from considerable problems in stating what exactly the obligations are and how they can be justified; and how blame might justly be apportioned and by whom, the very ideas of obligation and blame are in conflict within health care systems and professional nursing practice which have foundations deeply embedded in the notion of the supremacy of personal autonomy.

Two concepts, many conceptions

An obvious starting point is that the term ‘responsibility for health’ contains two distinct concepts, responsibility and health, and it might reasonably be suggested that combining them will obfuscate analysis. Health is variously understood, famously by Boorse (1975, 1977) and Nordenfelt (for example, 1996, 2007). In Boorse’s account health is descriptively merely the absence of disease, defined in terms of statistical normality, while Nordenfelt’s evaluative account understands health more holistically as the ability to realize life goals. These different conceptions can result in practical differences in health care all of which could justifiably claim to be directed at improving health (Nordenfelt, 1993). Similarly, the concept ‘responsibility for health’ will differ depending on which account of health is utilised. To understand why this potential confusion need not cloud the analysis, it is necessary to be clear about the difference between concepts and conceptions.

The distinction is that conceptions lie lower in a vertical continuum between general and specific usages of a word. Conceptions offer a more ‘determinate specification’ (Miller, 2010, p. 812) of the parent concept, operationalising and applying it. Inevitably this means that two or more conceptions can be derived from a single concept. Vertically each conception must be consistent with the parent concept or they will be conceptions of different concepts, but horizontally, between conceptions within a concept, there may be incommensurable differences. Where this happens we have, following Gallie (1956) ‘*essentially contested concepts*’. Gallie had in mind artistic and political concepts (Ruben, 2010), but it has been suggested that medicine meets the necessary criteria (McKnight, 2010) set out at some length by Gallie. A further relevant example is discrimination, used differently by the UK governing

bodies of nurses and doctors. Nursing's professional regulator, the Nursing and Midwifery Council (NMC) (2008) states that 'You must not discriminate in any way against those in your care.'¹ The UK medical regulator, the General Medical Council (GMC) states that 'You must not unfairly discriminate [...] '(GMC, 2006 p.10). Whilst operationalising a concept fundamental to professional healthcare practice, the two regulators have used different conceptions of the same concept; the NMC has used the word evaluatively, while in using the word descriptively, the GMC requires an evaluative adverb. It is not suggested that doctors treat patients differently (though it *could* be suggested), only that different conceptions of the concept 'discrimination' have resulted in a position where on application of the verb 'to discriminate' separate from evaluative adverbs, doctors are potentially able to do something that nurses are not, that is discriminate fairly (Hellman, 2008; Moreau, 2010).²

Argument about which conception is correct is ultimately futile as each can be derived from the parent concept, and this is potentially a problem, though rarely acknowledged, for inductive concept analysis methodology which may attempt an improbable synthesis between these essentially contested conceptions.³ Similarly, different conceptions of health are important in operationalising conceptions of 'responsibility for health', but ambiguity is manifested in the conceptions rather than the parent concept. Insofar as the task of this paper is to say something interesting about the parent concept, rather than any specific operationalising conception, the analysis is more fruitfully directed at the concept of 'responsibility'. The importance

¹ In England and Wales the National Health Service as a whole takes this evaluative line in the NHS constitution.

² In English law under the Equality Act 2010 Discrimination requires less favourable treatment

³ None of the 1261 'hits' in a BNI and CINAHL search using the term 'concept analysis' (1st February 2011) referenced Gallie's paper (The number of hits would include some identified twice).

of the different conceptions of health lie in determining obligations, outside the scope of this paper.

Work required of the concept

The justification of undertaking an analysis and the methodology employed depends on the work the concept is required to do.⁴ One purpose could be to undertake concept analysis to explore what responsibility for health (or more broadly ‘responsibility’ within the health care environment) means to individuals, with the aim of arriving at a composite definition which could be used in further research.

Concept Analysis (1): responsibility in use

Anyone wishing to clarify any concept relevant to nursing practice has a large and growing body of work to build upon. Despite substantial critiques from, *inter alia*, Paley (1996), Beckwith *et al.* (2008) and Risjord (2009), the proliferation of concept analyses in nursing journals shows little sign of abatement. It is perhaps surprising that many published examples show little appetite for engagement with the ontological, epistemological and (perhaps most surprising) methodological problems identified in the critiques, following instead a substantially standardised process rarely found outside the nursing literature. Were Walker and Avant’s (2011) concept analysis procedure to be followed, the literature, dictionaries and theses would be searched towards the aim of arriving at ‘a precise operational definition’ (p. 158); the result of answering the empirical question “how are the words ‘responsibility for health’ used”, rather than an analysis of the concepts denoted by the words (Wedgwood, 2006). Unfortunately many of the relevant papers found using the term

⁴ Walker and Avant (2011, p.160) suggest that it could be a concept that ‘has always bothered you.’

‘responsibility’⁵ manage to discuss and use the term without saying what it means. Three examples illustrate this; adolescent diabetes, women’s magazines, and public attitudes to health care policy.⁶

In the US, Anderson *et al.* (1990) developed a widely used questionnaire to measure ‘individual family member’s perceptions of who takes responsibility for a broad range of diabetes tasks’ (p. 479). The questionnaire asks participants to choose from a list of 3 choices against a number of situations or tasks, for example ‘remembering the day of clinic appointment.’ The options are:

1. Parent(s) take or initiate responsibility for this almost all of the time.
2. Parent(s) and child share responsibility for this about equally.
3. Child takes or initiates responsibility for this almost all of the time.

Within the paper, the choices are explained so that ‘the respondent assigned a 1 if the parent was predominantly “in charge” (p. 481) of the task’. It should be clear that I am not criticising the paper, merely pointing out that the term ‘responsibility’ apparently needs no explanation as none was offered to those completing the questionnaire. It is assumed that they know what it means, and what is available in the text by way of explanation refers in passing to being ‘in charge.’

This paper is one of many analysed in Hanna and Decker’s (2009) concept analysis of ‘assuming responsibility for self-care among adolescents with type 1 diabetes.’

⁵ Using the databases, CINAHL and MEDLINE (14th November 2011), there were 11475 ‘hits’ searching for ‘responsibility’ in the title, and 1123 ‘hits’ searching for ‘responsibility for health’ in the title. A full analysis or categorisation of all sources identified was not undertaken. A partial but unsystematic review suggested that many of the papers identified were not relevant to the argument presented in this paper.

⁶ The examples were chosen because they illustrate the points I wish to make. I do not claim that these papers are in any sense representative.

Similarly there is no discussion about what ‘responsibility’ means in the general sense. The conclusion of the analysis is that the attributes of assuming responsibility include that it is ‘[...] (c) a process with the goal of ownership and (d) a process involving autonomy in behaviours and decision making’ (2009, p.101). The model case (part of Walker and Avant’s (2011) procedure) offered is a fictional 17 year old who says that she ‘will be fully responsible when she is able to be totally independent in doing all the diabetes care tasks and being the one who makes the decisions about them without any reminders’ (p.102). Olinder *et al.* (2011) report a grounded theory study utilising interviews with adolescents where responsibility emerged as a core category and provided the principal ingredient in a model to facilitate the clarification of responsibility. They state that (2011, p.5) ‘A lack of responsibility seems to be a main reason for missed bolus doses and insufficient self management’, but this has several potential meanings.

Second, in a fascinating account of the discourse about responsibility for health in English – Canadian women’s magazines, Roy (2008) shows how the discourse reinforces ‘neo-liberal ideas by conceptualising responsibility for one’s health as not only something that can be chosen but something that *ought* to be chosen’ (p. 473). The discourses not only cover the familiar path of health promotion, but also urge that women be determined in pushing agendas in relationships with physicians and to be brave in the face of debilitating illness; ‘constructing continued optimism as an important moral obligation, how one with a disease or disability ought to behave (p. 472).’ In one reviewed article a woman with multiple sclerosis defines responsibility as ‘[...] accomplishing the things I wanted in life right now. Today’ (MacLean, 1999, p. 73, cited in Roy, 2008, p. 471). This seems to be a somewhat idiosyncratic

understanding of responsibility, re-emphasising potential pitfalls of inductive analysis. The paper generally presents an idealised understanding of responsibility promulgated in the magazines which, in claiming robust obligations whilst failing to address or even acknowledge barriers to meeting them, might be considered more moralistic than moral. The paper does not engage in a discussion about what the concept of responsibility means in general, focussing instead on the various conceptions presented, but the title resonates with the work on teenagers with diabetes; “‘Taking charge of your health’: discourses of responsibility in English-Canadian women’s magazines’.

Third, in the UK, the King’s Fund (2004) commissioned a survey to assess public attitudes to health policy. In the quantitative phase a series of yes/no questions were presented. ‘88% ...agreed that individuals are responsible for their health’ (2004 p. 11)⁷. However, more than ‘40% agreed that there are too many factors outside individual control to hold people responsible for their own health’ (2004 p. 11). The questionnaire does not appear⁸ to explain what is meant by responsibility for their health, but the high rate of agreement suggests that respondents understand what is meant.

There is no indication in any of three examples that the lack of definition or explanation of responsibility has caused problems; evidently those who answer the questionnaires have something in mind, but the form of the questions and the way that they are reported give little indication of what more detailed understandings might be. These incomplete understandings, even when they represent everyday

⁷ Elsewhere in the published document this figure is given as 89%.

⁸ The actual questionnaire used is not reproduced in the publication.

usage make a nuanced inductive concept analysis problematic. I shall return to these partial accounts, but for now I turn to a second use of the term, which recognises that some concepts have broader social functions (Miller, 2010).

Concept Analysis (2): responsibility as social function.

The concept ‘responsibility for health’ fulfils an important social function within socialised medicine, and is used for example in policy documents to explain respective roles within that system.⁹ In this context, clarifying meaning cannot be a matter for inductive analysis of partial usage because the concept is required to do the work of providing a framework for helping people to understand just what it is that they should or must do, and this social function cannot be fulfilled unless the recipients of the message understand what having ‘responsibility for health’ requires. Inductive analysis of the word ‘responsibility’ in use may give insight into how the message is variously received but that does not abolish the need for clarity in its transmission. An objection that it is not for the Government to tell us, for example, that we ought not to smoke would be to confuse the global concept of responsibility with its determinative conceptions. However, rejecting one or many conceptions does not entail rejection of the concept and understanding of the determinative conceptions requires a general understanding of the concept. If this is the case, and the concept ‘responsibility for health’ does form a social function within socialised¹⁰ medicine, then there should be clarity about what this means. A cursory glance at National Health Service documents reveals that this is not the case.

⁹ In fact the broad term responsibility is increasingly heard in myriad social and political contexts for example in welfare provision (Brown, 2009, Maltravers. 2007).

¹⁰ The UK National Health Service is possibly the paradigm case of socialised medicine. The drawing on collective resources for treatment might provide a reason for the view that certain health enhancing behaviours are morally obligatory, but not the only reasons. I do not mean to suggest that the concept responsibility for health has no meaning within private health care systems.

The (former) Prime Minister's¹¹ introduction to the strategy to reduce obesity provides a clear statement which illustrates the confusion:

There should be no doubt that maintaining a healthy weight must be the responsibility of individuals first – it is not the role of government to tell people how to live their lives and nor would this work (DH, 2008, p. iii).

First the Government tells us what we must do (maintain a healthy weight), and then it tells us that it is not their role to tell us how to do it. The relevant clause in the NHS constitution¹² states 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 (DH, 2009a, p.9).

Similar to the literature reviewed earlier, this leaves the meaning of 'responsibility' open to interpretation, particularly within the phrase 'some responsibility', and the normative prescription simply requires recognition that a significant contribution is possible, and not that it be made. Further explanation is provided in the handbook to the constitution. Entitled 'what this means in practice', the clarification is:

You can talk to your doctor, nurse (including health visitors and midwives) or therapist, use NHS Direct (online at www.nhsdirect.nhs.uk or telephone 0845 4647), or go online at NHS Choices (www.nhs.uk). You can ask about what support you might be offered in managing your condition yourself or changing to a healthy lifestyle (e.g. stopping smoking, reducing weight, exercise or reducing excessive alcohol consumption) (DH, 2010c, p. 67).

This explanatory note falls considerably short of explaining either the nature or the details of responsibility,¹³ and by utilising language which hints at information giving (you can), the clarification sets a rather different tone than the normative clause (you should) in the constitution, and the imperative (must) in the Prime Minister's introduction to a previous document. Having identified its social

¹¹ The Prime Minister at the time was Gordon Brown.

¹² The constitution applies to NHS services in England and Wales.

¹³ the document is addressed to 'Patients and the public'

function, the guidance fails to guide. The Scottish NHS version initially goes further.

Under the heading ‘What we expect from you’ it is stated that:

‘You can help yourself, other patients and NHS Staff if you do the following;’ Look after your own health and have a healthy lifestyle. This could mean; taking more exercise, eating a balanced diet, stopping smoking, not drinking too much alcohol, not using drugs, and using a condom if having sex’ (NHS Scotland, 2005, p.15).

Though the heading is stated as an expectation, the language in the text is softer (you can help yourself). Similar internal ambiguity is evident in the Report of the Prime Minister’s Commission on the future of Nursing and Midwifery in England (2010).

Recommendation 13 (2010, p.102) includes the statement that:

Nurses and Midwives must acknowledge that they are seen as role models for healthy living and take personal responsibility for their own health (Prime Minister’s Commission, 2010, p.102).

The language is declamatory (must), but the proposed draft pledge less so:

Nurses and midwives, recognising our important role in improving health and wellbeing and reducing inequalities, will engage actively in the design, monitoring and delivery of services to achieve this. We acknowledge that we are seen as role models and will try to live up to this responsibility (Prime Minister’s Commission, 2010, p.57).

The response was delayed because of the general election and subsequent change in government. Despite the sentiment, expressed by the Minister, that the report ‘does not go far enough’ (DH, 2011, p.5) the recommendations noted above will not be implemented in full. The section of recommendation 13 requiring that nurses take personal responsibility for their own health is ignored; the response is restricted to the implementation of the Boorman report (Boorman, 2009), ‘*NHS Health and Well-being*’ which recommended a less prescriptive provision of services centred on prevention ‘of both work related and lifestyle influenced ill health’ (p. 29). The recommended pledge will not be implemented. Instead, ‘Employers need to use the

Principles of Nursing Practice as a pledge...’ (DH, 2011 p.6). These Principles, developed and published not by the regulator but by the Royal College of Nursing (RCN) (Manley *et al.*, 2011), a union representing less than two thirds of registered nurses, do not acknowledge nurses as role models in a public health sense. Though the Commission’s relevant recommendations will not be implemented, the fact that they attracted such wide support from the nursing ‘establishment’ (including the Department of Health’s Chief Nursing Officer, the RCN and the NMC) lends them considerable authority, and the watered down response, facilitated by the same organisations, is further illustrative of the general confusion.

To recap, I have offered two possible accounts of how responsibility for health might be understood and analysed. The first account, which could be deepened by inductive concept analysis, is or could be theory forming, empirical and stems from ordinary usage of the word by members of the public and patients who answered questions about responsibility. It is incomplete rather than inadequate in its expression. The second is theory formed and normative but requires clarification and deeper understanding to be effective. The policy examples demonstrate that the concept has a social, action guiding function but there is no clarity about what is required and the mixed messages illustrate an account which is as inadequate as it is incomplete. The task for the remainder of this paper is to argue that the two accounts I have offered are not incompatible, and that they and other usages of ‘responsibility’ can be unified under a broader understanding of what responsibility for health means, and I proceed by introducing the philosophical literature on responsibility. Though this may provide a richer application of both of the accounts I have offered, philosophical illumination also reveals incoherence at the heart of

health care provision and practice; attempting to avoid this incoherence may be one cause of the partial accounts populating the literatures.

The philosophical literature

Causation

Causation plays a major part in responsibility. When we say that X was responsible for Y, meaning can be restricted to X caused Y. The causal claims can include non-moral and even inanimate objects. We say that ice was responsible for the collision, or the red sock was responsible for the pink washing. When we ask ‘who is responsible for the broken window?’ we ask how the window came to be broken. A small child throwing a stone is superficially and causally responsible for the broken window, but not, in Sie’s (2005) categorisation, deeply morally responsible because he is not a moral agent. Causation is also key in the relationship between being responsible for a thing and being responsible for our acts and omissions in relation to the thing. When we say that we are responsible for our health we cannot mean that we are responsible for all aspects for our health at all times. If ill health results from being struck by an asteroid, nothing that we did or omitted to do caused the injury. It could be said that my omission to be elsewhere was a factor but this is only relevant in the deeply morally responsible sense if I knew and understood that I was going to get hit, and that therefore I ought to have gone somewhere else to avoid it.

Causative links between actions or omissions and poor outcomes for the things that we are responsible for are central to the question of what we ought to do to keep well, and why. A group correlation between smoking and heart disease does not mean that all heart disease is caused by smoking, or even that the heart disease of

smokers was caused by smoking. Smoking, though correlated with heart disease is neither necessary nor sufficient for individual instances of heart disease. Inevitably the devil is in the detail for specific causative factors for specific diseases, but for this paper, it is enough to note that discussion about responsibility for health, involves deep, moral responsibility as well as superficial causal responsibility, and that because of the lack of certainty of individual causation it is not health *per se* that we are responsible for but rather our actions or omissions that threaten or enhance it.

Other forms of responsibility

H.L.A. Hart (1968) and others (for example, Cane 2002) have pointed out that responsibility comes in many forms, for example role responsibility and legal responsibility.¹⁴ It is important to distinguish between the various forms of responsibility, especially where they coincide. Consider the various forms of responsibility as they relate to Z, a user of heroin. Let us assume that Z has entered into an agreement (contract) with the health care team that he will not use heroin, and that if he does there is a consequence, say that he will be discharged from a rehabilitation unit (Houmanfar *et al.*, 2008). We know that there is a law¹⁵ prohibiting the possession of heroin, and so if he is found in possession he is liable to prosecution. For quasi-contractual¹⁶ and legal responsibility we can examine the agreement, or identify legislation or case law, and these are clear in defining what Z is obliged, contractually or legally to do (or not to do), as well as identifying what will happen to him if he fails in this responsibility.

¹⁴ These refer to various sorts of responsibility attached to individuals, but we also talk about collective responsibility and responsibility of institutions (Wilmot, 2000; Dubbink and Smith, 2011).

¹⁵ The Misuse of drugs Act 1971 provides for a maximum sentence of seven years imprisonment for possession of a class A drug (including heroin).

¹⁶ I say quasi-contractual because I do not want to imply that the sort of agreement that I refer to is necessarily a legal contract.

There may be moral reasons for Z to avoid using heroin (Smith 2002), and no doubt these have influenced decisions that have made possession of heroin unlawful and the therapeutic contract acceptable. Fines and imprisonment may result from a breach of a legal responsibility, and discharge from rehabilitation results from a breach of the agreement. That these breaches may also represent moral failure is contingent but not necessary. Moral responsibility differs in at least two respects here. First there are no unequivocal moral facts about taking heroin that make it absolutely the case that it is immoral.¹⁷ Many would hold that taking heroin is wrong and cite reasons in support, but there is also a view that taking heroin is morally permissible. Other health threatening behaviours also attract differing views about whether they are morally forbidden, allowed or (in some cases) obligatory or morally neutral. It cannot be said that taking heroin is immoral with the same certainty as it can be said that possessing heroin is unlawful. Z cannot deny the legal and quasi-contractual responsibility not to take heroin, but he can take the view that there is nothing morally wrong with it.¹⁸

Second, the consequences for failing to meet legal and contractual responsibilities are clearly articulated, but this is not the case when failing to meet a moral responsibility. The relationships between an agent, his moral obligations and the consequences of not meeting them form the basis of the philosophical concept of moral responsibility. Two versions are briefly reviewed; reactive attitudes and accountability.

¹⁷ This is not the place to discuss whether there can be moral facts or whether, if there can, it is true that taking heroin is wrong.

¹⁸ He cannot deny that the law prohibits possession, but he can argue that it ought not to. The relationship between law and ethics is far too complex to discuss in detail here, and I have taken a very simple line to make the point.

Moral responsibility (1): Strawson and the reactive attitudes

You cannot go very far into the philosophical literature on responsibility without encountering Peter Strawson's influential lecture and paper, *Freedom and Resentment*, first published in 1962. The paper's aim is to argue that our normal practices of moral responsibility are 'underpinned by reasons that are immune to the threat posed by determinism' (Maltravers, 2007 p.34). Determinism is the theory that everything that happens is determined by the things that precede it and the natural laws of physics. If true, this would effect the way we regard the things that people do, for despite our weighing up options and reflecting on our choices (both of which are also determined), we only end up doing the things that we would have done. Our part in the causal chain is fixed; choice is illusory, we can only do the things that we are determined to do. Incompatibilists (Van Inwagen, 1975) argue that if determinism is true, we cannot be morally responsible for the things we do.¹⁹ Compatibilists, like Strawson, argue that moral responsibility obtains even if determinism is true.

Fully causal determinism is virtually absent in the literature on autonomy and responsibility in health care, possibly because the idea of a fully determined life is so difficult to comprehend. There appears to be at least a compatibilist assumption if not an outright assumption of the falsity of determinism despite what Wallace (1994, p.58) refers to as 'the seductiveness of incompatibilism'. Nelkin (2007, and see Kane, 2005) cites several influential sources for the view that intuitively we start as incompatibilists; 'we are incompatibilists before we (compatibilists) start studying philosophy and talk ourselves out of it (2007, p.244)'. She proceeds to discuss a number of areas where intuitions tested empirically are inconsistent, and the view

¹⁹ Here the incompatibility is between freewill and determinism, but since moral responsibility requires freewill, moral responsibility and determinism are also incompatible in this account.

emerges that that we are instead compatibilists by inclination. In contrast to the absence of causal determination in the literature, other less complete forms of determination, for example, genetic, social and environmental are highly visible in the sense that these influences, whose effect on behaviour is correlated at the societal level (Raphael, 2006) can be suggested to threaten and impede moral agency and therefore responsibility. The question must be suggested; if our natural inclination (if we have one) is to be compatibilist in the matter of causal determinism, must consistency require that we also be compatibilist in the matter of genetic, social and other determinist mechanisms which fall short of full causation? This is hinted at in the King's Fund report (2004), which is incompatibilist in its reporting, if not its data. Nelkin's examples of inconsistency in intuitions support the view that individually and collectively humans are not as rational or consistent as we may hope or believe and this threatens arguments premised on intuition claims and reflective equilibrium (and see Sutherland, 1992; Thaler and Sunstein, 2009). The often repeated view that more research is necessary seems for once to be fully justified.

Strawson's (1962) paper is relevant not so much because of its compatibilist emphasis, but rather in the claims about the purposes and nature of moral responsibility. Moral responsibility is based on the reactions of other people to our character and actions. When we are wronged we feel certain reactive attitudes towards wrongdoers; resentment and indignation. Generally people care about what others think of them, and wishing to avoid being thought of badly is a powerful social regulator of behaviour. The significance of the paper, and those that developed the ideas, lies in the view that individuals are responsible for those things that elicit the reactive response in the wronged. Being responsible is understood in the fact and

process of being held responsible. Strawson was at pains throughout the paper to base his views on what he called 'common places', what we might consider as common morality, something which he says is easy to forget when we are engaged in philosophy. Other compatibilists (optimists as he calls them) have argued from consequentialist calculation that our practices of holding people responsible operate to regulate behaviour in socially useful ways, but that is to over-intellectualise the process:

What is wrong is to forget that those practices, and their reception, the reactions to them really *are* expressions of our moral attitudes and not merely devices we calculatingly employ for regulative purposes (Strawson, 1962 p.93, emphasis in original).

His claims about the practices of holding people morally responsible as well as their compatibility with determinism (should it be true) are based on ontological rather normative premises. There are exceptions in our practices for those, like children, or expressed in the language of the time, an 'idiot or a moral idiot' (p.82), and a recognition that a lack of intention also ameliorates the reactions.

Such reactive attitudes form part of the fabric of inter-personal relationships, but there are also vicarious attitudes felt by individuals not directly affected by wrongdoing. Instead of resentment we feel indignant or disapproving. We feel these attitudes of those who lie, distinct from and weaker than the resentment that we feel against those who lie to or about us. The moral demand here is that individuals should refrain from lying,²⁰ but in the general sense, these vicarious attitudes speak to the nature of all moral expectation and define them in terms of an emotional response:

²⁰ I put to one side for the moment the issue of whether lying can be justified or even required.

But these attitudes of disapprobation and indignation are precisely the correlates of the moral demand in the case where the demand is felt to be disregarded. The making of the demand *is* the proneness to such attitudes (Strawson, 1962 p. 90, emphasis in original).

As the author of a relatively short if very influential paper Strawson left it to others to develop the ideas (for example Fischer, 1987, Kahn, 2011) R. Jay Wallace deepened the account in several ways, concluding that:

It is reasonable to hold agents morally accountable when they possess the powers of reflective self control; and when such accountable agents violate the obligations to which we hold them they deserve to be blamed for what they have done (Wallace, 1994, p. 226).

Wallace (1994) also develops the nature of the obligation that is a necessary feature for responsibility in his account. Having the reactive emotions as a justifiable response to an action relies on the cause of the emotions having certain moral features such that the agent ought not to have done it. Or, he has failed to do something that he ought to have done.²¹ An agent can be responsible for a morally neutral act; he is a rational candidate for praise or blame even if the act is worthy of neither. Whilst retaining the link between the act and a response, Fischer's (1987) account emphasises the features of moral agency which make a person legitimately blameable. The extent to which he is held responsible depends on the nature of the act he is responsible for. If it is morally neutral, holding him morally responsible is inappropriate, even though he is morally responsible for it in light of his moral agency.

²¹ See Harris (1980) on the equivalence of acts and omissions

Moral responsibility (2): the accountability version

The quotation from Wallace (1994) appears to go some way towards the accountability version of responsibility. Korsgaard (1992, p. 306) notes the unattractiveness of taking ‘the assessment of others as the starting point in moral philosophy’, and Oshana’s (1997) alternative approach avoids working backwards from response. On this ‘accountability’ version of responsibility, a person is responsible if it is fitting that she give an account for her behaviour. This entails the presumptions that the individual has:

- (a) antecedently met the requirements of responsible agency.
- (b) has performed some act (or has exhibited some characteristic) of the sort subject to certain accepted standards of morality.
- (c) typically has fallen short of these standards (Oshana, 1997, p.77).

Fittingness implies that it is not necessary for the individual actually to give an account; it is enough that it is appropriate. Similar to the reactive attitudes approach there are exceptions for those who are not full moral agents; we could not ask someone with dementia or a small child to account for themselves any more than we would appropriately feel resentment towards them. In the case of direct wrongdoing it seems clear that an account is owed to the wronged, but it is not so clear to whom the account corresponding to vicarious disapproval in the reactive attitudes approach, is owed. Regardless of whether the account is actually given, Oshana (1994) claims that the approach has the advantage of focussing firmly on the agent and what he has done, placing the burden upon the actor, regardless of the reactions of others.

There are clear differences between the reactive attitudes and the accountability versions of the nature of moral responsibility. Consider Agent A, undertaking

behaviour B which elicits responses C. In the reactive attitudes version, the responses (C(ra)) consist of indignation, or objectively, disapprobation from others, a consequence of B in the sense that it has occurred after A has undertaken B, and is a result of B. A is morally responsible for B *because* C(ra). In the accountability version the process follows the other direction. We say if A has certain properties, and B is wrong, then he is liable to consequences (C(a)) in the form of being required to give an account. A is responsible for B *therefore* C(a).

There are many caveats in both versions but for now it is sufficient to draw attention to the similarities between the versions of responsibility rather than identify and unpick the differences. These similarities do little more than identify the constituent parts, but this is enough to expose the inadequacy of the concept in current usage within healthcare. These constituent parts or facets (Guttman and Ressler, 2001), are a person, an act (or omission), and a reaction or a consequence. Or, a responsible agent who has responsibilities, and can be held responsible. These three constituent parts are implied in any discussion of any type of responsibility, though the reactive attitudes are distinctive features of moral responsibility.

Applying the framework to the case studies

I considered three examples; teenagers with diabetes, Canadian women's magazines, and the Kings Fund Report. Does the three stage analysis extend understanding in these cases? In the first, the teenagers are on the cusp of full moral agency. The narrative concerns 'taking charge' or accepting responsibility.²² The responsibilities are the obligations detailed in the questionnaire, turning up for clinic appointments,

²² See Waller (2005) on the difference between 'take-charge' and 'just deserts responsibility'.

remembering to take medication and so on. Absent from the account is any consideration of the consequences of failing to meet the obligations though it seems plausible that a teenager neglecting to take medication may be subject to some reactive emotions at least from her parents. Olinder *et al.* (2011, p.6) briefly consider this but only to the extent that ‘nagging and criticism are not wanted. Sometimes they just want to be reminded, rather than asked why their blood sugar is high.’ The Canadian magazines’ narrative appears to assume moral agency in their readers. There is clearly some notion of obligation but little acknowledgement of consequences, though the moralist stance employed implies that those failing in their obligations will be thought less of. The King’s Fund report considers and rejects the notion of full moral agency, does not engage in any sense in what health related obligations might be and seeks to restrict the consequences of failing to meet these unspecified obligations on the grounds of incomplete agency.

All we can say from the potential inductive process is that the three stage analysis is not inconsistent with the three examples, and it is unclear how the three stage analysis could have been arrived at by an empirical study of use of the word responsibility. How does the three stage analysis illuminate the second use of responsibility that is its use as an action-guiding concept within health policy?

Applying the framework to health policy

It is fair to say that there has been some controversy in the application of the political concept of personal responsibility in a number of policy areas. As far as health (and welfare) is concerned the notion is perhaps more popular and developed in the Anglo-American post war tradition than on the European continent, though it

appears to be gaining ground in Europe where, paradoxically perhaps, socialised medicine is less developed than in the UK (Schmidt, 2007b, Ter Meulen and Maarse, 2008). As far as the emphasis on personal responsibility is concerned, policy appears to assume agency, is confused in the matter of obligation and has consistently ruled out overtly holding patients responsible. We will see that the ground is characterised by difficulties and apparent paradoxes problematising each stage of the application of the concept. In identifying some of these I assume that despite the rhetoric, individuals are not currently held (morally) responsible for their health or their health threatening behaviours, and so the question offered for more detailed analysis elsewhere is not in what ways are individuals responsible for their health within the system of socialised medicine, but why are they not?²³ We will look briefly at each stage in turn.

Moral agency

Workaday application of autonomy in healthcare understood minimally as a commitment to informed consent belies the complexity of the various conceptions (Coggon, 2007; Oshana, 1998). Allmark (2008, p. 41) defines individual autonomy as ‘the capacity of the individual to make and act upon judgments for which he is held morally accountable.’ If this is the case, the result of the equivalence of autonomy and accountability (or responsibility) could reasonably be expected to conclude that if a patient is considered to be sufficiently autonomous to be allowed to buy cream cakes, or to consent to weight reduction medication or surgery, then he is also sufficiently autonomous so as to be liable to be held responsible for his eating and the obesity which follows, regardless of the multiple factors which influence

²³ I am confident that many of us are held (morally) responsible within close interpersonal relationships but this lies outside the inquiry on moral responsibility within socialised medicine.

eating behaviour, recognised by the UK government in its foresight report (Butland *et al.*, 2007).

Oshana (2002) argues that the solution to this apparent paradox is that the equivalence of autonomy and responsibility is mistaken. A morally responsible agent has to be capable of normative competence as well as being able to act on desires and intentions. She gives the example of two versions of Hitler, the first version of which is incapable of recognizing any moral code which prevents him ordering genocide. She regards this first version of Hitler as not being a responsible agent, different from the second version who does recognise moral reasons for not ordering genocide but allows them to be overruled. Punishment for the first version, that is holding responsible, must be justified solely by referral to the utilitarian²⁴ approaches that Strawson (1962) and others opposed. This is an extreme example perhaps, likely to test the credibility of the reflective equilibrium approach, which should capture our²⁵ intuitions in clear cases (Fisher and Ravizza, 1998). The obese cream cake eater may not acknowledge the second helping as a moral wrong, but that does not mean that she is incapable of doing so. The example of the Hitlers makes the point that responsibility requires additional features especially concerning rationality, and these additional features do not figure in considerations of deciding whether a person is sufficiently autonomous to consent to treatment. In the UK, capacity is decided upon by application of tests outlined in the Mental Capacity Act 2005 which determine ability to understand and retain information and use it to make a decision. The rationality of the decision lies outside the process, reflected in Lord

²⁴ As far as utilitarian accounts are concerned, it is possible to punish an innocent man (in the sense that he is not fully morally responsible) in the pursuit of greatest utility.

²⁵ I am never sure when philosophers say 'our' as in should capture 'our moral intuitions about clear cases' whether they mean their individual intuitions, or the intuitions of people in general – and if the latter what evidentiary support is available.

Donaldson's famous observation that the absolute right to autonomy '[...] exists notwithstanding that the reasons for making the choice are rational, or irrational unknown or even non-existent'²⁶ (Brazier and Cave, 2011, p.118). Oshana (2002) claims that the error in lumping together autonomy and responsibility stems in part from a conflation of the global state of being autonomous with a locally autonomous act. The tendency to think of the former as being tied to responsibility results from the close ties between the latter and being responsible for the act in question. Workaday understanding of autonomy in healthcare very firmly concerns the latter.

Conversely, in discussing moral autonomy Dworkin (1988, p.35) states that 'A person is morally autonomous if and only if he bears the responsibility for the moral theory he accepts and the principles he applies.' And of interest is the view expressed in the United Nations Educational Scientific and Cultural organisation [UNESCO] (2008) Bioethics core curriculum²⁷ that:

'In ethics the notions of autonomy and responsibility are mutually related. There is no autonomy without responsibility; beyond responsibility, autonomy turns to arbitrariness which means that the person in his/her decisions does not take into consideration the interests of others (UNESCO, 2008 p. 27).

The relationship between responsibility and autonomy is too complex to be discussed in depth here, and my aim is simply to argue that there is a *prima facie* case for the view that if a person is considered autonomous then she is also responsible. Nevertheless, mainstream bioethics and liberal political opinion acknowledges limitations to responsibility for example in genetics (Levitt and

²⁶ The case was *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649, CA

²⁷ The UK ethics curriculum for medical students includes that students 'be able to demonstrate a critically reflective understanding of the rights and responsibilities of patients and possible justifications for limiting their rights' (Stirrat *et al*, 2010, p.57). There is no equivalent curriculum for UK nurses.

Manson, 2007), the neuroscience of decision making (Burns and Bechara, 2007), and the language of addiction wider than drug use (Foddy, 2011), whilst simultaneously promoting autonomy in the same persons. If patients are not held to account for their (allegedly) autonomously enacted health threatening behaviour then we must look further than moral agency to enquire why.

Obligation

Williams (2008) argues that philosophers usually discuss responsibility retrospectively, that is holding responsible, or consider the features of moral agency. Strawson's (1962) account is premised on the relationship between the agent and the response, and the technique of reflective equilibrium testing intuitions about clear cases. A clear case, for example tests intuition of, say a cat knocking over a vase. Our intuition tells us that we do not hold the cat responsible because it is not a moral agent. We have different reactive attitudes and to different extents if a small child knocks over the vase or if a passer-by twists her ankle and stumbles into it accidentally; we reserve full indignation for an autonomous person acting recklessly, or worse, maliciously. The attitudes we feel tell us something about what we think about the agency of the person or the circumstances of the action, whether there was coercion, or constraint or just bad luck, or whether the vase was appropriately protected by its owner. The purpose of these thought experiments is to test our intuitions about moral agency, but there is another explanation for a failure to experience the reactive attitudes; the act may be morally neutral, and this seems important in an attempt to apply the reactive attitudes account of responsibility to health care provision. Many people would fail to feel disapprobation against

smokers, not because they doubt agency (though they might), but because they think that there is nothing wrong with smoking.

We may conclude from this that the reactive attitudes approach to moral responsibility, notwithstanding Strawson's ontological claims, does not really help in understanding the social function of responsibility for health. Understanding responsibility as requiring an account is more appropriate in this context because it proceeds from moral agency to establishing what it is people are responsible for. Individuals owe an account for failing to meet an obligation, but not for acting in a morally neutral way. Responsibility for health requires obligation and this presents the major challenge to the use of responsibility in a social function, explaining the insipid telling of patient responsibilities seen in the NHS constitution and elsewhere (Royal College of Surgeons, 2005). The normative tension at the heart of professional health care is between respect for autonomy and responsibility.

Though the emphasis of autonomy in Anglo-American bioethics has been subjected to recent critique (for example Woods, 2007b; Walker, 2009; Varelius, 2006), it remains predominant (Gillon, 2003; Edwards, 2009), showing little sign of revision in at least its workaday understanding. Valuing, promoting and respecting autonomy above all else is in direct opposition with the notion of obligation. Dworkin (1988 p.41) states:

A moral theory that stresses the supremacy of autonomy will have difficulties with the concept of obligation. As the etymology suggests, to be obliged is to be bound. And to be bound is to have one's will restricted.

The result of this conflict can be seen throughout health promotion. For example in the health warnings on cigarette packets,²⁸ which are worded in terms of information giving, rather than direct appeals to the moral wrongness of smoking. Of the 14 messages printed on the back of cigarette packets, 11 are written descriptively, offering information, for example, ‘smoking clogs the arteries and causes heart attacks and strokes.’ Three are prescriptive. (i) Protect children: don’t make them breathe your smoke (ii) Smoking is highly addictive: don’t start and (iii) Get help to stop smoking: consult your doctor/pharmacist. At the risk of stretching the point a little, (i) merely obliges a smoker to smoke away from children, not to abstain altogether, (ii) is apparently addressed to non-smokers and (iii) obliges the smoker to get help, rather than stop. It has been argued that campaigns which set out to educate about health are, unlike other forms of education, evaluated not in terms of what people know, but in terms of how behaviour changes, because the purpose is an unacceptably morally loaded attempt to change health values to those of the educator (Allmark and Tod, 2007). The unresolved tension is between the giving of morally neutral information in support of autonomous decision making and the attempted revision of morally loaded values and associated obligations.

In the case of smoking these values lead to the view that health education should be directed at trying to get people to give up smoking, but a full rationale for the view that smoking is morally wrong is not offered. Butler’s (1993) account of the moral status of smoking is based on harm to others and this also was given as the rationale

²⁸ The list can be found in annex 1 of Directive 2001/37/EC of the European Parliament and of the Council of 5th June 2001.

for legislation prohibiting smoking in public places,²⁹ and could be offered for the child protecting injunction printed on cigarette packets. These other-regarding considerations are consistent with Mill's harm principle, placing justified restrictions on autonomy. But putting these to one side, whilst noting the beneficial effects to smokers and non smokers of banning smoking in public places (Meyers *et al.*, 2009), we are left with self-regarding reasons not to smoke, (or not to take drugs³⁰ or eat cream cakes), and it is here where the imposition of values threatens autonomous decision making. These values are based on a specific conception of health, normatively loaded but neither explained nor justified.

A further problem for 'responsibility for health' used in the sense of social policy, is that even if the issue of having obligations in a general sense in the current environment of valorising personal autonomy was accepted for other-regarding reasons, there remains the problem of identifying and justifying exactly what the obligations are and how they relate to a specific conception of health. A full understanding of 'responsibility for health' requires detailed acceptance of the concept of obligation and detailed justification for its determinative conceptions.

Holding responsible

Both the reactive attitudes and accountability versions of responsibility require engagement with our practices of holding individuals responsible. The reactive attitudes account appears to present problems for professional health care because

²⁹ See for example House of Commons Health Committee 2005, para 41 'The justification for the principle of a ban is straightforward: workers have a right to be protected from SHS (second hand smoke).'

³⁰ In the UK a longstanding radio programme asks guests to choose what records they would take if they were marooned alone on a desert island. They are also allowed a single luxury item. If the guest chose a lifetime supply of cigarettes and the means to ignite them would or should health promoters attempt dissuasion?

health care professionals are required by their professional bodies not to have the sorts of attitudes that Strawson claims are definitive of moral responsibility, even of its vicarious expression.³¹ The ontological nature of Strawson's claims (and see Stark, 2004) are in tension with the normative and regulatory demands made of health professionals, especially noticeable in nursing literature and regulatory documentation, for example concerning discrimination discussed earlier. Positive emotions, (Scott, 2000) even love (Stickley and Freshwater, 2002), towards patients are lauded in the nursing literature; negative ones are not though neither are fully under conscious control. Regarding the expression of emotion rather than its experience as the morally relevant feature may help but this seems to undermine a claim that (positive) emotions are to be cultivated. The NMC Code (2008) requires that nurses 'treat people kindly', and this similarly leaves unanswered the question of whether a nurse can treat someone kindly without being a kind person.³²

The accountability version of responsibility must engage with the question of if and to whom an account is owed. Just because it is fitting that a person gives an account, it does not necessarily follow that an actual account is required or justified (Smith, 2007), but if there is a reluctance to blame patients for their behaviour, this may be because of a narrow application of what blame means. Martin (2001) starts a wider categorisation of blame with the simple ascription of wrongdoing to someone who is morally accountable.

³¹ There are studies in the literature which have found these attitudes in nurses (for example Brown, 2006).

³² This is an expression of the familiar debates between act and agent centred approaches to nursing ethics.

It is the NHS which has told us, the public and its patients that we should take some personal responsibility for our health, and this is accepted by many. As the provider of potentially avoidable treatments, it seems consistent that the account is owed to NHS. If this were the case it would fall to health care professionals employed by the NHS to hold people to account, but this seems to fall outside the bounds of patient-professional relationship (Kelley, 2005). That is not to say that all moral evaluation of patient's behaviour is disallowed. Positive evaluation in terms of praise could form part of therapeutic relationship, but negative evaluation, that is blame, is not. This therapeutic version of the praise-blame asymmetry is the reverse of that observed in empirical studies (Nelkin, 2007; Hindricks, 2008). It would also be difficult for a nurse to accept an account from a recalcitrant patient knowing that she may bump into him in the smoking area; a problem acknowledged in the Prime Minister's Commission.

The area where tangible consequences³³ (liability blame in Martin's (2001) categories) for failure to meet health responsibilities is most plausibly defended is in the suggestion that persons with alcoholic liver failure be denied liver transplantation, or be prioritised lower in the waiting list than those whose disease was not caused by drinking. Though it can be argued that the disease of alcoholism restricts agency, holding responsible in this manner is defended (Glannon 1998) in certain circumstances (Brundy, 2007), or as a 'tie breaker' where other considerations are equal (Thornton, 2009). However, official guidance in the UK from the National Institute for Health and Clinical Excellence (2008) states that taking past behaviour into account is relevant only insofar as its continuation

³³ This is of course in addition to the health consequences of undertaking the risky behaviour (Harris 1995).

threatens the effectiveness of the proposed treatment. The forward looking nature of the official position supports a view that it does not amount to holding responsible, instead merely being one of several criteria that predict the effectiveness of the treatment. Even in this apparently clear case where the causal link between behaviour and disease is settled and the resource is absolutely rather than relatively scarce, the notion of holding patients responsible (at least in this way) is not allowed.³⁴

Conclusion

The discourse of personal responsibility for health is prevalent in the UK and elsewhere, and is set to remain as behaviour-related ill health continues its inexorable increase. The analysis I have offered breaks down the concept into three constituent parts; the agent, an obligation and a consequence, and I have argued that this overarching approach applies to each of the various incomplete conceptions found in the literature. Regarding responsibility for health as fulfilling a social function within professional health care is problematic in all three of these constituent parts, most significantly in its occasionally paradoxical relationship with personal autonomy, the respect and promotion of which remains the predominant moral imperative in Anglo-American bioethics. The analysis offered here remains largely at the conceptual level, and more detailed work is required in the application of the concept of responsibility for health to professional health care, both socialised and private. I suspect that this should and will result in a partial and tentative retreat from thoroughgoing respect for autonomy, but at minimum it will require a more nuanced public debate about what the healthy life consists in, how it ought to be

³⁴ For a useful and brief paper categorising the various arguments and counter arguments, see Sharkey and Gillam (2010).

maintained, and what obligations are owed to whom, for what reasons, and with what consequences. Currently responsibility for health is conceptually incoherent and if it is to retain its visibility in health policy, this is a situation requiring urgent remedy.

CHAPTER 6

What's wrong with tombstoning and what does this tell us about responsibility for health?

Abstract

Using tombstoning (jumping from a height into water) as an analogy, this paper claims that public health policies and health promotion tend to assess the moral status of activities following a version of health maximising rule utilitarianism, but this does not represent common moral experience, not least because it fails to take into account the enjoyment that various health effecting habits brings and the contribution that this makes to a good life, variously defined. It is proposed that the moral status of health threatening activities should instead be defined by a version of act utilitarianism where both maximising value and method of calculation are decided by individuals. In this account personal responsibility for health is reduced to the obligation to undertake calculations effectively, comprising of two duties; epistemic and reflective. If there is an individual epistemic duty, it is plausible to suggest that health promotion should present information in a way which facilitates it, but despite the prevalent language of autonomous choice, discussion of health promotion messages for example related to drinking and smoking demonstrates that this currently does not happen. Health promotion strategies should seek to encourage reflection about the harm our health effecting behaviour causes others.

Introduction

The practice of leaping from rocks or fixed man-made structures into the sea has been a recreational activity around coastlines for many years, but recent increasing frequency and fatalities¹ have brought it to popular attention. Organisations like The Royal Society for the Prevention of Accidents (RoSPA) and Royal National Lifeboat Institution (RNLI) have issued warnings and information films about the dangers and offer advice about how to minimise risks (RNLI, no date). There have been calls to ban the activity (Walker, 2007); temporary dispersal orders have been granted at least in part to prevent tombstoning (BBC 2011a), and a youth was charged with Breaching the Peace following a tombstoning incident which necessitated lifeboat rescue (BBC, 2007). Many videos of tombstoning can be found on video sharing websites, and it has been suggested that these should be removed or accompanied by warnings (Aiken, 2009).

It is clear that many people undertake tombstoning in its various guises, while others disapprove of it, and in some cases this results in attempts to discourage, prevent or punish tombstoners. This paper considers the moral status of tombstoning, and by analogy, other forms of health threatening behaviour, beginning by analysing the reported responses to a tombstoning accident. Three versions of its moral status are identified, all utilitarian in origin, and yet resulting in sharply contrasting conclusions because the utility calculations use different variables. Calls to disapprove of or to prevent tombstoning are consistent with a notion of responsibility for health based on health-maximising rule utilitarianism which does not represent the moral reality of tombstoners. An alternative act-utilitarian approach is advanced

¹ The Royal Society for the Prevention of Accidents (no date) state that in the five year period 2004 – 2008 there were 139 incidents which required rescue, including 12 fatalities.

using individually selected values and calculations. Responsibility for health, on this account, results in moral obligations in process rather than outcome, specifically two duties:² the epistemic duty and the reflective duty. These duties are outlined and their implication for public health discussed.

The case of Sonny Wells

Aged 20, Sonny Wells concluded a Sunday afternoon drinking with friends by ignoring signs stating ‘No diving – maximum penalty £500’ and jumping 30 feet off the pier at Southsea into just three feet of water. Pulled unconscious from the water and airlifted to hospital, his neck was broken in three places, and though surgical intervention restored feeling and movement to his hands, he remains paralysed from the chest down, permanently confined to a wheelchair. A week after the accident, his parents released photographs of him in the Intensive Care Unit as a warning to others (BBC 2008b), and the following month he appeared from his bed in a video, used by Hampshire Police to discourage people from tombstoning (BBC 2008c). Further videos featuring Sonny were made by the RNLI (no date) and the Dover District Community Safety Partnership (2011). Sonny’s mother is quoted as saying that:

[w]e know that we can't stop all youngsters and adults from tombstoning but if we can stop just a few of them from doing it then it would have been worthwhile. If they could see Sonny they wouldn't do it. It takes him half an hour to get dressed now instead of five minutes because he has to use his teeth (BBC, 2011b).

The chairman of the Dover Community Safety Partnership, which funded the video, is quoted in the same report: ‘We all must play our part in discouraging this dangerous and potentially fatal activity.’ These positions can be contrasted with that

² To paraphrase Goodin (1995), responsibilities are to utilitarianism what duties are to deontology. I have used the word duties because duties denote actions.

presented by RNLI and RoSPA. The websites of both organisations take the markedly different line that tombstoning is a high risk activity, and should be undertaken having taken steps to understand and minimise the risks. So, for RoSPA, the advice is:

Don't jump into the unknown. Consider the dangers before you take the plunge:

- Check for hazards in the water. Rocks or other objects may be submerged and difficult to see.
- Check the depth of the water. Remember tides can rise and fall very quickly.
- As a rule of thumb, a jump of ten metres requires a depth of at least five metres.
- Never jump whilst under the influence of alcohol or drugs.
- Check for access. It may be impossible to get out of the water.

Consider the risks to yourself and others. Conditions can change rapidly – young people could be watching and may attempt to mimic the activity. And, if you jump when you feel unsafe or pressured, you probably won't enjoy the experience (RoSPA, no date).

These statements are worthy of analysis because they express views about tombstoning from the viewpoint of those closest to it - from the parent, the tombstoner and the chairman of the local public body - rather than from professional bioethicists or politicians. The views about the moral status of tombstoning embedded within the statements are grounded in everyday experience, more closely allied to common-sense morality than moral or political philosophy. Archard (2011) argues that linkage of theory to common sense morality is inevitable, and that a defensible moral theory, which though 'at some distance from common-sense morality' (2011, p. 124) must at least be consistent with it. In arguing against the

view that philosophers can be considered moral experts,³ Archard claims that the role of philosophers should properly be that of advising or coaching non-philosophers, helping them to recognise the value of a better judgement. Brassington (2013) defends a role for philosophy and philosophical technique in bioethics, though recognises that it is charged that, ‘in respect of private activity, the input of a moral philosopher is mere moralising’ (p.22).

There is a significant difference between the outcome of a moral assessment and the process which arrived at it, as Archard points out, between the propositional and the performative. A philosophical analysis that refers to and builds upon reasoning by the actors concerned has the advantage of being readily understood and worthy of application; it is more coaching than moralising. However, grounding analysis in the common-sense morality of the protagonist is not a full inductive analysis, attempting to build a theory from the comments. Utilising a variant of reflective equilibrium neither builds nor applies theory; the aim is simply to show that established moral theory or at least more structured thinking is consistent with common-sense expressions.

The moral appraisal of tombstoning

It can be argued that everything that we do is a matter for moral appraisal, at least because we could be doing something else (Seedhouse, 2009). More realistically, the view that tombstoning is an act worthy of or even requiring moral appraisal is contained within Gert’s (2005, p.9) ‘correct’ view of morality which, following Hobbes, is simply that morality is ‘primarily concerned with the behaviour of people

³ But see Gordon (2012) for a response.

insofar as that behaviour affects others.’ Bernard Williams (1985, p.12) makes a similar point. If this is accepted then tombstoning is a moral issue to the extent that it affects others and the relevant question becomes, to what extent does it affect others? In the video produced by the Dover District Community Safety Partnership, Sonny said that:

[i]t’s not just what it does to you; it’s what it does to your family...your friends, and it’s just the way everyone has to live, you know...I have to have people on standby, on call, in case things go wrong. It’s not just my life that’s changed, their lives changed as well because it all revolves around me (Dover District Community Safety Partnership, 2011).

Sonny’s father Robbie Wells is quoted six weeks or so after the accident as saying; ‘It’s just selfish. It’s the impact on people around you, not just the injuries; it’s the years to come’ (BBC, 2008d). The advice from RoSPA and RNLI includes that the risks for others should be considered, identifying the possibility of setting a bad example to younger people as a special concern. These quotations support the view of tombstoning as a morally appraisable activity whose harms lie in its consequences especially insofar as they affect others.

Three moral positions

Illustrated by the comments above, it is possible to identify a number of different assessments of the moral status of tombstoning. The first would be that it is wrong and should be banned. Sonny passed a notice forbidding diving (BBC, 2008b) on pain of being fined a considerable amount of money, and his mother talked of ‘stopping’ people from doing it. Signs advising, (or requiring – it’s not always clear) patrons not to dive into swimming pools are common but this injunction does not apply to jumping in, feet first, an activity assumed to be safe enough into three feet of water from the edge of a swimming pool but not from a 30 foot pier. It is also not

clear whether the prohibition covers diving from the location of the sign or whether it covers the whole pier, including the end furthest from the shore where, though there will be other dangers, shallow water (the circumstance that injured Sonny) is not one of them. A ban on diving is not a ban on tombstoning itself, only jumping in a specified manner (head first) from that particular part of that particular pier. Other forms of prevention, such as erecting a barrier or other means of making unsafe jumping more difficult, do not appear to have been reported. The intention to prevent people from injuring themselves has apparently been treated as justifying the passing of by-laws, but as the foregoing nitpickery demonstrates, formulating both a law and its justification presents considerable difficulties, not least in the question of whether the harm is considered serious enough to warrant criminalisation at all.

The second position is articulated by the Chairman of the Dover Community Safety Partnership who, significantly, claims that individuals should be discouraged rather than stopped from this undertaking ‘this dangerous and potentially fatal activity.’ Detailed inferences cannot be drawn on the basis of the limited information available, but the statement is consistent with at least two understandings of the word ‘discourage’. The first is because of the potential harm caused, that tombstoning is a moral wrong, worthy of disapproval as well as discouragement, that is a position from tolerance.⁴ The second is that discouragement is merely prudential; in this case the discouragement is similar to that which discourages high risk financial investments. Given that the wrongness of tombstoning lies in its effects on others, I am inclined to assign the former interpretation. The third position is stated outright

⁴ This would be a paradigm example of tolerance generally understood as ‘putting up with what you oppose’ (McKinnon, 2006, p.3). Toleration requires disapproval and a failure to stop something when you could, but a more modest version might include a failure to attempt to stop that of which you disapprove.

by RoSPA and the RNLI, and amounts to saying that there is nothing wrong with tombstoning, as long as it is undertaken safely; and if the sensible advice offered is followed, the risk of possible adverse consequences can be minimised.

These three positions arrive at markedly different conclusions, though the moral methodologies share a significant feature, that is they agree that the wrongness of tombstoning rests in risk and occurrence of injury. It is not stated or implied anywhere that tombstoning is intrinsically wrong.⁵ These positions are all consequentialist positions. But a characteristic of the presentation of the morality of tombstoning as a consequentialist morality is that it has resulted in three different conclusions; that it is wrong and should be prevented, that it is wrong but should not be prevented, and that it is permissible.

Utilitarianism, public health, and private morality

It is widely recognised that the philosophical basis of public health is utilitarianism⁶ (Holland, 2007; Rothstein, 2004). But this is not to say that a single fully worked up utilitarian theory can be applied to all public health issues, calculations made, and (morally right) answers revealed, and though I assume that utilitarianism of one sort or another provides theoretical underpinning of public health generally, as well as

⁵ It could be argued that there is something intrinsically wrong with tombstoning separate from its consequences, that it is simply in itself, a worthless thing to do, but this will not be considered further here.

⁶ I do not wish to get bogged down in a dispute about whether the term 'consequentialism' should be used instead of the term 'utilitarianism'. There is considerable overlap between the terms and standardly utilitarianism is the paradigm case of a consequentialist theory. Foot (1985) regards consequentialism as what is wrong with utilitarianism, and Jacobsen (2008) argues that there is such a thing as non-consequentialist utilitarianism. In his entry in the Stanford Encyclopaedia of Philosophy, Sinnott-Armstrong (2012) states that '[...] there is no agreement on which theories count as consequentialist[...]' and though its broad meaning is known, shorn of specifying adjectives the naked term 'utilitarianism' is virtually useless as an action guide. I have used the term consequentialist to suggest that the wrongness of tombstoning rests in its consequences and thereafter I have used the term utilitarian as it is more likely to denote maximizing processes as I suspect that the term 'utilitarian' is more readily understood than the term 'consequentialist'. Certainly the term bioutilitarian appears in the bioethical literature but the term 'bioconsequentialist' generally does not.

the three positions on the moral status of tombstoning, it does not follow that tombstoning is a matter for public health ethical analysis at all.

The quotations at the beginning of the paper concerned what ought to be done about tombstoning rather than saying that Sonny had acted immorally, but it should not be inferred from the absence of public condemnation that tombstoning is regarded by those advocating regulation as morally permissible or that it simply is not a matter for moral appraisal. It is more plausible to infer an unstated view that tombstoning is regarded as morally wrong by those who attempt to prevent it. As I have argued, and as much as any other activity, tombstoning is a moral matter to the extent that it affects others, and this assessment of private morality should be prior to any consideration that it is a legitimate matter for public health intervention. In place of inferences and suspected moralism in transferring public health ethics into the private realm (and vice versa), it is suggested that private immorality is a necessary but not sufficient condition of something being subject to public health interventions of the sort that coerces behaviour to some degree.

At least two problems present themselves with this sequencing. First there is the possibility of genuine disagreement about moral status that can apply at the level of general rules of action, specified application of the rules, and anywhere in between. A simple view that regulations preventing tombstoning are not legitimate because tombstoning is a private matter could be rejected as question begging (Coggon, 2012). An attempt to make anything the subject of public health measures could be challenged with the response that the activity is morally permissible and therefore should not be regulated. There is not much unusual in this as political (and

philosophical) disagreement forms the daily backdrop to public health dilemmas, but it is enough to suggest a revision of the view that private immorality forms a necessary condition for something to be a fitting subject for consideration of public health measures. This revision would need to be of the form that a plausible defence of the view that something is immoral is required, and this must be supported by enough people so that political legitimacy for public health measures can be claimed. This might be considered imprecise but at the minimum, a defence of a moral assessment is required and this in itself would be a considerable advance.

The second problem is one of consistency of moral method. Because private morality assesses the moral status of something and public morality assesses the morality, generally, of preventing that something or a response to that something, they are doing quite different things. The moral methodology of public health ethics does not transfer into the private domain and though this may frustrate those seeking a single overarching moral theory, it is an understandable position for many who regard moral theory as secondary to moral practice (Sterba, 2005). Even if common morality is seen as being rooted in utilitarianism,⁷ the variant which I claim is predominantly used in public health causes problems when transferred to the private realm. The reason why utilitarianism arrives at such contrasting conclusions in the moral assessments of tombstoning is that two of the variables used in the calculations are different.

⁷ See Hooker (2000a) on Sidgwick's Common-sense morality, and Greene (2013) for a review of the empirical evidence for dual level utilitarianism.

Acts and rules

In the matter of health threatening behaviour, maximising calculations within public health ethics tend to operate at the level of rules rather than acts. There is reluctance for public health bodies to label (lawful) behaviours as immoral even as they attempt to reduce or prevent them. The reluctance to moralise or to override the greater (professed) good of respecting personal autonomy provides reasons why rules rather than acts are used because it allows the view to be both implied and inferred that it is tombstoning that is wrong rather than my acts of tombstoning or me as a tombstoner. The problem for anyone considering going to the pier in order to jump off it is that the rules that tell him that he ought not to do it are not his rules. The calculations have been formulated elsewhere by an unseen, unknown hand which has not taken his circumstances as much into account as they should have. The rule has been formulated, he might think, because people jump off the pier casually, after drinking, without checking the depth of water and the strength of the currents or who are improperly dressed or prepared. None of that applies to me – I'm dressed for it, I've researched the conditions and have come with support so that if an unforeseen event occurs I will be easily rescued. I'm not doing this on a whim; it's my main recreation, what keeps me going through the dreary week, the thought of gleefully flying through the air anticipating the invigorating shock of the cold briny sea. Who are you, he might ask, to tell me that I ought not to do it? His indignation will likely deepen when he realises that he's not being told, with justification, what he ought not to do, but rather what he must not do on pain of payment of a hefty fine. He's no anarchist – he really doesn't want to be in the position of considering breaking what he considers an unjust law, he just doesn't think it applies to him.

His utilitarian calculation (and I assume that he does one), differs in at least three ways from that used by those arguing from a public health perspective. First, it concentrates on each act of jumping, recognising that the advice from RoSPA has been followed so that the risks have not only been minimised but also to some extent quantified. It's not an exact calculation, but the binary calculation of risk, that is the likelihood and the severity of the general consequences can both be considered, without necessarily considering the consequences of the consequences, *ad absurdum*, which has been offered as an objection to act-utilitarianism (Streumer, 2003). Second, the calculation does what the rules cannot by allowing the individual to choose what to maximise, and then to perform the calculation using circumstances known only to him. When he has done these things he is able to give an answer not to the question of 'what is wrong with tombstoning?', but what, if anything, is wrong with me tombstoning from this place at this point in time, knowing these circumstances about my life. Third, the public health calculation concerns the outcomes of regulation, and not merely a moral appraisal of the regulated act or pastime.

The maximisation of health

Public health utilitarianism, including as applied to health threatening behaviour, maximises health generally. This health maximisation could be either from a position that health is of intrinsic value (in utilitarian terms that it is the ultimate utility to be maximised); or it could be a matter of pragmatic calculation because using an instrumental account that health is valuable only insofar as it enables or restricts other activities contributing to the overall good, however defined and measured is just too difficult to calculate in a rule utilitarian approach. I assume that it is more

likely to be the former, with health promotion tending to regard health in a narrow sense, largely physical, rather than within the World Health Organisation's famously all-encompassing definition. For example, a textbook aimed at nurses and health care professionals promotes not information facilitating autonomous choice, but has as a key message; '*Getting* people to change their lifestyle requires them to make unpalatable changes [...]' (Upton and Thirlaway 2010, p.19, emphasis added), and regards behaviour choices evaluatively: 'People in the UK have always drunk alcohol, sometimes sensibly⁸ and sometimes stupidly [...]' (p.107).

What does this tell us about responsibility for health?

It will not have escaped many who have read this far that the discussion about the instance of tombstoning and the associated responsibilities and views about moral status are analogous to other forms of health threatening behaviours, which constitute a significant threat to health and are subject to a range of public health measures of various sorts, including health promotion. An advantage of using cases is that they can be simple and emotionally engaging. Inferential reasoning, implied rather than stated can take the form of 'A did x which is commonly judged as a bad action with bad consequences; therefore a general maxim forbidding x is a good maxim' (Adapted from Spranzi, 2012, p.483). A further inferential move from the good maxim (of forbidding⁹ tombstoning) to more general responsibility for health requires an argument from analogy, a more complex and controversial technique (Macagno and Walton, 2009), common in bioethics and applied ethics.

⁸ The word 'sensible' also appears in UK government documents, for example, Department of Health 2010, p. 10.

⁹ To be clear, this is a moral maxim; forbidding means that tombstoning is wrong. It does not follow that it should be prevented or that sanctions should follow its performance.

The concept of responsibility for health forms a significant part of public health ethics. Discourse is frequently concerned with the notion of *personal* responsibility for health, and while philosophical analysis can bring clarity to the confused concept, much of the debate is political in nature. Despite its many ambiguities the concept personal responsibility for health forms part of the NHS constitution,¹⁰ and is accepted by a large number of people (King's Fund, 2004). There are three parts to responsibility for health (Snelling, 2012a): (1) a moral agent having (2) responsibilities and (3) liable to be held responsible in failing to meet them. This paper discusses the second part, responsibilities, and in doing so makes some assumptions about the nature of moral agency (the first part), and virtually ignores the third part (being held responsible).

Dworkin (1988) suggests that there is an essential contradiction between autonomy and obligation, and this is certainly the case where autonomy can mean simply the supremacy of personal choice and taking responsibility for health can mean doing what you are advised to do. However, the concepts of autonomy and obligation are not necessarily in conflict; the problem is that in this model obligations are defined by others. Obligations understood within an individual moral assessment augment rather than contradict personal autonomy, forming the process of moral decision making rather than the outcome, externally derived. The obligations are, principally, private obligations, and as the objections of the imagined tombstoner show, these are formulated in terms of acts rather than rules. In the private domain our responsibility

¹⁰ Under the heading 'Patients and the public – your responsibilities' the wording was initially: 'You should recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take some personal responsibility for it.' In the public consultation just concluded, the word 'some' is removed so that it reads '...and take responsibility for it.' The explanation is that this is a 'technical amendment – minor drafting change,' (DH, 2012), though a more significant reading could be made.

is to use act utilitarianism effectively, and this amounts to two duties: the epistemic duty and the reflective duty. These interrelated obligations form our responsibilities for health.

Epistemic duty

The epistemic duty is a duty to seek knowledge, to gather evidence, and at least on certain topics, a duty which stands in need of very little justification (Levy 2006). The epistemic duty requires moral agents to enquire about the likely effects that their behaviour has on their health and its purpose is to enable and facilitate the reflective duty.

Reflective duty (1): harms

The reflective duty requires an individual to place his health threatening action(s) in the context not only of his own life but also the lives of others affected by them. This includes family and friends but also the wider community if the behaviour has a financial or opportunity cost where there is socialised medicine. Several levels of reflection require consideration under this duty. The highest level requires deep reflection about the meaning of the good life and while the reflective duty encourages this it certainly does not require it. It does require, however, some consideration of the effect that health threatening behaviour has on others. The harms that should be considered fall broadly into three categories.

1. Direct harms resulting from the activity itself including injuring someone by jumping on him while tombstoning, or exposing others to second hand tobacco smoke.

2. Indirect harms caused not by the activity but by resultant ill health. These can be suffered (2a) by those immediately affected by poor health or death, like family members who are disadvantaged financially or who are harmed emotionally, and are also suffered (2b) by society generally through a number of mechanisms including in some cases opportunity costs *in lieu* of treatment.¹¹

Reflective duty (2): benefits

It should be noted first of all that there is claimed to be wide benefit in facilitating autonomous choice, and this is a reason why respect for autonomy has become so dominant in society generally and particularly so in bioethics. Gillon (2003) among others makes this point in defence of respect for autonomy being regarded as ‘first among equals’ in the principlist scheme. He explains that enjoyment of eating fatty food results in an autonomous decision to carry on eating despite knowing and agreeing that giving them up would ‘be better for me’ (p.310). He seems to mean here better for his health rather than better for him generally but it appears to be on the latter grounds that he determines to continue his indulgence of these ‘delectable’ foods. The reflective duty encourages clarity over the issues of benefit to avoid the error of conflating what’s good for health and what’s good more generally. Because these more general benefits cannot usually be described as ‘health benefits’ they are seldom taken into account by health maximising health promoters. When he was

¹¹ This might be more difficult to apply than might be thought. In a systematic review of the literature between 1997 and 2007, Allender *et al.* (2009) could find only two studies which calculate the financial cost of smoking related UK healthcare costs. Updating the figures, they suggest that these costs amount to £5.17 billion in 2005 – 6, compared with a figure, from the 2009 budget, of £8.1 billion raised in tobacco taxation, and a total NHS budget of £86.4 billion (H M Treasury 2009). Similarly, alcohol taxation raises £9 billion from alcohol receipts (Collis *et al.*, 2010) and alcohol harm costs the NHS approximately £3.5 billion annually (National Treatment Agency for Substance Misuse, 2013)

Secretary of State for Health, Dr John Reid caused a furore when he was reported as saying ‘As my mother would put it, people from those lower socio-economic categories have very few pleasures in life and one of them they regard as smoking’ (BBC, 2004). It is of interest that he is reported as saying that the rationale for his reluctance to disapprove is that individuals should not be patronised, but nevertheless it is a rare acknowledgement that people derive pleasure from smoking and drinking and eating, and in some cases this pleasure is more deep rooted, forming a part of character, desired or otherwise. See for example Oliver Reed’s quotation that ‘I don’t have a drink problem. But if that was the case and doctors told me I had to stop I’d like to think I would be brave enough to drink myself into the grave’ (Sellars, 2008).¹²

What might be considered an extreme case of the tensions between risk and pleasure is provided by the adventures of Andrew McAuley, who left his wife and small child on the Australian shoreline in December 2006 and paddled into the sea fulfilling a long held ambition to kayak unaided to New Zealand. Two months later he drowned, agonisingly close to reaching his goal. His widow, Vicki McAuley, wrote a book detailing their life together as well as the planning and execution of the expedition.

After paddling out of the bay, Andrew McAuley talks to a bow mounted camera:

I’m really worried I’m not going to see my wife again, and my little boy. And I’m very scared [...] I’m very scared. I’ve got a boy who needs his father [...] and a wife who needs a husband, and I’m wondering what I’m doing here. I’m wondering why I’m doing this, I really am. And I don’t have an answer. [...] People ask me why, and I love adventure (McAuley, 2010, p.6).

¹² His bravery deserted him in 1987 when he gave up drinking for a year because of kidney problems, but nevertheless he died at 61 from a heart attack, an acute episode of a disease known to be associated with high levels of alcohol consumption. There is a line between autonomous choice and autonomy-restricting addiction, and Oliver Reed probably stepped over it. This very important point is not considered here.

These examples of lives defined by adventure or hedonism do not extend to the millions of people smoking and drinking and eating more than recommended, but they do illustrate that these habits and many others which threaten health can contribute to a good life variously defined because they are enjoyable and self-chosen; something that health promotion aimed solely at changing behaviour fails to recognise. Kekes (2008, p.10) states the case eloquently:

Moralists forget that morality involves not merely a set of commands and prohibitions, but also the pursuit of an enjoyable life. No reasonable person can deny that we all have responsibilities, but it is just as important to recognise that enjoyment must be part of any life that could reasonably be called good.

Reflective Duty (3): calculations - act or rule?

A problem for the comparison of tombstoning with the more general targets of health promotion is that health promotion is formulated as rules, whereas the tombstoner more readily uses acts in his preferred utilitarian calculations. Although there are clear differences in how to calculate right action between acts and rules, Brad Hooker (2000b), who has advanced a detailed account of rule utilitarianism, concedes that in ordinary morality, not only are the outcomes often the same between act and rule utilitarianism, but also the versions agree on how, generally speaking, people should go about their day to day moral thinking. As Upton (2011) points out, we do best by careful deliberation on acts which require it, but that generally the familiar rules 'with which we have grown up' (p.435) serve as an effective starting point. Such deliberation results in the distance between act and rule utilitarianism being less significant in practice than might be expected, confirming that a kind of amalgam version is useful and workable as an action guide despite the apparently fatal objections to both theories operated alone.

It is difficult to be clear about what constitutes an act for the more common targets of health promotion. For smoking, and moving from the general to the specific, the act could be (at a pinch) being a smoker, or (just) smoking, or smoking a cigarette, or even taking a drag from a cigarette. It would be absurd to require a utility calculation before each drag or each cigarette, and in any case they would be identical and could lead to fallacious reasoning similar to the fallacy of the heap of sand or the fallacy of the beard (Clark, 2002): this drag on this cigarette won't cause me any long term harm, therefore neither will the next, nor the next...therefore smoking won't cause me any long term harm. Advocating act utilitarianism for smoking so that it is analogous to tombstoning requires the act to be conceptualised more generally, as the act of being a smoker; that is the thing (like a single act of tombstoning) that is harmful to health. This will apply to established smokers but a different calculus would apply to those who have never smoked or those who have smoked and given up but are vulnerable to restarting. In these cases the act of lighting or smoking a cigarette may lead to the individual (re)turning from a being non-smoker into a smoker (that is the thing that is harmful) and so the smoking of a single cigarette or perhaps a few cigarettes over the course of an evening assumes a greater significance here than for the established smoker. Arriving at a theoretical preference for the level of analysis is ambiguous between and within the practical cases of tombstoning and smoking, but accepting, with Hooker (2000b) that in practice the approaches are similar, leaves the basic tension unresolved. What is needed is a theory that can account for both levels of evaluation.

R.M Hare's dual level account

Häyry's view (in 1994) was that R.M.Hare's dual level account in his book *Moral Thinking*, offered the best solution to the debate between act and rule versions of utilitarianism. Generally we can be guided by the intuitive rules which constitute the first level of moral thinking, formed by experiences and moral emotions, but conforming to a version of general rule-utilitarianism. The second level, acts, requires critical thinking that has selected the set of *prima facie* principles for use in intuitive thinking, and also can be employed when the intuitive principles conflict. There is potentially some confusion as to the extent to which the *prima facie* rules need to be universalisable. If they are universal rules then the formulation will be of the sort that 'people shouldn't smoke', whereas an individual is more likely to formulate a rule in terms of whether 'he should smoke',¹³ or perhaps even (recognizing that this is problematic for utilitarianism) that 'he is permitted to smoke.' Hare's critical level equates act utilitarian calculations with that kind of rule utilitarianism 'which allows its rules to be of unlimited specificity and which therefore is not distinguishable from act-utilitarianism' (1981, p.43). For practical purposes it does not really matter at the critical level whether the agent specifies universal rules so that they apply to his circumstances, or takes an outright act-utilitarian approach, but both of these approaches stand in opposition to the rules generated by orthodox health promotion which are much more general in orientation.

What to maximise and how

Having reflected on the wider risks and the benefits of the act or the behaviour under consideration, utilitarian moral theories require that a calculation be undertaken,

¹³ Universalised, this might take the form of everyone in circumstances that are the same as mine should smoke (or is permitted to smoke).

placing the positive value of the act or behaviour against the potential harm that injury or death brings to those affected. The maximised value can be variously chosen; health, welfare, utility, preference or happiness, and while difficulty in calculation is acknowledged as a significant problem with all utilitarian theories, weighing up pros and cons of decisions, and not only in the moral domain, is a fundamental part of everyday life. It is clear what is meant when we say that all things considered this or that decision is better even though we would be hard pressed to show our detailed working out.

A problem with this is that if the decision making process cannot be articulated neither can it be scrutinised. In law, decision making processes can be challenged via judicial review which can find that decision making processes considered irrelevant criteria or failed to consider criteria which they ought to have done, but no appeal process exists in the reflective duty. It would be difficult to separate an objection, from a person whose objections matter, that the wrong conclusion (that I go tombstoning) has been reached, from an objection that the reflective process is inadequate (that the interests of my family have not been given sufficient weight). This might be a matter for discussion and potentially, blame, but ultimately it is a matter for the individual, similar to the question of what property should be maximised. Only a person at the centre of the decision knows his own thoughts and feelings and is much more able than a disinterested observer to judge the likely¹⁴ consequences of his action on those who are affected by it. An attempt to prescribe a decision making process is vulnerable to the same moralising critiques as prescribing actions, though the defence of moral expertise is probably stronger here. The

¹⁴ Likely rather than actual consequences. A critique of all forms of utilitarianism is that consequences are very difficult to predict. Empirical research can diminish the strength of the critique. See Lang (2008) on the cluelessness objection.

reflective duty requires a process of calculation and recognises that there are many ways to perform it. The choice and justification of maximising property and decision making procedures are matters for the actor, and he is accountable for them.

At the centre of her grief at losing her husband and father to her child, Vicki McAuley was quoted a week after his death as saying:

These are a few words that I'd like to say to my most wonderful man. To have the courage to pursue your dreams and believe that anything is possible is a rare gift [...]. You are our hero. You live for adventure. You've just had one incredible adventure this time, and we were with you all the way [...] Ant, you have taught me how to live (Chandler, 2007).

It would be easy to characterise his behaviour as selfish or reckless, and many would. But Vicki McAuley has not because she alone really knows what it meant to him, and what it would have meant for him to forgo his ambition. His epistemic and reflective duties were performed, and though the result was catastrophic, the decision was, as far as process is concerned, moral. Strawson's (1962) reactive attitudes account of responsibility defines the moral status of an act in terms of its provoked response, amply demonstrated in the anger of Sonny's parents and Vicki McAuley's pride; Andrew McAuley met his responsibilities and Sonny Wells did not.

Policy implications

Autonomy is (purportedly) valorised within western health care systems, and autonomous decisions need information, recognised by the need for sufficient information for valid consent for care and treatment. However, illustrated by the ready adoption of behavioural insight (Cabinet Office, 2011; Yeung, 2012), current practice within health promotion is not to facilitate the epistemic duty, but rather to present information in a way designed to persuade people to change their behaviour.

Unlike the process of gaining consent for treatment, the value of behaviour change, predicated upon the value of health, overrides the value of facilitating autonomous decisions. As Allmark and Tod (2007) have pointed out, health education, unlike other forms of education is evaluated not in terms of what people know but whether behaviour has changed.

For example, the strategy to reduce drinking is skewed away from education and towards behaviour change. Putting to one side the fact the evidence upon which the recommendations are based will be almost 20 years old by the time a review is completed (House of Commons Science and Technology Committee, 2011) current guidance, though written for a public audience, is difficult to interpret. A key document is 'Your drinking and you' (NHS, 2012), which gives the lower risk guidelines as 'No more than 3-4 units on a regular basis'. Clarification is offered for the word 'regular': 'Regular in this context means drinking in this way every day or most days of the week.' It is unnecessarily unclear why the daily allowance is given as 3-4 units with no indication as to whether it is 3 or 4 units. Of the 22 other countries used as comparisons in the House Of Commons Report, only Japan, the USA and Portugal (unofficially) use a range rather than a single daily amount. The definition of regular could mean four, five, six or seven days a week. None of the other countries has this ambiguity, and only Poland uses anything other than a daily or a weekly allowance. The guidance (p.2) goes on to state that if you are drinking just above the guidelines:

- Men are twice as likely to get cancer of the mouth, pharynx or larynx (part of the neck and throat), while women are 1.7 times as likely.
- Women increase their risk of breast cancer by around 20%.

- Men and women are both 1.7 times as likely to develop liver cirrhosis.
- Men are 1.5 times as likely to develop high blood pressure, with women 1.3 times as likely.

For even higher consumption the same categories, adjusted for increased likelihood are given. It is impossible for anyone to make any sort of risk assessment based on this information because the likelihoods of developing the diseases highlighted are given in relative rather than absolute terms.¹⁵ The figures are virtually meaningless, and in addition the consequences of developing the diseases are not given – my blood pressure may be higher, but what does this mean for my health? Calculation of risk requires both understanding of the likelihood and the consequences of an adverse event occurring.

Information in smoking cessation material is similarly skewed. While there is evidence that mass media campaigns have some success in smoking cessation (Farelly *et al.*, 2012; Bala *et al.*, 2008), the evidence about how the messages are presented is inconclusive. It has been recommended that preference should be given to negative messages (Durkin *et al.*, 2012) and there is some evidence to suggest that emotionally evocative advertisements work better than descriptive ones (Durkin *et al.*, 2009). Farelly *et al.*'s (2102) study lumped together emotional and/or graphic antismoking advertising and found this category more effective in quitting behaviour than comparison advertisements. The most recent UK advertisement¹⁶ graphically shows a tumour growing on the side of a cigarette as it is being smoked, and while this obviously reinforces the proven links between smoking and cancer at the group level, like the alcohol information discussed earlier, it does nothing to facilitate

¹⁵ A point given wider discussion in Fitzpatrick's (2001) celebrated polemic.

¹⁶ Available at <http://www.bbc.co.uk/news/health-20805059> (last accessed 3rd January 2014)

epistemic duty and therefore reflective duty, because risk cannot be calculated.¹⁷ Other recent advertisements have invited smokers to consider the effect their habit has on others, for example from 2009, the ‘scared and worried’¹⁸ campaign showed a boy explaining to camera what he was not worried about, but concluded with a shot of him with his father smoking a cigarette on a fishing trip: ‘[...] but I am worried about my Dad smoking. I’m worried that my dad will die.’ In an emotionally challenging way, this advertisement invites the reflective duty, more consistent with the responsibilities for health outlined in this paper, highlighting that the wrongness of the father’s smoking is in the pain expressed in the boy’s visible concern. In a similar vein, an advertisement from Australia¹⁹ shows a young boy of about 4, standing alone in a train station having been separated from his mother. His concern turns to distress and as his tears begin the narrator says: ‘if this is how your child feels after losing you for a minute, just imagine if they lost you for life.’

Although of interest, the reworking of mass media campaigns alone will not satisfy facilitation of responsibility for health as conceptualised by the epistemic and reflective duties. It would require a wholesale shift from ‘getting’ people to change their negatively evaluated behaviour to giving them information to enable an autonomous decision and encouraging them to consider the interests of others as they make it. The most that can be hoped for is that the Government and its agencies embark on a fuller justification of its strategies. This may mean a renewed commitment with explanation of the operationalization of the concept of autonomous

¹⁷ For a discussion on how these messages can foster autonomy see Barton (2013)

¹⁸ Available at <http://www.theguardian.com/society/video/2009/feb/18/worried-smoking-children> (last accessed 3rd January 2014)

¹⁹ Available at <http://www.youtube.com/watch?v=SfAxUpeVhCg> (last accessed 3rd January 2014)

decision making, and ways of encouraging a more morally reflective life, though this is clearly a much bigger issue than health promotion.

This is not to say that regulation and restrictions on unhealthy food availability, or tax regimes that increase the price of alcohol and cigarettes are necessarily unethical. Though something being a fitting matter for private moral assessment is insufficient for it being a proper subject for public morality, this does not mean that the public has no interest in behaviour affecting individual health. But at the very least the essentially private nature of these behaviours requires public health authorities to provide a full explanation for policy interventions seeking regulation. Something within the sphere of our individual influence being bad not for us, but our health, narrowly defined is not sufficient. Our behaviour causing direct harm to others probably is enough, though causing indirect harm probably is not. Financial reasons alone present further difficulties in calculation in a system of socialised medicine and these provide better reasons for some measures (tax) than for others (bans).

Conclusion (1): what's wrong with tombstoning?

The account that I have offered is more aligned to the approach to tombstoning advocated by RoSPA and RNLI, and the analysis of this paper shows that it is because it focuses upon and facilitates the epistemic duty. Whether individual cases of tombstoning can be regarded as morally permissible depends on whether the framework of facilitation offered has been followed, and whether there has been adequate reflective attention given to the facts. If they have, tombstoning is morally defensible. I say defensible rather than permissible because the reflection is subject to evaluation and therefore disagreement and so should be regarded as a necessary

rather than sufficient condition. A search for ‘people are awesome’²⁰ via the video sharing website YouTube further illustrates this. With very few exceptions, the people undertaking all manner of daredevil feats, tombstoning, base jumping, tightrope walking and extreme cycling are properly prepared and equipped, and it is assumed that what might be called this ‘professional’ approach implies that they have given the activity serious consideration. It is easy to accept the invitation to marvel at the skill, courage, enjoyment and sheer verve of the acrobats. People really are awesome. Contrast this with a search for ‘ultimate fails’.²¹ Amongst the assorted pratfalls, confused pets and distracted walking into glass doors are many examples of people falling off bikes and skateboards and hurting themselves. Like Sonny Wells, most ‘victims’ are ill prepared. There are few helmets or protective pads, and failure often is the result of laughingly inadequate preparation though onlookers’ initial mirth often fades with the realisation that serious injury may have resulted. What is wrong with tombstoning? Nothing at all, potentially.

Conclusion (2): responsibility for health

A change in emphasis from responsibility for health as following public health advice to a model of responsibility which instead requires private process is closer to the espoused predominant value of respecting autonomy. It will require the giving of information about health in a more neutral way to facilitate the epistemic duty. The major challenge is in the reflective duty, which becomes the principal personal responsibility for health. It will remain the case that decision making will be influenced by factors outside individual control, but these will be reduced by a more reflective approach to deciding what our individual good life consists in and how this

²⁰ For example <http://www.youtube.com/watch?v=hhKXsLFKYqc> (last accessed 3rd January 2014).

²¹ For example <http://www.youtube.com/watch?v=Ujwod-vqyqA> (last accessed 3rd January 2014).

impacts on those who share our lives. Our responsibilities, that is our obligations, will be more clearly identified but not by the state in various guises. It probably is the case that most of us do have moral obligations in respect of our health, and that they are largely unfulfilled. Insufficiently challenged weakness of will in the consumption of tobacco and alcohol and all manner of health threatening habits possibly are, for many of us, immoral. And though the end results are similar, the key difference between this conclusion and the similar, if unstated, one of orthodox health promotion, is that this account of responsibility for health is one of individual process rather than collective outcome. The only duties we all have in respect of our health are the epistemic and reflective duties, though other autonomy-compatible responsibilities will follow for many.

CHAPTER 7

Challenging the moral status of blood donation

Abstract

The World Health Organisation encourages that blood donation becomes voluntary and unremunerated, a system already operated in the UK. Drawing on public documents and videos, this paper argues that blood donation is regarded and presented as altruistic and supererogatory. In advertisements, donation is presented as something undertaken for the benefit of others, a matter attracting considerable gratitude from recipients and the collecting organisation. It is argued that regarding blood donation as an act of supererogation is wrongheaded, and an alternative account of blood donation as moral obligation is presented. Two arguments are offered in support of this position. First, the principle of beneficence, understood in a broad consequentialist framework obliges donation where the benefit to the recipient is large and the cost to the donor relatively small. This argument can be applied, with differing levels of normativity, to various acts of donation. Second, the wrongness of free riding requires individuals to contribute to collective systems from which they benefit. Alone and in combination these arguments present moral reasons for donation, recognised in communication strategies elsewhere. Research is required to evaluate the potential effects on donation of a campaign which presents blood donation as moral obligation, but of wider importance is the recognition that other-regarding considerations in relation to our own as well as others' health result in a range not only of choices but also of obligations.

Introduction

It is a commonplace that health, variously understood, is a good thing and that work to protect, maintain and restore it is therefore also good. The responsibility, that is the obligation, to meet the demands this principle requires falls to a number of individuals and organisations. In the UK, despite the discourse of ‘personal responsibility’ for health, moral, legal, and professional obligations to patients and the public rest principally with health professionals within socialised medicine. Where the notion of personal responsibility is referred to it is predominantly directed at individuals’ own health, offering self and other-regarding reasons for action. Self-regarding reasons take the form, to borrow Kantian terminology, of hypothetical imperatives; if you want to be healthy, you ought to undertake this action (or omit that action). Categorical imperatives are seen where reasons to protect an individual’s health are other-regarding, seen for example in health promotion messages which emphasise harm to others, commonly children, that ill health or early death of the individual brings.¹ Outside caring and professional relationships, the notion of legal and moral responsibility for others’ health is rarely seen,² and where it is, it requires omissions. Legislation to ban smoking in public places was justified in order to protect the health of others (Ferguson, 2011),³ recklessly infecting someone with HIV is a criminal offence⁴ (Bennett, 2007), and more

¹ A recent NHS advertisement has a boy explaining what he is not worried about. ‘But I am worried about Dad smoking. I’m worried that my Dad will die.’ Available at <http://www.youtube.com/watch?v=BmUtR8DcMAc&feature=related>

² I do not include the obligation to pay taxes which funds, in part, other people’s health care.

³ Smoking, Health and Social Care (Scotland) Act 2005; Health Act 2006. Justification for the legislation was the harm principle as reported in the House of Commons Health Committee report (2005), but see also Coggon (2009a, b, 2012) for a discussion of the ban applied to prisoners in Rampton Hospital where prisoners’ own health was also a factor.

⁴ See R v. Dica 3 A11 ER 593.

mundanely, patients are exhorted not to attend GP surgeries if they think that they are infected with swine flu.⁵

The question of moral responsibility to act for other's health is seldom addressed and I shall use the example of blood donation to argue that this responsibility is plausible in certain circumstances. Within the broader category of tissue and organ donation, it is possible further to distinguish types of acts and their moral statuses, from the obligatory to the supererogatory, and though the rule of rescue (McKie and Richardson, 2003) and family responsibilities apply and complicate in some instances of donation, they are seldom seen in one of the commonest donation acts: blood donation. Using publically available documents and communications material, this paper both analyses the moral status presented and offers an alternative normative account. I argue that hitherto, blood donation has been regarded in the UK and elsewhere as altruistic and supererogatory. I suggest that this position is wrongheaded, and instead that blood donation should be regarded as morally obligatory for two reasons. First the principle of beneficence makes donation obligatory where large health gains by recipients are accrued from relatively small costs from donors, and second, fairness and particularly the wrongness of free riding obliges those who would accept blood to give, or to offer to give it. The implication for advertisements and public awareness is discussed, but perhaps the most significant implication of this analysis is to increase the emphasis of the notion of obligation, challenging the predominance of individual autonomy in western bioethics.

⁵ The advice contained in the NHS leaflet was 'Do not go into your GP surgery or local accident and emergency department unless you are advised to do so or you are seriously ill, because you might spread the illness to others. Ask a flu friend to go out for you.' Available at http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_177903.pdf

Analytical framework

The analytical framework utilised in this paper draws upon two distinctions from the work of David Hume. First, the separation between the descriptive and the normative, the is and the ought, is maintained as far as possible, though in places the absolute distinction is difficult to maintain. Second, though not as celebrated as the is/ought distinction, Hume (2007 [1748]) also distinguished practical from theoretical philosophy.⁶ ‘Theoretical’ philosophy is concerned with explaining human nature, whilst the aim of practical philosophers is to explain to people what they ought to do, making

us feel the difference between vice and virtue; they excite and regulate our sentiments; and so they can but bend our hearts to the love of probity and true honour, they think, that they have fully attained the end of all their labours (Hume [1748], 2007 p.5).

In this quotation, practical philosophy is aligned more with the normative than the descriptive domain. The key feature is the difference between a reasoned philosophical exploration of the moral status of something, in our case blood donation, and the way that this is presented to those making donation choices. Theoretical philosophy, *inter alia*, open-mindedly selects and defends a theoretical approach, applies it to an issue, anticipates objections and considers alternatives. In contrast, A Humean practical philosopher presents arguments and conclusions seeking to persuade, to ‘excite the sentiments’, and ‘bend the heart’ of those to whom the message is directed. So in the analytical framework, the normative has at least two dimensions, the theoretical and the practical. Initially at least it is assumed that these two parts are consistent, allowing a normative position to be inferred from practical presentation, and also that a fully reasoned normative position should result

⁶ He actually uses the terms ‘easy’ and ‘abstruse’.

in practical presentation reflecting this view. The framework applied to blood donation addresses these issues:

1. *Descriptive*. This is primarily an account of why people donate and why they do not, analogous to Hume's theoretical philosopher.⁷
2. *Normative – theoretical*. This consists of an account of the normative status of blood donation; whether it is required, or supererogatory or merely prudential.⁸
3. *Normative - practical*. Communicative strategy principally takes the form of media advertisements. Embedded within the advertisements are messages; some subtle and some not so subtle about the moral status of blood donation. By their nature, the advertisements are a blunt tool, addressed to all; donors, lapsed donors, and non-donors. Communication with registered donors is more individually directed, by letter, text and via social networking media, and insofar as the purpose of television advertisements is to raise awareness widely, it is most usefully directed at non-donors, offering predominantly moral reasons for action, persuasive rather than deliberative in nature.

Application of these constituent parts differs between nations but there are also similarities, coordinated by the World Health Organisation (WHO), and I will use

⁷ I do not mean to suggest that individuals choose to donate or not to donate for reasons which are exclusively moral (Portmore, 2008). The issue is highly complex, influenced by many social and psychological factors. The Theory of Planned Behaviour suggests that moral values are influential in determining the attitudes and subjective norms preceding an intention to donate (Ferguson *et al.*, 2012), but it would be as significant an error to see donation exclusively in terms of moral reasons as it would be to ignore them altogether.

⁸ Some, notably those of the Jehovah's Witness faith, regard blood donation as morally forbidden, but I do not consider that here as I am interested in blood donation within a system of therapeutic use of blood and blood products which those who regard its use in this way stand outside.

their documentation in particular as it is consistent with, but wider than UK⁹ policy. To be clear; the paper concerns blood donation practice in the UK, though the analysis is transferable to some extent. The analysis is presented in two parts, each starting with what I take to be the ‘official position.’ First, descriptive claims are discussed and those made by the WHO are presented. It is argued that this position predominantly regards donation as altruistic, and this claim is tested and critiqued against a brief review of the empirical literature on donor motivation. Second, the presented moral status of blood donation is analysed. A full normative account is not offered by blood collection agencies in the UK, and so it is inferred from UK communication material which presents blood donation as an act of supererogation. An alternative account of blood donation as moral obligation is outlined, supported and illustrated by examples of communication material from blood donation in India and organ donation in the UK, both of which are plausibly transferable to blood donation.

Part 1: description

The ‘official’ position

In 2010 WHO published a framework for action with the aim of ensuring that 100% of donations are voluntary, phasing out paid and replacement donations (WHO, 2010). In using this document as my primary source, it is necessary to quote at some length:

A voluntary non-remunerated blood donor gives blood, plasma or cellular components of his or her own free will and receives no payment, either in the

⁹ There are separate organisations covering England, Scotland, Wales and Northern Ireland, though the English organisation also covers North Wales. Unless stated, references are to websites and documents from the (english) National Blood Service, part of the NHS Blood and Transplant Authority.

form of cash or in kind which could be considered a substitute for money (WHO, 2010 p.14).

The rationale for the emphasis on voluntary donation is primarily safety:¹⁰

Voluntary donors are recognized to be the safest donors because they are motivated by altruism and the desire to help others and by a sense of moral duty or social responsibility. They have no reasons to withhold information about their lifestyles or medical conditions that may make them unsuitable to donate blood. They are not placed under any pressure by hospital staff, family members or the community to donate blood and they entrust their blood donations to be used as needed, rather than for specific patients. The only reward they receive is personal satisfaction, self-esteem and pride (WHO, 2010, p.18-19).

Having identified voluntary donation as a consequentialist instrumental good, that is it is safest, the WHO goes on to claim altruism is what might be considered a fundamental principle:

A blood donation is a “gift of life” that cannot be valued in monetary terms. The commercialization of blood donation is in breach of the fundamental principle of altruism which voluntary blood donation enshrines (WHO, 2010 p.19-20).

It is claimed that donors give for altruistic reasons and out of a sense of social responsibility:

Voluntary blood donors donate blood for altruistic reasons and receive no reward except personal satisfaction in helping to save lives and improve the health of individuals they will never meet. While they choose to donate their blood out of a sense of social responsibility, recognition of the importance of their individual donations and appreciation by the blood service and wider community help to create a sense of belonging to a special group of people (WHO, 2010 p. 92).

But there is also recognition that donors have self-interest in giving:

¹⁰ This argument is derived from Titmuss' (1970) important work. Three arguments for the preference of voluntary donation are (1) Commercial supply reduces voluntary donation in the 'crowding out effect' (2) paid blood is inherently unsafe, and (3) there is a risk of exploitation and harm to poor donors who sell blood through economic necessity. Empirical evidence for these positions is scant (Farrugia *et al.*, 2010). For a more detailed examination of Titmuss's work, see Sykora (2009), and for a critique see Rapport and Maggs (2002).

Voluntary blood donors themselves benefit from health education and encouragement to maintain healthy lifestyles as well as regular health checks and referral for medical care, if needed. Provided that they receive good donor care when they donate blood, they feel personal satisfaction and self-esteem which provides a sense of social engagement and belonging that is recognized and valued by the community (WHO, 2010, p. 20).

These quotations are representative of compliant organisations. For example the UK Blood Transfusion Service (UKBTS), states simply that ‘All blood donors in the United Kingdom are non-remunerated volunteer donors’ (UKBTS, 2010), and the International Society for Blood Transfusion (ISBT) has the requirement for voluntary donation as part of its Code of Ethics, and the promotion of altruism as one of its aims (ISBT, no date). In the EU, directive 2002/98/EC of the European Parliament and of the Council required member states to encourage voluntary donation.¹¹

The ‘official’ position: a critique

There is a tendency both to conflate altruism with voluntary unremunerated donation, and to present it as a simple binary choice between the unremunerated and remunerated. Both of these tendencies significantly oversimplify, and the predominance of the claim to altruism is at the expense of two further positions which are nevertheless identified in the WHO (2010) report. First that blood donation is prudential and self-interested; that donors’ sense of satisfaction and the receipt of other benefits is and should be reasons to donate (*Voluntary blood donors themselves benefit from health education and encouragement to maintain healthy*

¹¹ The full text of article 20 of directive 2002/98/EC is ‘Member States shall take the necessary measures to encourage voluntary and unpaid blood donations with a view to ensuring that blood and blood components are in so far as possible provided from such donations.’ (see Farrell, 2006, for a review of blood safety in the EU).

lifestyles as well as regular health checks and referral for medical care, if needed (p. 20)).

Second, that blood donation forms part of a moral duty or social responsibility ([...] *motivated by altruism and the desire to help others and by a sense of moral duty or social responsibility (p18)*). A closer examination of this phrase reveals an important moral distinction. I will suggest that the tone of communication and the environment in which blood donation operates presents a predominant discourse of supererogation, by definition a non-obligatory act ([...] *altruism and the desire to help others*). However the second part of the sentence, preceded by the word ‘*and*’ suggests that donors also have a sense of duty or responsibility and both of these words involve the notion of obligation. The sentence appears self-contradictory. One possible explanation is that even though blood donors are the subject of the sentence, what is meant is that some blood donors see donation as supererogatory and some see it as obligatory. But if this is the case there is plenty of untaken opportunity to make it clear, and the WHO document refers to donors throughout as a single homogenous group. Noting again the descriptive nature of the claims and the absence of an unambiguous statement of the moral status of blood donation, a more plausible explanation is that the position is muddled and contradictory.

Free will or legitimate pressure?

In the light of extensive and continuing philosophical debate about the concept, it is noteworthy that the expression ‘free will’ is used; it adds nothing to clarify the term ‘voluntary’ or the claim that donors ‘...are not placed under any pressure’, and may obscure them. The ISTC code of ethics (ISTC, 2000) talks not of pressure but of the

absence of coercion, more defensible normatively and empirically. In comparison, procedures to obtain valid consent for examination and treatment (see Department of Health [DH] for example which uses the term ‘freely’), include the criterion that consent must be given ‘without undue influence¹² being exerted’ (DH, 2009b p.11). Blood donation organisations, for example the American Red Cross (no date), actively encourage the recruitment of other donors, influence from friends is given as a reason by a significant proportion of donors (Sojka and Sojka, 2008), and research has been undertaken to seek the best method of encouraging donors to recruit friends (Lemmens *et al.*, 2008). In making these observations about the language of statements made by different organisations, it is not claimed that subtle and contestable differences between the concepts influence, pressure and coercion were uppermost in the thoughts of either the writers or their intended audience, nor is it suggested that there is anything necessarily unethical about recruiting friends or allowing peer group and other pressure to influence potential donors. But there is a tension between the stated official position that blood donation is voluntary (of their own free will) and altruistic, and the recognition that undefined forms of pressure are effective, desirable and morally acceptable. Conceptually the claim to altruism appears simplistic; can it be supported by empirical research findings?

A very brief review of empirical literature

I do not offer a full discussion of the many empirical studies which assess donor behaviour and motivation. There are a number of reviews (Gillespie and Hillyer, 2002; Devine *et al.*, 2007; Masser *et al.*, 2008; Goette *et al.*, 2010; Bendall and

¹² Stewart and Lynch (2003, p. 600) report the legal case of Mrs U where undue influence requires ‘[...] something more than pressure’, but it is unclear whether the DH is using the phrase in a legal or everyday sense.

Bove, 2011) which discuss factors influencing behaviour. What these and other studies show is that the area is much more complex than Titmuss' altruistic model proposes, and this has been apparent for some time. In 1976, for example, Condie *et al.*'s US study showed that social pressure and degree of free rider tendency were more important motivators than altruism, and though much of the research since then has shown higher levels of altruism in donors, there are a number of methodological problems and potential biases in the research which is undertaken largely within systems assuming altruistic donation (Buyx, 2009).

Methodological problems reported by Bendall and Bove (2011) include a reliance on self-reported surveys which have the potential for social desirability bias. In contrast, an Iranian study (Maghsudlu and Nasizadeh, 2011) used physicians to decide on a single predominant donating motivation based on donor interviews and found that although altruistic reasons were the biggest group at 39.1%, almost as many (38.6%) were primarily motivated by self-regarding reasons, including perceived health benefits. In this study, undertaken in a religious society, religious beliefs accounted for 11.4% of donations. In the US, Gillum and Masters (2010) hypothesised that since blood donation is perceived as an altruistic behaviour, and religions commonly advocate pro-social behaviour, there would be a correlation between religious observance and blood donation. The data, when controlled for socio-demographic factors, provided scant evidence for their hypothesis.

Steele *et al.* (2008) noted that studies use different definitions of altruism and measure it in different ways. In their study, instead of asking donors why they donate, a large sample (12,064) of donors recruited at blood donor sessions

completed previously validated scales for altruism, empathetic concern, and social responsibility motivation. There was no significant difference in altruistic behaviour score between regular donors and those who subsequently lapsed. Older people had progressively higher scores on the altruistic measures, contrary to Maghsudlu and Nasizadeh (2011) who found that older people were more likely to donate for self-regarding reasons. Surveys often report different results than field experiments which test actual rather than declared behaviour. For example, surveys have predicted that incentives such as free cholesterol testing will increase donation rates, but this has not been confirmed experimentally (Goette *et al.*, 2009; Stutzer and Goette, 2010).

In Canada, Hupfer (2006) found that students identified more closely with an advertisement emphasising self-interest rather than altruistic messages and in one of the few UK papers, Fergusson *et al.* (2008) found in three studies that motivation was more benevolent than altruistic, benefitting both donor and recipient. They claim that, though subtle, the shift in emphasis is important because self-interest has not been highlighted in recruitment campaigns. Steele *et al.* (2008, p.51) concluded that ‘it may be time to try to appeal to self-interest as younger donors appear to respond positively to appeals that emphasize how donating blood may help them personally’. Research in this area has tended to be quantitative (Arnold and Lane, 2011), though it is recognised that qualitative studies can be useful in examining complex behaviour. For example, In a Spanish study, Belda Suarez *et al.* (2004) used discourse analysis and found that donors perceived themselves to be the same as other donors and non-donors, and only a minority attributed to themselves higher awareness and kindness; an image ‘fostered by the institutions responsible for

promoting donation' (2004, p. 1445). It is argued that presenting messages in this way may discourage some individuals from donating.

There are a great many difficulties and challenges in researching donor motivation, but for now I simply want to make the point that the empirical evidence is contradictory and complex, and fails to support the 'official' position, which acknowledges mixed motivations but is clear that predominantly donation is and should be altruistic.

Part 2: normative

The separation between the empirical and the normative seems quite straightforward in terms of factual claims and empirical research findings, though it presents greater problems in an analysis of the moral status of blood donation. This is because there is little in the way of 'theoretical' discussion from blood collection agencies. There is, however, 'practical' presentation of the moral issues involved in blood and other tissue and organ donations, and here I analyse some aspects of these, inferring the 'theoretical' moral position from the practical presentations.

The 'official position': supererogation inferred

The Donor Management Manual produced by DOMAIN (Donor Management in Europe¹³) states that:

'The effect on recruitment will most likely increase when the recruitment messages focuses on these factors.

- Donating blood is a good thing to do
- It generates social approval

¹³ DOMAIN is a European project that focuses on good donor management. Funded by the European Union, 18 blood organisations from 18 countries are members, including the four UK organisations.

- It can be easily accomplished: ‘yes, I can be a blood donor’(De Kort, 2010, p.90).

The strategy appears without an evidence base, but the prevailing view, that blood donation is a good, generating social approval is presented. The most recent UK¹⁴ television advertisement is described below:

A man stands at the gate of a primary school waiting for his daughter. They see each other and smile. An on screen legend fades in: ‘*Motorway pile up. Thursday 7.52pm*’

A woman is having her hair cut. In close up she is laughing. An on screen legend fades in: ‘*Chemotherapy starts Monday 10am*’.

A man holds an infant in his arms then gently places him in a cot. In a wider angle shot it is apparent that there are two cots in the room but the second cot is empty. An on screen legend fades in: ‘*Liver transplant. Next Tuesday 7am*’. The man wistfully plays with the mobile above the empty cot.

Narrator: Give blood and you can save someone’s life. Today. Please don’t leave it to someone else. Type your postcode into blood.co.uk.’

The screen fades to the NHS blood transfusion service logo over their strapline. ‘Do something amazing.’

The events that require blood transfusion are situated in the near future, and so potential donors can help the individuals by their actions.¹⁵ The everyday nature of the stories could also be designed with the aim of suggesting to the audience that they themselves might need blood. But the strap line ‘Do something amazing’ supports the WHO position that blood donation is altruistic and praiseworthy.

Supererogation, both as a concept within and outside normative ethical theories is underdeveloped and problematic. Urmson’s seminal essay ‘Saints and Heroes’

¹⁴ Available at <http://www.blood.co.uk/video-audio-leaflets/tv-radio-ads/>). This advertisement is not currently being aired but it remains available on the blood transfusion website

¹⁵ The previous campaign in the UK used celebrities who identified individuals who had helped them or a relative in the past. For example the chef Gordon Ramsay, says that ‘without this man I would have died from a ruptured spleen.’ (available at http://collection.europarchive.org/tna/20090605173026/http://blood.co.uk/pages/video_06.htm .

recognised that the tripartite categorisation of moral acts into the forbidden, the obligatory, and the permissible is ‘totally inadequate to the facts of morality’ (Urmson 1969, p.60), unlike regulation which operates exclusively within these categories (Nuffield Council on Bioethics, 2011). The problem, for morality if not regulation, is that the category consisting of permitted acts includes those of very different types, united simply by the properties that they are neither forbidden nor obligatory. The category includes acts that are amoral or trivially moral as well as morally good acts which exceed that demanded by obligation: the heroic act.¹⁶

Formally, the necessary properties of a supererogatory act are given by Mellema (1991, p. 3). An act is supererogatory if:

1. It is an act whose performance fulfils no moral duty or obligation
2. It is an act whose performance is morally praiseworthy or meritorious
3. It is an act whose omission is not morally blameworthy.

The relationship between the term and its necessary conditions is circular (Heyd, 1982) and the conditions apply to individual acts of donation more than donation in a general sense. Those whose donation requires overcoming needle phobia or forgoing something of value might, for example, be regarded as particularly praiseworthy. The principal concern here is whether blood donation is presented as morally obligatory or not and since this question forms part of an environment of supererogation the status of other elements are also of concern. There is little that addresses the normative question directly and so I propose to infer it from documents and presentations that are available and in doing so I offer two justifications for the

¹⁶ The webpage of the united States organisation ‘Blood centres for the Pacific’ is www.bloodheroes.com and the system of small rewards for donation in the form of tee shirts and restaurant vouchers is known as ‘hero rewards’.

logical sleights of hand which follow. First I return to Hume's two types of philosopher and suggest that the practical philosopher need not adhere rigidly to logical rules, for his purpose is to engage with an audience to whom the rules are largely unknown. Second I can dilute my claim a little so that instead of saying that the 'official' position is that blood donation is not obligatory, I can say that this position is consistent with the evidence rather than it is demonstrated by it. So with caveats in place, and with the intention to acknowledge the sleights of hand as they occur, how do the necessary features of supererogation apply to blood donation in the UK?

The first and third conditions share the important feature of being defined in terms of what they are not rather than what they are. There is no evidence that blood donation is considered obligatory, and none either that failure to donate is blameworthy. The sleight of hand here is to accept the absence of evidence for something as evidence of the absence of something. However, it would be surprising if there was a clear statement of a moral position in official documents because this is not their purpose, but also because there is a clear normative tension in UK healthcare practice between any notion of obligation and the predominant moral imperative to respect and promote personal autonomy (Snelling, 2012a).

The second condition presents a more difficult challenge. The criterion is positively stated and so some evidence must be offered that donation is praiseworthy. I do this by offering evidence that donation is praised, and that donors are regarded as an appropriate recipient of gratitude, 'generally the mark of supererogation' (Heyd, 1982, p.65). The sleight of hand here is to suggest that because an act is praised, it is

praiseworthy. Gratitude can be appropriately offered for things that we are required to do¹⁷ and care is required when inferring praiseworthiness that the stated praise and gratitude do not fall within the category of gratitude offered for an obligatory act.

Gratitude is a positive emotion ‘one feels when another person has intentionally given or attempted to give, one something of value’ (Bartlett and deSteno, 2006 p.139), and can be regarded in at least two ways (McCulloch *et al.*, 2001). First as an appropriate response to beneficent behaviour to the extent that it might be considered that this response is required in order to avoid being thought ungrateful and second as a motivator of pro-social behaviour. Recipients of blood might be expected to feel gratitude but unlike the gratitude felt and expressed by patients for the personal care they receive from staff caring for them (Mullin, 2011), or the gratitude felt towards known donors (Gill and Lowes, 2008) this cannot be expressed to the individual.¹⁸ However, gratitude can be felt and expressed by recipients to the pool of donors, and this forms part of the regimen of gratitude fostered by blood donation organisations.

In the UK, a video¹⁹ posted on the webpage of the NHS Blood and Transplant Authority (NHSBT) starts by offering thanks from the organisation. A maroon background is seen on screen with a bright red heart shape in the centre, with the capitalised legend ‘DEEPLY VALUED’. The commentary states: ‘Thank you for coming today and for giving blood and platelets. Your contribution is important and deeply valued.’ A later section shows a mother sitting with her daughter describing

¹⁷ Driver (1992) argues that it is possible for an obligatory act to be considered praiseworthy, and gives some examples to show that some obligatory acts are more praiseworthy than others that are supererogatory.

¹⁸ This is in contrast to acts of donation where the recipient is known or later identified, for example living kidney donation.

¹⁹ Available at <http://www.blood.co.uk/video-audio-leaflets/tv-radio-ads/>

transfusions required following childbirth. She contrasts those who give to family members, which might be expected or required, against those who donate to strangers. She says ‘I think that they’re really special people’, echoing the language of the WHO report. A further section shows the chief executive of the organisation talking to a donor of 140 units:

Thank you so much for coming along today. I understand you’ve made nearly 140 donations? That is fantastic. I’m so grateful because it’s through people like yourselves (sic) that Blood and Transplant is able to save so many lives, and without you we would not be able to do our job.

During the writing of this paper, I was in communication with NHSBT. I received a helpful e mail giving requested information. At the foot of the e mail the writer thanked me for the nine donations I have made, having clearly looked me up on a database. This is an example of the role of vicarious gratitude as an intended motivator of pro-social behaviour, more likely to induce a return to Ledbury Community Centre than pointing out that nine donations in 30 years of adult life is a pretty meagre return.²⁰ This is not a trivial point as it contributes to the general *milieu* of gratitude. Though the emotional gratitude expressed by recipients in the video is clearly of a different sort to that expressed by my e mail interlocutor and the Chief Executive, it would be a thin account of gratitude expression which regarded it solely in terms of a calculation to encourage repeated donation. A more plausible account is to regard the emotional response felt by recipients and the vicarious gratitude expressed as genuine responses to acts of perceived supererogation, expressed simply in the tag line of NHSBT: ‘Do something amazing.’

²⁰ And at the risk of expressing ‘shallow gratitude’ (Baumeister and Ilko, 1995) for the modest success of writing this paper, I am happy to thank and acknowledge him in return.

An alternative normative position

In this section an alternative account of the moral status of blood donation is advanced in two arguments; those from beneficence and justice. Examples of television advertisements utilising these arguments support the case that they are already familiar, though to different audiences or differently applied.

The argument from beneficence

The principle of beneficence is familiar to healthcare professionals because of its inclusion as part of the principles based approach to bioethics (Beauchamp and Childress, 2008). One perceived strength of the principles is that they can be derived from any of the major moral theories. This theoretical hedging is also a source of critique from Clouser and Gert (1990) who argue that the theoretical source of the principle of beneficence is Mill and utilitarianism. An act of beneficence is an act that helps others, but Beauchamp and Childress (2008) are clear that not all acts of beneficence are obligatory and though they take care to root their system in common morality, its purpose is to guide action within the special relationships that health care professionals have with those in their care. This relationship can make benevolent acts obligatory that would be supererogatory in common morality, and the same might be said for other special relationships, for example within families. As the blood donation video described earlier acknowledges, I am (ordinarily) obliged to care for and about my family in ways that I am not for my neighbour or a stranger (Smith, 1993). This seems to present a problem for an attempt to define blood donation or any other beneficent act towards strangers in terms of obligation. Peter Singer has attempted to reset the normative bar in a field that is similar in many

ways; charitable donation to developing countries. The formal expression of his argument is:

First premise: Suffering and death from lack of food, shelter and medical care are bad.

Second premise: If it is in your power to prevent something bad from happening, without sacrificing anything nearly as important, it is wrong not to do so.

Third premise: By donating to aid agencies, you can prevent suffering and death from lack of food, shelter, and medical care, without sacrificing anything nearly as important.

Conclusion: Therefore, if you do not donate to aid agencies you are doing something wrong (Singer, 2009, p.15-16).

The premises can be rearranged so that they apply to blood donation. The first can be restated as 'suffering and death from lack of donated blood are bad'. The second can remain as it is and the third can be similarly amended. The consequentialist calculation juxtaposes the benefit of donation against cost. In applying these premises, Singer (2009) recognises that the second is vague, but his discussion concerns a relatively small monetary sacrifice in return for a large gain in health for the poorest in developing countries. For example, he quotes a figure of approximately \$250 per life saved in a programme to prevent diarrhoea (Singer, 2009, p.89).

Some advertisements from across the world are robust in presenting an opportunity to help an identified individual as morally obligatory. For example, from India, a series of advertisements produced by BBC Media Action²¹ includes one about a girl

²¹ BBC Media Action is BBC's International charity. It 'is using media and communication to provide access to information and create platforms to enable some of the poorest people in the world to take part in community life, and to hold those in power accountable'
http://www.bbc.co.uk/mediaaction/what_we_do/governance_and_rights

with thalassemia.²² The advertisement does not specifically mention weighing of costs and benefits, but it obviously invokes an appeal to beneficence:

Daytime in a coffee shop. A man, about 30 sits alone reading a magazine. A girl, aged about 8, pretty, round faced with long black hair approaches. (After the initial greeting the script is reproduced from subtitles).

Girl: 'Hello Uncle'

Man: [*Smiles, puts down his magazine and turns to face the girl*]. 'Hellooooo.'

Girl: 'I wanted to say thank you to you.'

Man: 'Thank you! For what?'

Girl: 'Actually, you see I have thalassemia.'

Man: [*looks away, perhaps for a parent?*] 'Oh.'

Girl: And every month an aunty or uncle like you give (sic) blood and help me.' [*the camera cuts to the man's face. His smile is dropping*] 'But I don't know who they are. So, I say thank you to everyone. So thank you!

Man: 'But I have never donated blood.'

Girl: [*she wrinkles her nose*] 'Hmmm'. [*Pause. Then she smiles*] Never mind. Next time? Bye! [*she turns and walks away*].

Man: 'Bye'. [*His smile fades further and he watches pensively as the girl approaches another table*].

Narrator: Donate blood from the age of 18. You can save someone's life.

The screen fades to a picture of a hanging bag of blood, with the bulleted legend: 'You can donate blood every three months. Make sure it is a licensed and registered blood bank. Does not cause weakness.'²³

The final scene is of the girl now being held up by the man who is standing in front of a building. They are wearing different sets of clothes, so presumably this is after a donation. The man is looking at the girl.

Girl: [*smiling*] 'Try it!'

²² Available at <http://www.youtube.com/watch?v=fhoPEUXFcT4>

²³ Thanks to Dr Sabita Menon for the translation.

Man: [Turns to face camera] ‘It feels good’.

I am not suggesting that presentation of blood donation in this way is a central feature of the campaign. Other advertisements in the series present other perspectives, not least reassurance that blood donation does not cause weakness. The sleight of hand here is to attempt to transfer this advertisement from India to the UK, where blood transfusion services are very different. India aspires to voluntary unremunerated blood donation, but about 45% of blood for transfusion is collected from family or replacement donors (National Aids Control programme, 2007), and there are a number of web-based organisations which assist patients and their relatives in their search for suitable donors.²⁴ It is estimated that 50% of blood comes from paid donations, and only 5% of voluntary donors are repeat donors (Pal *et al.*, 2011). Ramani *et al.* (2007, p.259) state that ‘[...] blood-transfusion services in India are a highly-fragmented mix of competing independent and hospital-based blood-banks, serving the needs of urban populations.’ The Central Drugs Standard Control Organisation website²⁵ reports that there were 2517 licenced blood banks as of July 2011, of which 973 were government operated and 1544 were private, and Pal *et al.* (2011) estimated that in total, 34% of blood banks were unlicensed. The advertisement would have been seen only by those with access to television and who had a number of options for donation, including being paid and being directly asked by the girl’s relatives. This makes donation motivation and the relationship between donor and recipient significantly different than in the UK. However, the non-financial costs and benefits of donation are similar, and the arguments implied and

²⁴ For example, see <http://www.friends2support.org/>

²⁵ Using data from the Ministry of health and Family Welfare. <http://cdsco.nic.in/html/BloodList.html>

emotions shown in the advertisement are applicable elsewhere, albeit with slight modification, and so the advertisement is worthy of analysis.

There are similarities and differences between the UK and Indian advertisements. Costs to donors are not discussed in detail, so it must be assumed that these are understood by potential donors at least in broad terms; the mild pain and inconvenience and possibly feeling slightly unwell are placed against the benefit gained by the recipient, which is always significant and frequently lifesaving. Both invite donation to save an identified person's²⁶ life. The Indian advertisement thanks the donor (albeit mistakenly) retrospectively while the UK one looks to future donations. In the Indian advertisement, there is identification and focus on the donor, absent from the UK advertisement which focuses exclusively on recipients. Interestingly the final words in the Indian advertisement, spoken by the man are self-regarding, a reference to well-known phenomenon that individuals feel a sense of satisfaction after donation.²⁷ The significant difference is the suggestion from India, framed in the wrinkle of an innocent nose that failure to donate, for this individual, is blameworthy, that is donation is something he ought to have done.

The very notion of supererogation is a problem for consequentialism.²⁸ If greater overall benefit is obtained by donation, then that is what we ought to do. If greater

²⁶ And of course it is no accident that the individual is an appealing child. Singer (2009) discusses studies which show that the propensity to donate money is increased when the focus is on one rather than many beneficiaries, and of course the opposite effect was well known in perhaps apocryphal quotation attributed to Stalin; 'The death of one man is a tragedy. The death of millions is a statistic.'

²⁷ An advertisement feature from Florida includes an interview with a doctor who suggests that blood donors have a reduced risk of cancer. The suggestion is that blood donors tend to be individuals who also consult their doctors more often, but the clear implication is a causal effect between giving blood and reduced chance of contracting cancer. Even if a more generous interpretation is allowed, this film remains a direct claim of the personal benefits of blood donation. (available at <http://www.youtube.com/watch?v=8MNmeLaVLdM>)

²⁸ And for Kantianism (see Baron, 1987).

overall benefit is obtained by not donating then we ought not to do it. The supererogatory position presented by the UK advertisement, that donation is neither obligatory nor forbidden cannot easily be reconciled with consequentialist calculations, even of the everyday sort implied. Because of its everyday nature, theoretical precision in the definition of what is being maximised and how is not necessary especially as the balancing is clearly significantly asymmetrical; the asymmetry between costs and benefits also addresses a common objection to consequentialism, that it demands too much (New, 1974; Mulgan, 2001). Application of a broadly consequentialist approach regards blood donation as morally obligatory, recognised in the Indian if not the UK advertisement.

The argument from justice: the wrongness of free riding

Famously, Hart (1955) and Rawls (1971) argue, from fairness, that there is an obligation to contribute to collective goods that we benefit from, that is we ought not ‘free ride’ on the collective actions of others. The free rider argument is invoked elsewhere within bioethics, for example in the debates between Harris (2005) and Chan and Harris (2009) in favour, and Brassington (2007b, 2011) against, concerning obligation to support and participate in medical research, and also by John (2011) in the question of vaccination. Subtly different versions are applied in individual circumstances according to costs of contribution, and the nature and extent of benefit. An advertisement in the UK utilises the free riding problem in presenting organ donation as obligatory.²⁹

A woman about 45 years sits comfortably on her legs in an armchair. Her teenaged son is on the sofa next to her. She looks at him and smiles then turns her attention back to the television which is out of shot and from where

²⁹ Available at http://www.uktransplant.org.uk/ukt/adverts_and_video/adverts_and_video.jsp

comes the sound of laughter. The boy is also laughing. The camera focuses on his elbow; he absentmindedly scratches it and when he removes his hand an intravenous cannula is revealed.

Commentary: *If someone you love is offered a lifesaving organ, what would you do?*

The boy's breathing becomes laboured and he coughs. A drip stand appears behind the sofa and a bag of intravenous fluid appears connected to the cannula. The mother watches the television apparently unaware of the transformation.

Commentary: *Nothing?*

The boy's hand rests on the sofa arm. Its colour changes from pink to grey. The fingers become clubbed.

Commentary: *Nearly all of us would take an organ but most of us put off registering as a donor.*

In close up, his healthily bright eye becomes, after a weary blink, bloodshot and dilated. He sinks back in the sofa rubbing his face unveiling oxygen cannulae and the paraphernalia of acute illness behind him; oxygen bottle and bleeping monitors. His mother turns to him and her smile fades.

Commentary: *If you believe in organ donation, prove it.*

Screen legend: Three people who need a transplant die every day.

Commentary: *Register now.* [on screen is a screen capture of www.organdonation.nhs.uk The cursor moves to the on screen button marked 'register now']

Organ donation provides a singular case of the free riding problem. Specifically the contribution requested by the advertisement is simply that individuals sign up to the organ donation register, but despite the provisions of the Human Tissue Act 2004,³⁰ which state that removal of organs for transplantation is lawful if the deceased gave appropriate consent (for example via the organ donation register), in practice permission is required from relatives (Institute of Innovation and Improvement, 2010, and see Shaw, 2012). Where consent of the patient to post mortem donation

³⁰ And the Human Tissue (Scotland) Act 2006.

has not been given because, for example, in common with 70% of the population, the organ donor register has not been signed, he can avoid being considered a free rider if his relatives consent to donation on his behalf.³¹ Alternatively if while alive the potential donor has avoided free riding by signing the register, this can be overridden by his relatives refusing donation and in this case the accusation of free riding might be more justly aimed at the relatives. Genuine free riding in this case would be restricted to those who would accept an organ but have ensured that their wish not to donate an organ is known and therefore likely to be acted upon.³²

It has been argued to derive an obligation to contribute from the fact of obtaining a benefit commits the is/ought fallacy (Hardin, 2007), and further standard objections to the wrongness of free riding are provided by Nozick (1974). The strongest objection is to systems enforcing contribution, but this is not the case either for blood or organ donation.³³ A further objection is the cost to an individual in doing his share must be outweighed by the benefits of the actions of others. The cost/benefit ratio differs between organs, blood and other acts of donation, and benefits are stratified. Almost everyone benefits to some extent from the system of blood and organ donation. Though only recipients receive life saving benefits, these are dependent on the existence of the system of potential benefits and so they require the lesser benefit to many, and the lesser benefit to the many exists only so that greater benefit to a few recipients is possible. So when calculating benefits to the individual

³¹ The free riding of the dead person is retrospective, that is the claim is that he would have accepted an organ.

³² It is this latter provision which forms the minimal normative expectation in the NHS Constitution (DH, 2009a) 'You should ensure that those closest to you are aware of your wishes about organ donation'.

³³ A thin version of this would be presumed consent, currently in force in some countries and being introduced in Wales (Edwards, 2008). True enforceability would mean removal of organs even in the face of refusal to consent from relatives and prior to death from the deceased. This is seldom suggested; but see Fabre (2006).

of the collective system, it makes no sense to consider only actual benefits to the many. The gain to individuals must be assumed to be derived from potential rather than actual benefit, and since this is significant, the cost/benefit objection is met. Nozick also objects that it is wrong to give benefits to patients and then demand payment; that is moral obligations cannot accrue in lieu of unrequested benefits. It is the case that individuals do not ask for the potential benefit of blood or organ receipt, but this is not so where individuals seek and consent to receiving organs or blood. Nozick's objections to the principle of fairness, particularly the need to avoid free riding can be answered.

Despite the singularity of its application to organ donation, it is clear that the free rider argument is used in the advertisement. Though the actual words are expressed in the hypothetical, 'if you believe in organ donation...' this is nearly everyone. The normativity is unambiguous; you *ought* to donate your organs. There are differences between the application of the free rider problem to organ donation and blood donation, not only in the calculations for cost and benefit but also in process, principally because of the nature of contributing an organ post mortem and the decision making processes involved. Blood donation is closer to standard accounts of free riding (Cullity, 1995), complicated by stratified benefit. However, there do not appear to be any material features of the system of blood donation to distinguish it from the system of post mortem organ donation such that the free riding argument applies to the latter and not the former.³⁴ If this is the case, then it is concluded that if

³⁴ In order to prevent free-riding Jarvis (1995) offered the 'modest proposal' that only those individuals signed up as organ donors should be eligible to receive them. A more modest version of this modest proposal, that those willing to donate should be prioritised for receipt (Eaton 1998, Trotter 2008) avoids the potential to waste organs, and has attracted, in the US, some public support (Spital 2004), and was enacted in Israel in 2008 (Lavee *et al.*, 2010).

the need to avoid free riding is a reason to make organ donation morally obligatory, it must also make blood donation morally obligatory.³⁵

Arguments extended

In contrast to the ‘official’ position, I have examined two familiar arguments that blood donation is a morally obligatory act. The first based on the duty to assist others applies to all adults, and the second, based on the moral obligation to avoid free-riding applies only to those who would accept blood. Both of these arguments rely, though in different ways, on weighing up costs and benefits. For the broadly consequentialist beneficence argument, this calculation includes benefits for others, and for the free-riding argument, in order to meet Nozick’s objections, the calculation is restricted to self-regarding benefits. Both of these arguments can be applied to donation of other tissues. For beneficence, acts become less obligatory and increasingly supererogatory as the costs and risks to the donor increase. The free rider argument will not apply where the donor has no chance of ever being a recipient, for example, sperm donation. The level of normativity can be represented on a table (see table 2, pp. 224-5) where acts are more obligatory at the top and more supererogatory descending down the table. The table is for illustrative purposes only and the ordering is open to challenge, but as a heuristic device it is helpful in stratifying calculations. It is consistent with the view (O’Neill, 1996, p.207-208) that supererogation ‘...is measured by that which is required: *in supererogatory action the ordinary measures of duty rather than the categories of duty are exceeded* (emphasis in original). On this account, different acts of donation amount to different

³⁵ There is heightened interest in the concept of solidarity, and the arguments from beneficence and justice that I have offered could be presented within this framework. Further analysis is warranted elsewhere (see Reichlin, 2011; Prainswick and Buyx, 2011).

amounts of the same thing, rather than different kinds of things. The question is at what point on the scale does donation change from being obligatory to supererogatory. At present, the ‘official line’ appears to be drawn between post mortem organ donation and blood donation, and the argument of this paper is that it should be drawn lower, at least under blood donation, and probably a lot lower than that, and especially where the need to avoid free riding applies.³⁶

There remains the question of the specific features and extent of the obligation to donate blood. Clearly, ought implies can, and so the obligation cannot apply to those who have received blood³⁷ or, for example, have had a tattoo in the last four months.³⁸ The obligation is to give blood if you can, or to offer to give blood. To say that you ought to give blood is to suggest a number of distinct obligations (Zimmerman, 1996). Since it is more than sixteen weeks since I last gave blood, ought I travel to Gloucester to give again, or can it wait until the mobile unit comes to my small town next month? What if on that day I cannot attend because I have promised to take my neighbour to visit her sick relative? I would say that it is clearly a moral ought rather than a non moral ought, but beyond that there is no need for further analysis here. There are many contingencies and the normativity of each potential act of donation must be evaluated in the light of its circumstances. My analysis concerns being a blood donor generally rather than considering each

³⁶ In the US in 1978, a man dying from leukaemia asked a judge to compel his cousin to donate bone marrow to save his life, and in refusing the request the judge left the cousin in no doubt that his refusal was ‘morally indefensible’ (Steinbock, 1980). Regarding the act of donation of bone marrow as an obligation presents some difficulties, not least because, as in this case, of the complications of the Rule of Rescue (McKie and Richardson, 2003) and family obligations.

³⁷ The full list is available at <http://www.blood.co.uk/can-i-give-blood/who-cant-give-blood/>

³⁸ It would be going too far to suggest that you ought not have a tattoo because it interferes with your opportunity to donate.

opportunity or act of donation.³⁹ Following Zimmerman (1996)⁴⁰ the obligation is best regarded as *prima facie*, but in any case the importance of the arguments presented rests in their conclusion that blood donation is obligatory at all rather than in any specific sense.

Advertisements, nudges and a threat to the framework

The most important purpose of an advertising campaign is to increase and maintain the numbers of donations. Eligible individuals can, of course, decline to give blood, but the temptation to make it clear that they are not acting in a morally acceptable way must be tempered by the possibility that this will be widely regarded as moralistic rather than moral, reducing rather than increasing donation. In this case it would be a plausible position, though apparently paradoxical, to maintain that on consequentialist grounds blood donation is morally obligatory, but that advertisements should continue to present it as supererogatory. This would present some problems for the analytical framework utilised in this paper

First, the assumption that there is, or should be, consistency between the theoretical and practical expression of the moral status of blood donation is challenged questioning the normative inferred from the descriptive. However a critique of this method and findings does not invalidate the ‘alternative’ moral status of blood donation which can stand outside the framework if necessary. A more serious critique would be that focussing on the most effective presentation renders an analysis of moral status of donation redundant. Nagel (1970) perceived ethics as a

³⁹ This analysis will differ for different acts of donation. Signing up to the bone marrow donation register will be of little value if I find a trivial reason not donate on the one occasion in 20 years when I am asked to make good on my intentions.

⁴⁰ Who followed W.D. Ross (1930).

branch of psychology, but even if the relative importance of moral philosophy was to retreat in the face of insights from psychology and neuroscience, it does not follow that philosophical analysis is of no value at all.

In other fields, negative marketing has been found more likely to result in self-protection and inaction (for example, Brennan and Binney, 2010) and studies cited earlier suggested that advertisements should emphasise self-regarding rather than other regarding reasons to donate. The role of psychological framing is influential; popularised by Thaler and Sunstein's (2009) book, 'Nudge' which has become 'an instant classic' (Coggon, 2012, p.12), behavioural insight has become an important part of UK public health policy⁴¹ (Cabinet office, 2010; 2011), claiming some success in, for example, required choice for organ donation, and reducing missed appointments by simple behavioural interventions (Cabinet Office 2011, Martin *et al.*, 2012).⁴² Despite the claims made for framing, a recent review by the Cochrane Library (Akl *et al.*, 2011) found very little evidence of its effectiveness.

Further research into the practical applications of framing and nudging applied to blood and organ donation may yield interesting and useful insights. However, though important, the significance of TV advertisements and other public presentation is not restricted to the narrow matter of procuring the most blood.⁴³ Placed in the wider

⁴¹ According to the Cabinet Office (2011, p.4) the cabinet office team has 'strong links' to Professor Richard Thaler, co-author of 'Nudge'.

⁴² There are however, differences in the stated motivations between its theory and practice. The UK Government's aim is to find 'intelligent ways to encourage, support and enable people to make better choices for themselves' (Cabinet Office, 2011 p.9), which sits uneasily with Thaler and Sunstein's (2009, p.40) view that 'framing works because people tend to be somewhat mindless, passive decision makers.'

⁴³ There are seldom media stories explaining that treatment has to be curtailed because of insufficient supply, so it is assumed that despite occasional pressure the current system, including the advertisements, meets the needs placed upon it, though blood donation organisations would doubtless prefer the problem of having too many donors rather than too few (Carter *et al.*, 2011). As I write this there is some concern about the potential for shortages over the olympic summer resulting in more targeted approaches to individual donors.

context of the role of autonomy and choice related to health enhancing and threatening behaviour, highlighting the normativity of blood donation could serve to emphasise the general notion that health is a legitimate matter for public concern, and that other-regarding considerations in relation to others' health as well as our own result in a range not only of choices but of obligations. As I have shown, presenting donation in this light is already a feature of blood donation advertisements overseas, and organ donation advertisements from the UK.

Conclusion

Western bioethics reveres personal autonomy and its facilitation above all else. However, if the concept of responsibility for health is to be meaningfully operationalized in an age of alarming increase of lifestyle induced ill health, the notion and extent of obligation must be defined, justified and defended. This remains problematic for self-regarding reasons for action, more so for normative consideration of other-regarding acts which are seen as mere supplicants at the feet of the personal autonomy god. I have argued that individuals have other-regarding responsibilities for other's health, where the cost is small and the benefit large, and where the imperative to avoid moral free riding is clear. Blood donation is a paradigm example of pro-social behaviour which has hitherto been regarded and presented as altruistic and supererogatory. However, application of arguments from beneficence and justice challenge this established moral status, recognised in part by somewhat inconsistent communicative strategies. Offering blood for donation for the benefit of others is a moral obligation, and in the absence of evidence of an unintended deleterious effect, this should be made visible and unambiguous in public discussions, documents and advertisements

Table 2. Costs and benefits of acts of tissue donation (overleaf).

Table 2. Costs and benefits of acts of tissue donation

Act	Costs to donor	Benefits to recipient	Free rider argument?	Notes
Samples for research	Very little. Time perhaps, or minor tissue extraction. Or perhaps no cost at all.	New drugs and treatments improve treatments	yes	
Cadaveric organ donation	Thinking about mortality. 10 minutes to sign register with regular updating, and discussion with relatives.	Organ donation saves (heart) and improves (cornea) many identified lives.	Yes. Presented in advertisements	17,751,795 people on organ donation register. ¹ Official NHS position – obligatory. Consent rate 65% ²
Blood donation	About an hour of donors time Slight pain around needle site Occasional transient feeling slightly unwell	Many lives saved and morbidity improved Wide indirect benefit from knowing that blood is available if needed	Yes.	1.4m donors in 2010 ³ 2m units donated.
Platelet donation	More frequent donation than blood. Requires connection to apheresis machine. Takes approximately 90 minutes.	Lifesaving and life prolonging	Yes	14500 platelet donors ⁴

¹ March 2011 figure <http://www.organdonation.nhs.uk/ukt/statistics/statistics.asp>

² http://www.nhsbt.nhs.uk/annualreview/pdf/nhsbt_annual_review_2010-2011.pdf

³ http://www.nhsbt.nhs.uk/annualreview/blood_components/

⁴ June 2012. Personal communication from Gareth Humphries, NHSBT.

Bone marrow donation (stem cell donation)	Registering as a donor If required, daily injections for five days followed by collection via blood. A few days time needed for donation. Occasionally a minor procedure under general anaesthetic	To an individual recipient – chance of cure from an otherwise fatal disease.	Yes.	More than 770000 on registers. 750 donations to unrelated recipients in 2009. ⁵
Egg donation	Minor procedure involving general anaesthetic, some pain	Potentially life changing to childless couples	No	1258 donors in 2010 ⁶
Sperm donation	Weekly visits to clinics, tests, interviews Possibility of offspring contact after 18 years	Potentially life changing to childless couples	No	480 donors in 2010 ⁷
Live organ donation	Major operation Possibility of needing both kidneys later (e.g. trauma to remaining kidney). Risk of death in operation (1 in 3000 for kidney donation ⁸)	Potentially lifesaving to identified recipient	Not at present. A narrower argument from reciprocity may apply.	1045 living donations in 2010. 60 altruistic donations (including paired donations) ⁹

Note:

This table is for illustrative purposes only. It has not included benefits to donors, such as the ‘warm glow’ of altruism. Donation of bone marrow and live organs to relatives may have special value to donors.

⁵ http://www.nhsbt.nhs.uk/pdf/uk_stem_cell_strategic_forum_report.pdf Existing registers are to be amalgamated into a single register managed by the Antony Nolan trust

⁶ <http://www.hfea.gov.uk/3411.html> includes both those who donate all their eggs in a treatment cycle (non-patient egg donors) and those who share their eggs with up to two recipients (egg share donors)

⁷ <http://www.hfea.gov.uk/3411.html>

⁸ http://www.organdonation.nhs.uk/ukt/how_to_become_a_donor/living_kidney_donation/pdf/living_kidney_donation.pdf

⁹ http://www.nhsbt.nhs.uk/annualreview/organ_donation_transplantation/focus_living_donation.asp

CHAPTER 8

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

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.

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-affecting 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 (NHS, 2013a, p.11).¹

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'

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 wellbeing, and take some personal responsibility for it' (DH, 2009a). 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.

(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 wrong² 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-affecting 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 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

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 (Keogh, 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.

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 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

³ See also Schafer and Ferraro (2011).

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 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 (2013a, 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 relate to 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 nurse⁴ 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.

⁴ <http://www.bbc.co.uk/news/health-25549054>

Moral agency

Unlike the issue of capacity for decision making, which in practical application at least requires a 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 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-affecting 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

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.

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 compatibilists’ 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, 2014a).

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) 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.

⁷ For example <http://www.who.int/suggestions/faq/en/>

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-affecting 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.

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 incompatibilism, a position that is reversed when concrete emotional examples are used in experiments (Nicholls, 2011). It is also argued that incompatibilist intuitions are explained by errors in popular understanding of what determinism is (Murray and Nahmias, 2012), which, when addressed result in compatibilist 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

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

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-affecting 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, 2014a). 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.

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 feelings 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, 2011b) others from doing what Sonny had done, and his father spoke of Sonny's 'selfishness' (BBC, 2008d) 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 moralism⁹ (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 undertaken in pursuit of an individual notion of the good life. Or at least I would hope that it is. If I found

⁹ In a similar vein, Watson (2013) discusses judgmentalism, but points out that nonjudgmentalism can be considered a vice.

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, 2014a). 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

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)

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 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) (Williams, 2013, p. 11).

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 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).

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 consistency¹² within if not between relationships. The concern that I would feel would proceed to a stronger and considered remonstrance 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 makes 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

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/>

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 educate

others (BBC, 2008d) 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 and 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: 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 health¹⁵ though currently policy is that this cannot be considered. Public attitudes have been reported in favour.¹⁶ As well as identifying procedural problems, Harris (1995) argues that this would constitute double jeopardy by

¹³ According to the Health and Social Care Information Centre (2012) 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, no date). 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.

¹⁶ For example in the US Gollust and Lynch (2011), and see Bowling (1996).

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: health care 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

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.

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 considerately¹⁸ (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 (General Medical Council [GMC], 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 (GMC, 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 [...].'

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, 2004a).

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

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.

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 health care, 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 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

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

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 health care 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-affecting 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 universalisable 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-affecting 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 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 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.

Part III: Conclusion

CHAPTER 9

Conclusion

In this thesis I have attempted to set out the nature of our personal responsibility for health. I noted throughout that currently there is inconsistency both within and between the constituent parts that I identified in Chapter 5, according to what I referred to, loosely, as ‘official’ understandings. In a sense the thesis is presented as a response to this environment; one in which certain assumptions about health dominate discourse, characterised by various tensions between and within two highly valuable things: health and autonomy. Despite their protestations to the contrary I tend to the view that policymakers and many health professionals regard and present health in a reductionist and overtly normative rather than a holistic sense and that this results in a range of measures and prescriptions applied to citizens with little thought or understanding as to their own conceptions of health. In applying population-level measures and health-promoting rules to enhance this vision of health, individual autonomy takes a subordinate role. This is perhaps inevitable with many public health interventions where measures cannot be individualised, for example in water fluoridation. However, there are other areas of health promotion where, as I have indicated, personal responsibility for health can be supported. The thesis attempts to contribute to redressing this imbalance of valuing health over autonomy by

proposing an outline of a unified account of responsibility for health, which recognises that there is such a thing as responsibility for health, but argues that it is not captured or represented in the current conceptualisation. The account requires a great deal of filling out; it much bigger than a PhD thesis. I have not for example, discussed the duties in any detail or offered any suggestions about their strength and direction or how they can be calculated. Importantly, the magnitude of the argument from an obligation to avoid using health care resources is in need of greater analysis, and other obligations, for example those concerning communicable diseases have not been considered.

In this concluding chapter I will first give a brief summary of the main themes of the thesis before discussing in more depth how my normative conclusions, the epistemic and reflective duties, are challenged in current practice, I will discuss the prospects for the papers presented as the core of the thesis making a contribution to the various debates that follow from challenges to what I have presented as orthodox professional health care. I acknowledge that the normative messages, addressed to the public as well as health care professionals and policymakers are unlikely to be received or influential just by being published in academic journals, and ways of engaging the public and nurses are briefly discussed. I conclude that the epistemic and reflective duties as I have set them out also apply to health care professionals, and debate within professional health care about personal responsibility for health is important in their education and practice.

Summary of the thesis

I argued that the notion of responsibility for health as currently conceptualised tends too much to a collective model of public health by articulating an account that obliges individuals to follow health related advice. This account is prescriptive, though it claims otherwise in dressing its injunctions in the apparel of autonomy and the illusion of choice. But critique of responsibility for health as I presented it is not outright rejection of the notion, which can be better understood in its constituent parts of a moral agent having obligations and being held to account for them. Understood like this, responsibility in respect of health is the same as responsibility in respect of other valuable things; the strength and direction of the obligation depends on the importance that one gives to health in the context of individual lives.

As one moves away from rule based reasoning to reasoning that emphasises acts, the importance of the individual actor is heightened, because he or she is the only one able to make necessary judgements. Conceptualising responsibility for health more in the light of individual circumstances and values inevitably changes its nature from judgements about simply whether to follow a rule to calculating right action. The responsibility has changed from outcome to process. There is such a thing as a moral obligation to look after our health, and for many it involves the sorts of things that we are exhorted to do by established practice in health promotion. But these obligations are not owed to the State, nor in the main to ourselves, but principally to those who share our lives and have an interest in them. Though not owed to it, the obligations may still be mediated by the State in some degree because our actions are in many cases not fully autonomous, and

along with similar actions by others, have an impact on very many other citizens. Most obviously this is seen and presented where health care resources are needed to treat diseases contracted through individual behaviour, but this element of obligation, even if one accepts that it is there, can be over-emphasised. On the account that I have offered, our obligations are to establish what the effects of our behaviours are on our own and others' health and wellbeing and, having done this, to make a reflective decision about whether it is permitted or forbidden to behave in that way. As I argued in chapter 4, my preference is for a dual level utilitarian approach to making this judgement, which I suggested was consistent with evidence of how we reason in practice. This means that the obligations are not the same for everyone, and this alone puts it at odds with health-maximising rules. The reasoning I have employed also concludes that we have obligations for others' health and wellbeing. These need not be stringent obligations, but as I have presented them in relation to blood donation they can be material in mandating action.

The final element of the three part concept is holding people responsible for their actions, something that, as I have explored, is central to understanding responsibility and which is played out daily in almost countless news stories and personal interactions and yet is underexplored in health care. My account does not attempt, as professional health care regulators do, simply to outlaw blaming practices, but instead situates them alongside the obligations largely within personal relationships. To deny that individuals cannot be held responsible is to deny that they have any responsibility at all.

At the start of the thesis I suggested that moral responsibility for health is important because it is prior to public health policy, that is regulation and treatment allocation decisions require an account of the moral status of the thing that they are proposing to regulate or deny treatment for. This is a reason for the moral status of health-affecting behaviours to be challenged but the conclusions that I reached concerning the nature of the obligations also exist independently of any system of health care delivery. However, the obligations are inevitably framed within the context of professional health care and the system in which it operates and in the next section I consider how the duties I set out are problematic within current professional practice.

A challenge to current practice: epistemic duty

There are significant problems for the epistemic and reflective duties as I have presented them, many related to the philosophical and operationalised understanding of autonomy. Owens and Cribb (2013) argue that much of the discussion of autonomy in bioethics is related to procedural autonomy, that is the *capacity* for making choices, and we see this, as I suggested in Chapters 2, 3 and 4, in procedures to determine capacity for decisions. There is a tension in the ‘official’ version of autonomy as I have characterised it. In bioethics, autonomy is often seen, as in the principlist scheme, as *primus inter pares* (Gillon, 2003). For example, it is emphasised in moral questions at the end of life, successfully (as far as the law is concerned) when applied to refusal of treatment, and unsuccessfully in requests for assisted dying. But at the same time as it is revered within bioethics, it is undermined in public health ethics, in at least two ways. Most clearly is the straightforward restriction on the ability to undertake

chosen actions that operate in different ways, exemplified by the intervention ladder developed by the Nuffield Council on Bioethics, discussed in Chapter 1. More importantly for the themes in this thesis, however, is the undermining of autonomy in the presentation of information, which I discussed briefly in chapter 6.

The epistemic duty could potentially be understood so that it is each individual's responsibility to seek information from *all* the sources available to him, but this would ordinarily be too onerous¹ and probably not possible for most individuals. The duty is principally to those who share his life, and so the context in which this relationship operates also defines the amount and level of information required. More important is the correlative duty on behalf of the State and professional health education and promotion to provide the required information in a way that can be easily understood. Our unwillingness, inability and/or disinclination to access and process information is a problem with procedural versions of autonomy. If the concern for supporting personal decision making is genuine, we need to challenge, in Owen's and Cribb's (2013) suggestion, the dichotomy between pure information giving and the perils of controlling. As I suggested in chapter 6, much health promoting material is designed to lead people to desired conclusions rather than to give them information useful for autonomous decision making.

The developing field of health literacy offers a potential solution to the problem of the difficulty of individuals being unable to process data upon which to base

¹ As Prainsack and Buyx (2011) suggest, in an extreme form of 'responsibilisation', a responsible individual actively seeks to learn about as many risks as possible so as to take precautions against them.

their decisions. The World Health Organisation defines and explains health literacy following a broad and inclusive definition developed in 2012 by the European Health Literacy Consortium:

Health literacy is linked to literacy and entails people's knowledge, motivation and competence to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course (WHO, 2013, p.4).

This definition illustrates the dilemma between health and autonomy; even though the overall aim is to maintain or improve quality of life during the life course, the purpose is to enable decision-making, open to the possibility that decisions will be made to undertake activities which WHO would rather we did not. The definition understands health literacy simply in terms of using information in health promoting ways, echoing the observation made by Allmark and Tod (2007) that I discussed in Chapter 6 about the purposes and evaluation of health education; the aim of increasing health literacy attempts to 'get' (Upton and Thirlaway, 2010) people to change their habits rather than make well informed decisions about their life. In this case at least, autonomy is subsumed to health - a narrowly and centrally defined version of health.

Gerd Gigerenzer (2014, and Gigerenzer *et al.*, 2008) offers an alternative to the view that inability to understand complex information justifies or even requires libertarian paternalism of various sorts, by suggesting that statistics can be presented in ways that are more meaningfully understood. He describes studies undertaken to assess understanding of statistics by doctors who routinely discuss screening choices with patients, finding that the number correctly able to identify

(from a list of four options) the chance of a positive mammogram predicting the presence of cancer² is, at 20%, less than would be expected from random choice. He demonstrates how screening companies in the USA have manipulated statistics to make their product more attractive,³ and also that presenting information in terms of natural frequencies and death rates rather than as relative risks and survival rates can significantly improve understanding and therefore informed decision making. This information can be presented on accessible cards for patient use. Gigerenzer's work has mainly concentrated on the risks and benefits of screening but exactly the same statistical explanations can be used in information about the risks of smoking and drinking and other health-affecting behaviour. Similar information about the absolute risk associated with smoking has been produced in an academic journal (Woloshin *et al.*, 2008) but this has not, generally, been used by health educators.

Gigerenzer *et al.* (2008) start their paper with a story about how the statistics on prostate cancer survival were misused by the New York mayor Rudy Giuliani, who contrasted a survival rate of 82% in the US with a 44% survival rate in England, 'under socialized medicine' (Gigerenzer *et al.*, 2008, p.53). The authors of the paper were generous in ascribing the error to the statistic being misunderstood⁴ rather than a deliberate intention to mislead for political purposes. In the UK we have seen the Chairman of the UK Statistics Authority

² The question required interpretation of commonly used statistics about the efficiency of screening.

³ In the UK where screening is undertaken by the NHS, financial incentives are not so marked. However, financial incentives for GPs have been used in the past and been found to be correlated with uptake (Lester *et al.*, 2010).

⁴ The error is committed by confusing five year survival rates with death rates. Screening programmes detect cancers, including non-progressive ones, earlier, and so the survival rate is skewed because it counts sub clinical cancers which never would have caused death, as well as starting the five year survival 'clock' earlier.

confirm that statistics have been misapplied to give the impression that real-terms NHS funding has been maintained when in fact it had been cut⁵ (BBC, 2012) and as I write this in July 2014, the Prime Minister was challenged by the House of Commons Library for misusing statistics about waiting time in accident and emergency departments.⁶ Similar questions of bias can be levelled at the way that statistics are used in health promotion, even where the goal of enabling choice is claimed. In the case of Mayor Giuliani and the doctors in Gigerenzer *et al.*'s study, it is plausible to suggest that a lack of knowledge is at the heart of the misleading presentation, but it would be difficult to apply this explanation to health promoting material which is written by specialists in the full knowledge that it is misleading and therefore cannot respect a person's autonomy. If an individual's epistemic duty as I have suggested it is to have any meaning at all in professional health care then radical change in the way that information is presented will be required so that it supports rather than undermines autonomous decision making. Developing the concept of health literacy, but without the institutionalised value driven bias, will support the epistemic duty but without this development, it is difficult to see how the epistemic duty as I have presented it can have any practical meaning at all.

A challenge to current practice: reflective duty

There are clear links from the epistemic duty to the reflective duty. Knowledge is necessary for reflection. Neither is enforceable, though the epistemic duty is, as I

⁵ Misapplication of statistics by politicians of all shades is barely a surprise. There is lengthy page on the UK Statistics Authority webpage which details numerous disputes between politicians with the Chairman, currently (July 2014) Sir Andrew Dilnot, adjudicating in the squabbles. <http://www.statisticsauthority.gov.uk/reports---correspondence/correspondence/index.html>

⁶ The blog can be found at <http://commonslibraryblog.com/2014/07/03/have-ae-waiting-times-fallen/> After an initial posting it was removed and when it reappeared, though the analysis was unchanged, some comments about the Prime Minister's use of statistics had been removed.

have discussed, relatively easy to facilitate. As I discussed in Chapter 6, the reflective duty as I have described it is comprised of a number of elements. The harms of health-affecting behaviour can be considered in the light of sufficient and unbiased information. However, the value placed on the activity and the appraisal of the effects on connected others can only be realised by an individual within relationships.

Hieronimi (2014) argues that reflection is required as a pre-requisite of relationships that 'constitute us as morally responsible' (2014, p. 41), forming part of a relational account of autonomy (MacKenzie, 2008). This account of autonomy sees individuals as free choosers but also recognises that they are socially situated, having values that are, to some extent, defined by personal relations and interdependency (Christman, 2004). The account is associated with feminist philosophy, but general dissatisfaction with an overly individualistic understanding of respect for autonomy can also be found in communitarian critique (Gauthier, 2000). However much bioethicists and others bemoan the (over)emphasis on individual rights in health care and the insularity that this implies and fosters, practical steps to address this are difficult. It is not possible to *force* people to take information into account or *require* them to consider the effects that their behaviour and its possible consequences have on others. Public health measures that 'compensate' collective health care through extra taxation ameliorate this to some extent. For example, as I discussed in chapter 3, Cappelen and Norheim (2005) argued for increased taxation of tobacco as a 'liberal egalitarian' way to raise funds to pay for increased costs of health care for smokers. A campaign to tax sugary drinks is probably more important for

health gains than income generation⁷ and is supported by the Academy of Medical Royal Colleges (2013).⁸ Noticing price differentials between drinks and noting a public and political debate which would precede such a move might encourage people to consider the financial impact of their food choices, but it is unlikely to encourage consideration of the effects that their food choices has on those close to them.

There is some engagement by health care professionals with relational autonomy in professional health care, but this has tended to involve procedures for informed consent, and is wary rather than supportive of the social situation of individuals. The Department of Health's reference guide to consent (DH, 2009b) recognises that individuals do not decide alone, but this concerns the context of coercive relationships and the possibility of 'undue influence', and the remedy is simply for health care professionals to 'arrange to see the person on their own in order to establish that the decision is truly their own' (DH, 2009, p.11). This appears to be a very thin but perhaps inevitable solution. In a more detailed exploration of informed consent and relational autonomy, Stoljar (2011) points out that some oppressive social practices can undermine autonomy and her conclusions are similarly non-specific; providers should be alert to social conditions and take 'positive steps to counteract' (p. 383) the effects of internalized norms, including encouraging 'imaginative reflection on different options' (p.383). A more relational version of autonomy so far as health care decisions are concerned can be encouraged but there is need for great caution as well. This is best performed within individual episodes of care where the health

⁷ Briggs *et al.* (2013) calculate a reduction in obesity of 180,000 people and tax revenue of £276 million following the introduction of a 20% 'sugar tax'.

⁸ See Mytton *et al.* (2012) for a review of the evidence and examples of policy in other countries.

professional knows the patient, but as I indicated in Chapters 6 and 7, general health promoting material can refer to other-regarding considerations.

Neil Levy (2014) also notes the values of liberal individualism but does so more approvingly. His suggestion to constrain autonomy to some extent is based on the fallibility of human reasoning which I have discussed throughout the thesis, especially in chapter 4. He suggests employing informed consent specialists who can correct the psychological illusions that characterise decision making. These specialists might even express their disagreement with a decision where it does not represent the patient's previously expressed values. Rather than just ensuring that patients have 'sufficient information' (whatever that means) to make a decision, we 'should tell patients when we think their decisions are distorted by cognitive illusions or when they are misapplying their values' (Levy, 2014, p.300). This discussion may take the form of 'rational persuasion' which can itself, in certain circumstances, be considered paternalistic (Tsai, 2014), and Levy's suggestion is consistent with ideas of relational autonomy, though more structured and for different reasons. In considering whether the action is consistent with his values the patient must first reflect on what those values are.

These suggestions are worthy of consideration and further philosophical and empirical investigation as a way to encourage the reflective duty, which must navigate between recognising the value of a social construction of self which encourages individuals to consider the effects of their actions on others, and over valuing it, which has implications in confidentiality and oppression. Family centred care is a concept more at home within children's health care than adults,

though there may be scope to extend this cautiously. For example the King's Fund recently released a patient and family centred care toolkit (Kings Fund, 2014) to support service development. As Rhodes (1998) concluded in relation to genetic information, there are moral responsibilities towards others and yet overriding this when these responsibilities are unmet is problematic and should be undertaken only exceptionally (Juth, 2014). The reflective duty can also be encouraged using mass marketing approaches as I described in relation to smoking in Chapter 6, where other-regarding considerations in relation to health-affecting behaviours can be emphasised. Similarly, reflection can be encouraged in relation to blood donation and other tissue donation behaviours as I discussed in Chapter 7. However, *requiring* a reflective duty, even if we wanted to, presents challenges for professional health care but these can be met to some extent on an individual level for certain patients in certain circumstances, though as I have discussed, open and unbiased discussion seems unlikely in an environment of misleading information and value-laden assumptions about health.

Potential impact of the thesis

There are implications for public health ethics in the normative conclusions of my thesis, and it is to be hoped that policymakers may use the work and the ideas in it to inform if not direct their responses to the undoubted challenges that confront us. A liberal presumption of light-touch regulation is consistent with accepting the nature of responsibility for health as I have presented it, but it does not stand in opposition to *all* regulation or collective action in pursuit of public health. It is neither possible nor desirable to attempt to separate public and

private notions of health so that they are distinct entities. But it does mean that the tension between autonomous choice and health-increasing policies should be examined in more detail. I do not mean by this that there should be more debate and learned arguments in the academic press, but rather that these debates and the assumptions about health and disease which underpin them should be the focus of greater public discussion. There has recently been a call for a national debate about the funding of the NHS expressed in the a letter to *The Times* newspaper (Oldham *et al.*, 2014) signed by, amongst others, the heads of the medical and nursing Royal Colleges that concluded ‘We believe the route is an all-party mandated, independently conducted "national conversation" on the scope, provision and funding of health and social care.’ The authors called on political leaders to assist this proposal but there is no detail on how it should be done. A national debate on funding and provision of health care would assist reflection on responsibility for health, more so if the debate encompassed philosophical questions about the value of health and autonomy.

Having spent a good deal of time and energy arriving at the conclusion that we ought to be more thoughtful, it is helpful to consider how this thesis and the papers and points within it may contribute to increasing thoughtfulness in the ways that I advocate. It would be an extreme form of academic arrogance which imagined that just because a paper has been published in an academic journal that some sort of cascade will magically get the message to those to whom it is directed and once there, result in increased reflection.⁹ But, in line with

⁹ The impact of academic research is part of its overall assessment within the Research Excellence Framework (REF), which is assessed, *inter alia*, by whether public awareness of a health risk or benefit has been raised, public engagement or involvement in research has improved or public behaviour has changed (HEFCE, 2012, p.52). The papers presented in this

Brassington's suggestion about the concerns of philosophy, if I think that my moral claims have value then I am obliged in some sense to try and support people to engage and agree with them.¹⁰

As far as the normative conclusions relating to organ donation is concerned, it might be expected that donation organisations would take the lead in encouraging reflection on donation practice, and so they do via advertisements as I discussed in Chapter 6. Public discussion about the moral status of donation can also be encouraged through universities. On 20th March 2012 I made a brief presentation at a public event at the Manchester Library¹¹ and some educational material for use in schools based in part on the paper has been produced.¹² So I can say that there has been some public discussion about the ideas in my work though it is so far limited, and engaging in public discussion remains an aim for future work.

For the normative conclusions in respect of our own health public discussion is probably best achieved within professional health care education. Public discussion about health policy and promotion is always welcome but there is a danger that conclusions similar to my own would be unsupported by the current infrastructure of health promotion and education. A patient might, for example, decide that he wants more information about absolute risk but find that outside inaccessible academic texts it is unavailable. Perhaps of more immediate concern

thesis as chapter 5 and 7 were submitted to the 2014 REF by my current employer, The University of Worcester.

¹⁰ Brassington (2007, p.1) says that philosophy is 'about getting people to change their behaviour', echoing the language (though not the method) of nursing texts on health promotion which I criticised in Chapter 6.

¹¹ <http://events.manchester.ac.uk/event/event:x3c-gy5tuu7c-54yxsa/>

¹² <http://www.isei.manchester.ac.uk/research/wellcome75/>

is how the ideas developed in the thesis can influence nursing philosophy and practice.

Nursing Philosophy (journal and activity)

Two of the papers (Chapters 5 and 8) in the thesis were published in the journal *Nursing Philosophy*. This is an academic journal associated with the International Philosophy of Nursing Society (IPONS), a society which has as one of its aims ‘to conduct and support philosophical inquiry in a manner that informs and engages with health care practice, theory, research, education and policy from national and international perspectives’.¹³ The papers published there seem to me to fulfil the aims of the Society in this respect at least. In Chapter 8, I noted that there is a persistent minority of nurses holding negative views of groups of people of whom they disapprove. I suggested that the patient-nurse relationship does not allow this and invited nurses to reflect on the nature of the failed obligations that they are holding patients responsible for. I cannot see any objection to this invitation, but acknowledge that the prospect of it being met is slim. I suspect that few of the nurses holding negative views of certain patient behaviour read *Nursing Philosophy*.

Reading and writing for the journal *Nursing Philosophy* cannot but set one to considering the ways in which detailed philosophical thinking can advance nursing practice. A normative claim that nurses ought to understand what responsibility for health consists of, in all its guises and complexities, follows from a claim that it is of central importance to nursing practice because it speaks

¹³ <http://www.ipons.co.uk/>

to the patient-nurse relationship. It was this search for understanding that initially led me to the philosophical literature on responsibility. What I found in a small section of the vast literature were some central themes and broad concepts, not of all which seemed to me to have direct relevance to my practice as a nurse and then an educator. I would not want to claim that nurses looking to philosophy to improve and enrich their practice must seek to instrumentalise all of what they find there, but it has always seemed to me that the practice of nursing philosophy (or philosophy of nursing) has separate and necessary elements from the practice of (just) philosophy. These elements include a practical and potentially action guiding purpose, arguably given more purpose by a nurse looking to philosophy to improve his practice than by a philosopher looking to inform and then to influence nursing practice from outside. Dickenson (2000) found that health care professionals and ethicists tend to look at the same problems from different directions, often arriving at different conclusions.

I argued that nurses ought to understand what responsibility for health consists of, and buried in this claim is the implication that what I mean is that *all* nurses ought to understand what responsibility for health consists of. If this was not the case I would be required to explain which nurses are burdened with my normative expectations and which are not. Perhaps I mean that that all *good* nurses ought to understand, but I could couple this with the claim that all nurses ought to seek to become good nurses and I appear to be back at square one. Certainly I mean that all registered nurses ought to understand, and that includes young men and women, relatively inexperienced in life and nursing having just completed an undergraduate preparation course. Given this, I do not think that I

can extend my claim that all nurses should understand what responsibility for health means to the claim that they should be familiar with or even aware of the extensive philosophical literature on responsibility. I certainly would not make this claim for myself six years after embarking on the PhD. However, a critical and thoughtful outlook is required if nurses are to challenge the simplistic versions of health and health promotion which I have described in this thesis.

A return to a smoking patient: advocacy and autonomy

It is not so much that nurses, especially student nurses, do not possess the capacity for thinking deeply about responsibility for health; rather that the environment is set against it. Unlike other health care professions, nursing claims for itself a role as patient advocate, set out clearly in the Code:

You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support (NMC, 2008, p.3).

Yet there are contested versions of advocacy consistent with the versions of responsibility for health which I have presented in this thesis. An understanding of advocacy as acting in the best interests of the patient (Spence, 2011) can be at odds with a model of advocacy which is concerned with a

nurse actively supporting patients in relation to their rights and choices, clarifying their healthcare decisions in support of their informed decision-making and protecting basic human rights such as autonomy (Cole *et al.*, 2014, p. 2).

These conceptions of advocacy can be examined in relation to the problem of a nurse trying to decide what to do when a patient asks for her support so that he can have a cigarette with which I concluded the introductory chapter. Recently issued NICE guidance on smoking cessation in acute, maternity and mental

health services recommends ‘ensuring there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.’ (2013c, p. 6). The document discusses benefits of smoking cessation and despite claims that the health of visitors to the units will benefit, it is smokers’ health that they are seeking to improve using ‘strong leadership and management’ to ensure ‘compliance’. I discussed the legal challenge to smoking at Rampton Hospital in Chapter 3, and noted that the consultant psychiatrist supported the continuation of the ban after the expiry of the exemption order. The legal judgement noted in several places that patients should be prevented from smoking for their own good. The Royal College of Nursing also supported banning smoking in psychiatric hospitals at the House of Commons select committee hearings,¹⁴ and again in a written response to the consultation concerning the Health Bill in 2006, stating that the ‘RCN believes this cultural norm [of widespread smoking] should not be allowed to perpetuate as it contributes to the poor health outcomes and life expectancy commonly seen in this group’ (RCN, 2006). In the tension between advocating for health and advocating for choice, the RCN very clearly takes the former route, consistent with the ‘official’ conception of responsibility for health. This is in opposition to Cole *et al.*’s definition of advocacy which emphasises the nurse supporting the patient’s choices rather than what she thinks is good for him. The NMC requirement for advocacy is apparently capable of being interpreted either way, indicative of the practical choice that has to be made by professionals between advocating for a ban or advocating for choice.

¹⁴ The transcripts can be found here
<http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/485/5111704.htm>

My suggestion throughout the thesis has been that before we seek to prevent our patients from smoking, or support others in this endeavour, we should ask ourselves, what, exactly, he is doing wrong by smoking, and through my examination of the arguments I have concluded that that decision is a matter for him. He may be doing something wrong, but if he is, it is for those who share his life to hold him responsible for it. Reflecting on the different conceptions of responsibility for health as I have presented them results in contradictory action guidance for nurses, and while it is clear that not all registered nurses in the UK will have the same view, from the point of the view of the patient who wants a cigarette, having two nurses on his ward who are prepared to advocate for him in completely different ways seems odd. The rightness or otherwise of allowing him to go outside to smoke, or accompanying him while he does it is open to debate which should consider the points raised in this thesis. The vagaries of the nursing duty rota should not be one of them.

Our role as health professionals, as I see it, is to support his reflective duty, and especially his epistemic duty but also to show epistemic humility. As Atkins puts it: 'It is in recognition of the fact that we cannot experience from another's perspective that we normally refrain from judging what will make another's life good *for them* (Atkins, 2000, p.75, emphasis in original). Starting an enquiry about personal responsibility for health has ended up discussing the way that this responsibility is understood by professionals, and how it relates to various conceptions of autonomy. Currently, we say that we are supporting autonomous choice but we do much to subvert it, and we tend to treat our patients as isolated individuals instead of socially situated members of various communities. This

tension captures important quandaries at the heart of professional health care. If we want to people to be personally responsible for their health then we need to give them the tools to do it, and accept their informed decisions when they have made them. My role as a nurse educator who has had the privilege of studying these quandaries is to encourage and facilitate students' learning to meet their own epistemic and reflective duties so that they, in turn, can contribute to resolving them.

Concluding remarks

The central theme of the thesis is the extent of an individual's responsibility for his health, and how can he be blamed if he fails to meet these responsibilities. By drawing on a number of philosophical, legal and professional literatures I have concluded that his only obligations are to enquire about the effects of his health threatening behaviour and then to use this knowledge to work out for himself how to weigh his own interests in pursuing his own version of a good life against the interests of others who are affected by it. Minimally, this includes everyone who also draws upon health care resources, but this argument can be overemphasised. Maximally this includes those who are directly affected because lives are shared; if there are obligations, they are owed in the main to these people and consequently it is they who can hold us to account.

My answer stands at odds with the orthodoxy and values within current health care practice, which may change in line with further discoveries about how people act, how health care is funded, and how societal values change in a world which, as I am apt to tell my children, will be subject to major challenges in the

coming years. All of these areas will be subject to further detailed analysis, and as important, public and political debate which may make the conclusions I have arrived at look simplistic and naïve as I look back on them in the years to come. I hope to continue to contribute to these debates as academic, teacher, nurse, voter, and father; and though the papers which form the core of the thesis have not had a significant impact (yet) on these vitally important debates, they have nevertheless contributed to a growing and diverse literature as well as having a significant formative impact on my own intellectual development. For that, at least, I am very grateful.

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Appendix

Pdfs of published papers.

Snelling, P.C. (2012a). 'Saying something interesting about responsibility for health', *Nursing Philosophy* 13, pp. 161-178.

Snelling, P.C. (2014a) 'What's wrong with tombstoning and what does this tell us about responsibility for health?' *Public Health Ethics*, 7(2), pp. 144-157.

Snelling, P.C. (2012b). 'Challenging the moral status of blood donation', *Health Care Analysis*. E-pub ahead of print. doi:10.1007/s10728-012-0221-4.

Snelling, P. C. (2014b). 'Who can blame who for what and how in responsibility for health?. Nursing Philosophy', *Nursing Philosophy*. E pub ahead of print doi: 10.1111/nup.12061.

Saying something interesting about responsibility for health

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Abstract

The concept of responsibility for health is a significant feature of health discourse and public health policy, but application of the concept is poorly understood. This paper offers an analysis of the concept in two ways. Following an examination of the use of the word 'responsibility' in the nursing and wider health literature using three examples, the concept of 'responsibility for health' as fulfilling a social function is discussed with reference to policy documents from the UK. The philosophical literature on moral responsibility is introduced, and in considering two versions, reactive attitudes and accountability, it is argued that in application both can be regarded, though with different emphasis, as being constituted in three parts: (i) a responsible agent; (ii) having obligations (responsibilities); and (iii) being susceptible to being held responsible (that is blamed) if he fails to meet them. The three-stage model is consistent with the examples of the word responsibility in use, but application to the social function model causes a number of problems for healthcare practice, especially for the reactive attitudes account. Apart from considerable problems in stating what exactly the obligations are and how they can be justified; and how blame might justly be apportioned and by whom, the very ideas of obligation and blame are in conflict within healthcare systems and professional nursing practice which have foundations deeply embedded in the notion of the supremacy of personal autonomy. It is concluded that current application of the concept of responsibility for health is conceptually incoherent, and if it is to retain its place in health policy and discourse, urgent remedy is required.

Keywords: responsibility for health, agency, professional ethics, obligation, blame.

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Introduction

It cannot be said that the issue of responsibility for health is new (Reiser, 1985), but current fiscal uncertainty, technological advances, and the unremitting increase in the prevalence and incidence of illnesses related to lifestyle combine to give the issue renewed significance. Despite this, there is little in the nursing literature about what the concept of 'responsibility for health' consists of, and why it is so important and so difficult. The simple aim of this paper, following Paley (1996), is to 'say something interesting' about responsibility for health. I offer two analyses of 'responsibility' as applied to professional health care. First, I discuss examples of the use of the word 'responsibility' found in the nursing and broader literature. Second, I consider the concept of 'responsibility for health' as fulfilling a social function. I then turn to the philosophical literature on moral responsibility, and in considering two versions, reactive attitudes and accountability, argue that in application both can be regarded, though with different emphasis, as being constituted in three parts: (i) a responsible agent; (ii) having obligations (responsibilities); and (iii) being susceptible to being held responsible (that is blamed) if he fails to meet them. The three-stage model is consistent with the examples in use, but application to the social function model causes a number of problems, especially for the reactive attitudes account. Apart from considerable problems in stating what exactly the obligations are and how they can be justified; and how blame might justly be apportioned and by whom, the very ideas of obligation and blame are in conflict within healthcare systems and professional nursing practice which have foundations deeply embedded in the notion of the supremacy of personal autonomy.

Two concepts, many conceptions

An obvious starting point is that the term 'responsibility for health' contains two distinct concepts, responsibility and health, and it might reasonably be suggested that combining them will obfuscate analy-

sis. Health is variously understood, famously by Boorse (1975, 1977) and Nordenfelt (e.g. 1996, 2007). In Boorse's account health is descriptively merely the absence of disease, defined in terms of statistical normality, while Nordenfelt's evaluative account understands health more holistically as the ability to realize life goals. These different conceptions can result in practical differences in health care all of which could justifiably claim to be directed at improving health (Nordenfelt, 1993). Similarly, the concept 'responsibility for health' will differ depending on which account of health is utilized. To understand why this potential confusion need not cloud the analysis, it is necessary to be clear about the difference between concepts and conceptions.

The distinction is that conceptions lie lower in a vertical continuum between general and specific usages of a word. Conceptions offer a more 'determinate specification' (Miller, 2010, p. 812) of the parent concept, operationalizing and applying it. Inevitably this means that two or more conceptions can be derived from a single concept. Vertically each conception must be consistent with the parent concept or they will be conceptions of different concepts, but horizontally, between conceptions within a concept, there may be incommensurable differences. Where this happens we have, following Gallie (1956), '*essentially contested concepts*'. Gallie had in mind artistic and political concepts (Ruben, 2010), but it has been suggested that medicine meets the necessary criteria (McKnight, 2003) set out at some length by Gallie. A further relevant example is discrimination, used differently by the UK governing bodies of nurses and doctors. Nursing's professional regulator, the Nursing and Midwifery Council (NMC) (2008), states that 'You must not discriminate in any way against those in your care.'¹ The UK medical regulator, the General Medical Council (GMC), states that 'You must not unfairly discriminate . . .' (GMC, 2006, p. 10). While operationalizing a concept fundamental to professional healthcare practice, the two regulators have used different conceptions of the same concept; the NMC has used the word evaluatively, while in using

¹In England and Wales the National Health Service as a whole takes this evaluative line in the NHS constitution.

the word descriptively, the GMC requires an evaluative adverb. It is not suggested that doctors treat patients differently (although it *could* be suggested), only that different conceptions of the concept 'discrimination' have resulted in a position where on application of the verb 'to discriminate' separate from evaluative adverbs, doctors are potentially able to do something that nurses are not, that is discriminate fairly (Hellman, 2008; Moreau, 2010).²

Argument about which conception is correct is ultimately futile as each can be derived from the parent concept, and this is potentially a problem, though rarely acknowledged, for inductive concept analysis methodology which may attempt an improbable synthesis between these essentially contested conceptions.³ Similarly, different conceptions of health are important in operationalizing conceptions of 'responsibility for health', but ambiguity is manifested in the conceptions rather than the parent concept. Insofar as the task of this paper is to say something interesting about the parent concept, rather than any specific operationalizing conception, the analysis is more fruitfully directed at the concept of 'responsibility'. The importance of the different conceptions of health lies in determining obligations, outside the scope of this paper.

Work required of the concept

The justification of undertaking an analysis and the methodology employed depends on the work the concept is required to do.⁴ One purpose could be to undertake concept analysis to explore what responsibility for health (or more broadly 'responsibility' within the healthcare environment) means to individuals, with the aim of arriving at a composite definition which could be used in further research.

²In English law under the Equality Act 2010 discrimination requires less favourable treatment.

³None of the 1261 'hits' in a BNI and CINHAIL search (1 February 2011) using the term 'concept analysis' referenced Gallie's paper (The number of hits would include some identified twice).

⁴Walker & Avant (2011, p. 160) suggest that it could be a concept that 'has always bothered you'.

Concept analysis (I): Responsibility in use

Anyone wishing to clarify any concept relevant to nursing practice has a large and growing body of work to build upon. Despite substantial critiques from, *inter alia*, Paley (1996), Beckwith *et al.* (2008), and Risjord (2009), the proliferation of concept analyses in nursing journals shows little sign of abatement. It is perhaps surprising that many published examples show little appetite for engagement with the ontological, epistemological, and (perhaps most surprising) methodological problems identified in the critiques, following instead a substantially standardized process rarely found outside the nursing literature. Were Walker & Avant's (2011) concept analysis procedure to be followed, the literature, dictionaries, and theses would be searched towards the aim of arriving at 'a precise operational definition' (p. 158); the result of answering the empirical question 'how are the words "responsibility for health" used', rather than an analysis of the concepts denoted by the words (Wedgwood, 2006). Unfortunately many of the relevant papers found using the term 'responsibility'⁵ manage to discuss and use the term without saying what it means. Three examples illustrate this: adolescent diabetes, women's magazines, and public attitudes to health-care policy.⁶

In the USA, Anderson *et al.* (1990) developed a widely used questionnaire to measure 'individual family member's perceptions of who takes responsibility for a broad range of diabetes tasks' (p. 479). The questionnaire asks participants to choose from a list of three choices against a number of situations or tasks, for example 'remembering the day of clinic appointment'. The options are:

⁵Using the databases, CINHAIL and MEDLINE (14 November 2011), there were 11 475 'hits' searching for 'responsibility' in the title, and 1123 'hits' searching for 'responsibility for health' in the title. A full analysis or categorization of all sources identified was not undertaken. A partial but unsystematic review suggested that many of the papers identified were not relevant to the argument presented in this paper.

⁶The examples were chosen because they illustrate the points I wish to make. I do not claim that these papers are in any sense representative.

- 1 Parent(s) take or initiate responsibility for this almost all of the time
- 2 Parent(s) and child share responsibility for this about equally
- 3 Child takes or initiates responsibility for this almost all of the time.

Within the paper, the choices are explained so that 'the respondent assigned a 1 if the parent was predominantly 'in charge' (p. 481) of the task. It should be clear that I am not criticizing the paper, merely pointing out that the term 'responsibility' apparently needs no explanation as none was offered to those completing the questionnaire. It is assumed that they know what it means, and what is available in the text by way of explanation refers in passing to being 'in charge'.

This paper is one of many analysed in Hanna & Decker's (2009) concept analysis of 'assuming responsibility for self-care among adolescents with type 1 diabetes'. Similarly there is no discussion about what 'responsibility' means in the general sense. The conclusion of the analysis is that the attributes of assuming responsibility include that it is '... (c) a process with the goal of ownership and (d) a process involving autonomy in behaviours and decision making' (2009, p. 101). The model case (part of Walker & Avant's (2011) procedure) offered is a fictional 17-year-old who says that she 'will be fully responsible when she is able to be totally independent in doing all the diabetes care tasks and being the one who makes the decisions about them without any reminders' (p. 102). Olinder *et al.* (2011) report a grounded theory study utilizing interviews with adolescents where responsibility emerged as a core category and provided the principal ingredient in a model to facilitate the clarification of responsibility. They state that (2011, p. 5) 'A lack of responsibility seems to be a main reason for missed bolus doses and insufficient self management', but this has several potential meanings.

Second, in a fascinating account of the discourse about responsibility for health in English-Canadian women's magazines, Roy (2008) shows how the discourse reinforces 'neo-liberal ideas by conceptualising responsibility for one's health as not only something that can be chosen but something that

ought to be chosen' (p. 473). The discourses not only cover the familiar path of health promotion, but also urge that women be determined in pushing agendas in relationships with physicians and to be brave in the face of debilitating illness: 'constructing continued optimism as an important moral obligation, how one with a disease or disability ought to behave' (p. 472). In one reviewed article a woman with multiple sclerosis defines responsibility as '... accomplishing the things I wanted in life right now. Today' (MacLean, 1999, p. 73, cited in Roy, 2008, p. 471). This seems to be a somewhat idiosyncratic understanding of responsibility, re-emphasizing potential pitfalls of inductive analysis. The paper generally presents an idealized understanding of responsibility promulgated in the magazines which, in claiming robust obligations while failing to address or even acknowledge barriers to meeting them, might be considered more moralistic than moral. The paper does not engage in a discussion about what the concept of responsibility means in general, focusing instead on the various conceptions presented, but the title resonates with the work on teenagers with diabetes – '“Taking charge of your health”: discourses of responsibility in English-Canadian women's magazines'.

Third, in the UK, the King's Fund (2004) commissioned a survey to assess public attitudes to health policy. In the quantitative phase a series of yes/no questions were presented. '88% ... agreed that individuals are responsible for their health' (2004, p. 11).⁷ However, more than '40% agreed that there are too many factors outside individual control to hold people responsible for their own health' (2004, p. 11). The questionnaire does not appear⁸ to explain what is meant by responsibility for their health, but the high rate of agreement suggests that respondents understand what is meant.

There is no indication in any of three examples that the lack of definition or explanation of responsibility has caused problems; evidently those who answer the questionnaires have something in mind, but the form

⁷Elsewhere in the published document this figure is given as 89%.

⁸The actual questionnaire used is not reproduced in the publication.

of the questions and the way that they are reported give little indication of what more detailed understandings might be. These incomplete understandings, even when they represent everyday usage, make a nuanced inductive concept analysis problematic. I shall return to these partial accounts, but for now I turn to a second use of the term, which recognizes that some concepts have broader social functions (Miller, 2010).

Concept analysis (2): Responsibility as social function

The concept 'responsibility for health' fulfils an important social function within socialized medicine, and is used for example in policy documents to explain respective roles within that system.⁹ In this context, clarifying meaning cannot be a matter for inductive analysis of partial usage because the concept is required to do the work of providing a framework for helping people to understand just what it is that they should or must do, and this social function cannot be fulfilled unless the recipients of the message understand what having 'responsibility for health' requires. Inductive analysis of the word 'responsibility' in use may give insight into how the message is variously received but that does not abolish the need for clarity in its transmission. An objection that it is not for the Government to tell us, for example, that we ought not to smoke would be to confuse the global concept of responsibility with its determinative conceptions. However, rejecting one or many conceptions does not entail rejection of the concept and understanding of the determinative conceptions requires a general understanding of the concept. If this is the case, and the concept 'responsibility for health' does form a social function within socialized¹⁰ medicine, then there should be clarity

⁹In fact the broad term responsibility is increasingly heard in myriad social and political contexts, for example in welfare provision (Maltravers, 2007; Brown, 2009).

¹⁰The UK National Health Service is possibly the paradigm case of socialized medicine. The drawing on collective resources for treatment might provide a reason for the view that certain health-enhancing behaviours are morally obligatory, but not the

about what this means. A cursory glance at National Health Service (NHS) documents reveals that this is not the case.

The (former) Prime Minister's¹¹ introduction to the strategy to reduce obesity provides a clear statement which illustrates the confusion:

There should be no doubt that maintaining a healthy weight must be the responsibility of individuals first – it is not the role of government to tell people how to live their lives and nor would this work. (Department of Health, 2008, p. iii)

First, the Government tells us what we must do (maintain a healthy weight), and then it tells us that it is not their role to tell us how to do it. The relevant clause in the NHS constitution¹² states 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. (Department of Health, 2009, p. 9)

Similar to the literature reviewed earlier, this leaves the meaning of 'responsibility' open to interpretation, particularly within the phrase 'some responsibility', and the normative prescription simply requires recognition that a significant contribution is possible, and not that it be made. Further explanation is provided in the handbook to the constitution. Entitled 'what this means in practice', the clarification is:

You can talk to your doctor, nurse (including health visitors and midwives) or therapist, use NHS Direct (online at www.nhsdirect.nhs.uk or telephone 0845 4647), or go online at NHS Choices (www.nhs.uk). You can ask about what support you might be offered in managing your condition yourself or changing to a healthy lifestyle (e.g. stopping smoking, reducing weight, exercise or reducing excessive alcohol consumption). (Department of Health, 2010, p. 67)

This explanatory note falls considerably short of explaining either the nature or the details of respon-

only reasons. I do not mean to suggest that the concept responsibility for health has no meaning within private healthcare systems.

¹¹The Prime Minister at the time was Gordon Brown.

¹²The constitution applies to NHS services in England and Wales.

sibility,¹³ and by utilizing language which hints at information giving (you can), the clarification sets a rather different tone than the normative clause (you should) in the constitution, and the imperative (must) in the Prime Minister's introduction to a previous document. Having identified its social function, the guidance fails to guide. The Scottish NHS version initially goes further. Under the heading 'What we expect from you' it is stated that:

You can help yourself, other patients and NHS Staff if you do the following. Look after your own health and have a healthy lifestyle. This could mean: taking more exercise, eating a balanced diet, stopping smoking, not drinking too much alcohol, not using drugs, and using a condom if having sex. (NHS Scotland, 2006, p. 15)

Although the heading is stated as an expectation, the language in the text is softer (you can help yourself). Similar internal ambiguity is evident in the Report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England (2010). Recommendation 13 (2010, p. 102) includes the statement that:

Nurses and Midwives must acknowledge that they are seen as role models for healthy living and take personal responsibility for their own health. (Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010, p. 102)

The language is declamatory (must), but the proposed draft pledge less so:

Nurses and midwives, recognising our important role in improving health and wellbeing and reducing inequalities, will engage actively in the design, monitoring and delivery of services to achieve this. We acknowledge that we are seen as role models and will try to live up to this responsibility. (Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010, p. 57)

The response was delayed because of the general election and subsequent change in government. Despite the sentiment, expressed by the Minister, that the report 'does not go far enough' (Department of Health, 2011, p. 5), the recommendations

noted above will not be implemented in full. The section of recommendation 13 requiring that nurses take personal responsibility for their own health is ignored; the response is restricted to the implementation of the Boorman report (Boorman, 2009) 'NHS Health and Well-being', which recommended a less prescriptive provision of services centred on prevention 'of both work related and lifestyle influenced ill health' (p. 29). The recommended pledge will not be implemented. Instead, 'Employers need to use the Principles of Nursing Practice as a pledge . . .' (Department of Health, 2011, p. 6). These Principles, developed and published not by the regulator but by the Royal College of Nursing (RCN) (Manley *et al.*, 2011), a union representing less than two-thirds of registered nurses, do not acknowledge nurses as role models in a public health sense. Although the Commission's relevant recommendations will not be implemented, the fact that they attracted such wide support from the nursing 'establishment' (including the Department of Health's Chief Nursing Officer, the RCN, and the NMC) lends them considerable authority, and the watered down response, facilitated by the same organizations, is further illustrative of the general confusion.

To recap, I have offered two possible accounts of how responsibility for health might be understood and analysed. The first account, which could be deepened by inductive concept analysis, is or could be theory-forming, empirical and stems from ordinary usage of the word by members of the public and patients who answered questions about responsibility. It is incomplete rather than inadequate in its expression. The second is theory-formed and normative but requires clarification and deeper understanding to be effective. The policy examples demonstrate that the concept has a social, action-guiding function but there is no clarity about what is required and the mixed messages illustrate an account which is as inadequate as it is incomplete. The task for the remainder of this paper is to argue that the two accounts I have offered are not incompatible, and that they and other usages of 'responsibility' can be unified under a broader understanding of what responsibility for health means, and I proceed by introducing the philosophical literature on responsibility. Although this may

¹³The document is addressed to 'Patients and the public'.

provide a richer application of both of the accounts I have offered, philosophical illumination also reveals incoherence at the heart of healthcare provision and practice; attempting to avoid this incoherence may be one cause of the partial accounts populating the literatures.

The philosophical literature

Causation

Causation plays a major part in responsibility. When we say that X was responsible for Y, meaning can be restricted to X caused Y. The causal claims can include non-moral and even inanimate objects. We say that ice was responsible for the collision, or the red sock was responsible for the pink washing. When we ask 'who is responsible for the broken window?', we ask how the window came to be broken. A small child throwing a stone is superficially and causally responsible for the broken window, but not, in Sie's (2005) categorization, deeply morally responsible because he is not a moral agent. Causation is also key in the relationship between being responsible for a thing and being responsible for our acts and omissions in relation to the thing. When we say that we are responsible for our health we cannot mean that we are responsible for all aspects for our health at all times. If ill health results from being struck by an asteroid, nothing that we did or omitted to do caused the injury. It could be said that my omission to be elsewhere was a factor but this is only relevant in the deeply morally responsible sense if I knew and understood that I was going to get hit, and that therefore I ought to have gone somewhere else to avoid it.

Causative links between actions or omissions and poor outcomes for the things that we are responsible for are central to the question of what we ought to do to keep well, and why. A group correlation between smoking and heart disease does not mean that all heart disease is caused by smoking, or even that the heart disease of smokers was caused by smoking. Smoking, though correlated with heart disease, is neither necessary nor sufficient for individual instances of heart disease. Inevitably the devil is in the detail for specific causative factors for specific dis-

eases, but for this paper, it is enough to note that discussion about responsibility for health involves deep, moral responsibility as well as superficial causal responsibility, and that because of the lack of certainty of individual causation it is not health *per se* that we are responsible for but rather our actions or omissions that threaten or enhance it.

Other forms of responsibility

H.L.A. Hart (1968) and others (e.g. Cane, 2002) have pointed out that responsibility comes in many forms, for example role responsibility and legal responsibility.¹⁴ It is important to distinguish between the various forms of responsibility, especially where they coincide. Consider the various forms of responsibility as they relate to Z, a user of heroin. Let us assume that Z has entered into an agreement (contract) with the healthcare team that he will not use heroin, and that if he does there is a consequence, say that he will be discharged from a rehabilitation unit (Houmanfar *et al.*, 2009). We know that there is a law¹⁵ prohibiting the possession of heroin, and so if he is found in possession he is liable to prosecution. For quasi-contractual¹⁶ and legal responsibility we can examine the agreement, or identify legislation or case law, and these are clear in defining what Z is obliged, contractually or legally to do (or not to do), as well as identifying what will happen to him if he fails in this responsibility.

There may be moral reasons for Z to avoid using heroin (Smith, 2002), and no doubt these have influenced decisions that have made possession of heroin unlawful and the therapeutic contract acceptable. Fines and imprisonment may result from a breach of a legal responsibility, and discharge from rehabilita-

¹⁴These refer to various sorts of responsibility attached to individuals, but we also talk about collective responsibility and responsibility of institutions (Wilmot, 2000; Dubbink & Smith, 2011).

¹⁵The Misuse of Drugs Act 1971 provides for a maximum sentence of 7 years' imprisonment for possession of a class A drug (including heroin).

¹⁶I say quasi-contractual because I do not want to imply that the sort of agreement that I refer to is necessarily a legal contract.

tion results from a breach of the agreement. That these breaches may also represent moral failure is contingent but not necessary. Moral responsibility differs in at least two respects here. First, there are no unequivocal moral facts about taking heroin that make it absolutely the case that it is immoral.¹⁷ Many would hold that taking heroin is wrong and cite reasons in support, but there is also a view that taking heroin is morally permissible. Other health-threatening behaviours also attract differing views about whether they are morally forbidden, allowed or (in some cases) obligatory or morally neutral. It cannot be said that taking heroin is immoral with the same certainty as it can be said that possessing heroin is unlawful. Z cannot deny the legal and quasi-contractual responsibility not to take heroin, but he can take the view that there is nothing morally wrong with it.¹⁸

Second, the consequences for failing to meet legal and contractual responsibilities are clearly articulated, but this is not the case when failing to meet a moral responsibility. The relationships between an agent, his moral obligations, and the consequences of not meeting them form the basis of the philosophical concept of moral responsibility. Two versions are briefly reviewed: reactive attitudes and accountability.

Moral responsibility (I): Strawson and the reactive attitudes

You cannot go very far into the philosophical literature on responsibility without encountering Peter Strawson's influential lecture and paper, *Freedom and Resentment*, first published in 1962. The paper's aim is to argue that our normal practices of moral responsibility are 'underpinned by reasons that are immune to the threat posed by determinism' (Maltravers, 2007, p. 34). Determinism is the theory that everything that happens is determined by the things

that precede it and the natural laws of physics. If true, this would effect the way we regard the things that people do, for despite our weighing up options and reflecting on our choices (both of which are also determined), we only end up doing the things that we would have done. Our part in the causal chain is fixed; choice is illusory, we can only do the things that we are determined to do. Incompatibilists (Van Inwagen, 1975) argue that if determinism is true, we cannot be morally responsible for the things we do.¹⁹ Compatibilists, like Strawson, argue that moral responsibility obtains even if determinism is true.

Fully causal determinism is virtually absent in the literature on autonomy and responsibility in health care, possibly because the idea of a fully determined life is so difficult to comprehend. There appears to be at least a compatibilist assumption if not an outright assumption of the falsity of determinism despite what Wallace (1994, p. 58) refers to as 'the seductiveness of incompatibilism'. Nelkin (2007, and see Kane, 2005) cites several influential sources for the view that intuitively we start as incompatibilists: 'we are incompatibilists before we (compatibilists) start studying philosophy and talk ourselves out of it' (2007, p. 244). She proceeds to discuss a number of areas where intuitions tested empirically are inconsistent, and the view emerges that we are instead compatibilists by inclination. In contrast to the absence of causal determination in the literature, other less complete forms of determination, for example, genetic, social, and environmental, are highly visible in the sense that these influences, whose effect on behaviour is correlated at the societal level (Raphael, 2006), can be suggested to threaten and impede moral agency and therefore responsibility. The question must be suggested; if our natural inclination (if we have one) is to be compatibilist in the matter of causal determinism, must consistency require that we also be compatibilist in the matter of genetic, social, and other determinist mechanisms which fall short of full causation? This is hinted at in the King's Fund (2004) report, which is incompatibilist in its reporting, if not its data. Nelkin's

¹⁷This is not the place to discuss whether there can be moral facts or whether, if there can, it is true that taking heroin is wrong.

¹⁸He cannot deny that the law prohibits possession, but he can argue that it ought not to. The relationship between law and ethics is far too complex to discuss in detail here, and I have taken a very simple line to make the point.

¹⁹Here the incompatibility is between free will and determinism, but as moral responsibility requires free will, moral responsibility and determinism are also incompatible in this account.

examples of inconsistency in intuitions support the view that individually and collectively humans are not as rational or consistent as we may hope or believe and this threatens arguments premised on intuition claims and reflective equilibrium (and see Sutherland, 1992; Thaler & Sunstein, 2009). The often repeated view that more research is necessary seems for once to be fully justified.

Strawson's (1962) paper is relevant not so much because of its compatibilist emphasis, but rather in the claims about the purposes and nature of moral responsibility. Moral responsibility is based on the reactions of other people to our character and actions. When we are wronged we feel certain reactive attitudes towards wrongdoers: resentment and indignation. Generally people care about what others think of them, and wishing to avoid being thought of badly is a powerful social regulator of behaviour. The significance of the paper, and those that developed the ideas, lies in the view that individuals are responsible for those things that elicit the reactive response in the wronged. Being responsible is understood in the fact and process of being held responsible. Strawson was at pains throughout the paper to base his views on what he called 'common places', what we might consider as common morality, something which he says is easy to forget when we are engaged in philosophy. Other compatibilists (optimists as he calls them) have argued from consequentialist calculation that our practices of holding people responsible operate to regulate behaviour in socially useful ways, but that is to over-intellectualize the process:

what is wrong is to forget that those practices, and their reception, the reactions to them really *are* expressions of our moral attitudes and not merely devices we calculatingly employ for regulative purposes. (emphasis in original) (Strawson, 1962, p. 93)

His claims about the practices of holding people morally responsible as well as their compatibility with determinism (should it be true) are based on ontological rather normative premises. There are exceptions in our practices for those, like children, or expressed in the language of the time, an 'idiot or a moral idiot' (p. 82), and a recognition that a lack of intention also ameliorates the reactions.

Such reactive attitudes form part of the fabric of interpersonal relationships, but there are also vicarious attitudes felt by individuals not directly affected by wrongdoing. Instead of resentment we feel indignant or disapproving. We feel these attitudes of those who lie, distinct from and weaker than the resentment that we feel against those who lie to or about us. The moral demand here is that individuals should refrain from lying,²⁰ but in the general sense, these vicarious attitudes speak to the nature of all moral expectation and define them in terms of an emotional response.

But these attitudes of disapprobation and indignation are precisely the correlates of the moral demand in the case where the demand is felt to be disregarded. The making of the demand *is* the proneness to such attitudes. (emphasis in original) (Strawson, 1962, p. 90)

As the author of a relatively short if very influential paper, Strawson left it to others to develop the ideas (e.g. Fischer, 1987; Kahn, 2011). R. Jay Wallace (1994, p. 226) deepened the account in several ways, concluding that:

It is reasonable to hold agents morally accountable when they possess the powers of reflective self control; and when such accountable agents violate the obligations to which we hold them they deserve to be blamed for what they have done.

Wallace (1994) also develops the nature of the obligation that is a necessary feature for responsibility in his account. Having the reactive emotions as a justifiable response to an action relies on the cause of the emotions having certain moral features such that the agent ought not to have done it. Or, he has failed to do something that he ought to have done.²¹ An agent can be responsible for a morally neutral act; he is a rational candidate for praise or blame even if the act is worthy of neither. While retaining the link between the act and a response, Fischer's (1987) account emphasizes the features of moral agency which make a person legitimately blameable. The extent to which he is held responsible depends on the nature of the

²⁰I put to one side for the moment the issue of whether lying can be justified or even required.

²¹See Harris (1980) on the equivalence of acts and omissions.

act he is responsible for. If it is morally neutral, holding him morally responsible is inappropriate, even though he is morally responsible for it in light of his moral agency.

Moral responsibility (2): The accountability version

The quotation from Wallace (1994) appears to go some way towards the accountability version of responsibility. Korsgaard (1992, p. 306) notes the unattractiveness of taking 'the assessment of others as the starting point in moral philosophy', and Oshana's (1997) alternative approach avoids working backwards from response. On this 'accountability' version of responsibility, a person is responsible if it is fitting that she gives an account for her behaviour. This entails the presumptions that the individual has:

- (a) antecedently met the requirements of responsible agency
- (b) has performed some act (or has exhibited some characteristic) of the sort subject to certain accepted standards of morality
- (c) typically has fallen short of these standards. (Oshana, 1997, p. 77)

Fittingness implies that it is not necessary for the individual actually to give an account; it is enough that it is appropriate. Similar to the reactive attitudes approach, there are exceptions for those who are not full moral agents; we could not ask someone with dementia or a small child to account for themselves any more than we would appropriately feel resentment towards them. In the case of direct wrongdoing it seems clear that an account is owed to the wronged, but it is not so clear to whom the account corresponding to vicarious disapproval in the reactive attitudes approach is owed. Regardless of whether the account is actually given, Oshana (1997) claims that the approach has the advantage of focusing firmly on the agent and what he has done, placing the burden upon the actor, regardless of the reactions of others.

There are clear differences between the reactive attitudes and the accountability versions of the nature of moral responsibility. Consider Agent A, undertaking behaviour B which elicits responses C. In the reactive attitudes version, the responses <C(ra)> consist

of indignation, or objectively, disapprobation from others, a consequence of B in the sense that it has occurred after A has undertaken B, and is a result of B. A is morally responsible for B *because* C(ra). In the accountability version the process follows the other direction. We say if A has certain properties, and B is wrong, then he is liable to consequences <C(a)> in the form of being required to give an account. A is responsible for B *therefore* C(a).

There are many caveats in both versions, but for now it is sufficient to draw attention to the similarities between the versions of responsibility rather than identify and unpick the differences. These similarities do little more than identify the constituent parts, but this is enough to expose the inadequacy of the concept in current usage within health care. These constituent parts or facets (Guttman & Ressler, 2001), are a person, an act (or omission), and a reaction or a consequence. Or, a responsible agent who has responsibilities, and can be held responsible. These three constituent parts are implied in any discussion of any type of responsibility, although the reactive attitudes are distinctive features of moral responsibility.

Applying the framework to the case studies

I considered three examples: teenagers with diabetes, Canadian women's magazines, and the Kings Fund report. Does the three-stage analysis extend understanding in these cases? In the first, the teenagers are on the cusp of full moral agency. The narrative concerns 'taking charge' or accepting responsibility.²² The responsibilities are the obligations detailed in the questionnaire, turning up for clinic appointments, remembering to take medication, and so on. Absent from the account is any consideration of the consequences of failing to meet the obligations, although it seems plausible that a teenager neglecting to take medication may be subject to some reactive emotions at least from her parents. Olinder *et al.* (2011, p. 6) briefly consider this but only to the extent that 'nagging and criticism are not wanted. Sometimes

²²See Waller (2005) on the difference between 'take-charge' and 'just deserts responsibility'.

they just want to be reminded, rather than asked why their blood sugar is high.' The Canadian magazines' narrative appears to assume moral agency in their readers. There is clearly some notion of obligation but little acknowledgement of consequences, although the moralist stance employed implies that those failing in their obligations will be thought less of. The King's Fund report considers and rejects the notion of full moral agency, does not engage in any sense in what health-related obligations might be, and seeks to restrict the consequences of failing to meet these unspecified obligations on the grounds of incomplete agency.

All we can say from the potential inductive process is that the three-stage analysis is not inconsistent with the three examples, and it is unclear how the three-stage analysis could have been arrived at by an empirical study of use of the word responsibility. How does the three-stage analysis illuminate the second use of responsibility, that is, its use as an action-guiding concept within health policy?

Applying the framework to health policy

It is fair to say that there has been some controversy in the application of the political concept of personal responsibility in a number of policy areas. As far as health (and welfare) is concerned, the notion is perhaps more popular and developed in the Anglo-American post-war tradition than on the European continent, although it appears to be gaining ground in Europe where, paradoxically perhaps, socialized medicine is less developed than in the UK (Schmidt, 2007; Ter Meulen & Maarse, 2008). As far as the emphasis on personal responsibility is concerned, policy appears to assume agency, is confused in the matter of obligation, and has consistently ruled out overtly holding patients responsible. We will see that the ground is characterized by difficulties and apparent paradoxes problematizing each stage of the application of the concept. In identifying some of these I assume that despite the rhetoric, individuals are not currently held (morally) responsible for their health or their health-threatening behaviours, and so the

question offered for more detailed analysis elsewhere is not in what ways are individuals responsible for their health within the system of socialized medicine, but why are they not?²³ We will look briefly at each stage in turn.

Moral agency

Workaday application of autonomy in health care understood minimally as a commitment to informed consent belies the complexity of the various conceptions (Oshana, 1998; Coggon, 2007). Allmark (2008, p. 41) defines individual autonomy as 'the capacity of the individual to make and act upon judgments for which he is held morally accountable.' If this is the case, the result of the equivalence of autonomy and accountability (or responsibility) could reasonably be expected to conclude that if a patient is considered to be sufficiently autonomous to be allowed to buy cream cakes, or to consent to weight reduction medication or surgery, then he is also sufficiently autonomous so as to be liable to be held responsible for his/her eating and the obesity which follows, regardless of the multiple factors which influence eating behaviour, recognized by the UK government in its foresight report (Butland *et al.*, 2007).

Oshana (2002) argues that the solution to this apparent paradox is that the equivalence of autonomy and responsibility is mistaken. A morally responsible agent has to be capable of normative competence as well as being able to act on desires and intentions. She gives the example of two versions of Hitler, the first version of which is incapable of recognizing any moral code which prevents him ordering genocide. She regards this first version of Hitler as not being a responsible agent, different from the second version, who does recognize moral reasons for not ordering genocide but allows them to be overruled. Punishment for the first version, that is holding responsible, must be justified solely by referral to the

²³I am confident that many of us are held (morally) responsible within close interpersonal relationships, but this lies outside the inquiry on moral responsibility within socialized medicine.

utilitarian²⁴ approaches that Strawson (1962) and others opposed. This is an extreme example perhaps, likely to test the credibility of the reflective equilibrium approach, which should capture our²⁵ intuitions in clear cases (Fischer & Ravizza, 1998). The obese cream cake eater may not acknowledge the second helping as a moral wrong, but that does not mean that she is incapable of doing so. The example of the Hitlers makes the point that responsibility requires additional features especially concerning rationality, and these additional features do not figure in considerations of deciding whether a person is sufficiently autonomous to consent to treatment. In the UK, capacity is decided upon by application of tests outlined in the Mental Capacity Act (2005), which determine ability to understand and retain information and use it to make a decision. The rationality of the decision lies outside the process, reflected in Lord Donaldson's famous observation that the absolute right to autonomy '... exists notwithstanding that the reasons for making the choice are rational, or irrational unknown or even non-existent'²⁶ (Brazier & Cave, 2011, p. 118). Oshana (2002) claims that the error in lumping together autonomy and responsibility stems in part from a conflation of the global state of being autonomous with a locally autonomous act. The tendency to think of the former as being tied to responsibility results from the close ties between the latter and being responsible for the act in question. Workaday understanding of autonomy in health care very firmly concerns the latter.

Conversely, in discussing moral autonomy Dworkin (1988, p. 35) states that 'A person is morally autonomous if and only if he bears the responsibility for the moral theory he accepts and the principles he applies.' And of interest is the view expressed in the United

²⁴As far as utilitarian accounts are concerned, it is possible to punish an innocent person (in the sense that he is not fully morally responsible) in the pursuit of greatest utility.

²⁵I am never sure when philosophers say 'our' as in should capture 'our moral intuitions about clear cases' whether they mean their individual intuitions, or the intuitions of people in general – and if the latter what evidentiary support is available.

²⁶The case was *Re T (Adult: Refusal of Medical Treatment)* (1992) 4 All ER 649, CA.

Nations Educational Scientific and Cultural Organization (UNESCO, 2008) bioethics core curriculum²⁷ that

In ethics the notions of autonomy and responsibility are mutually related. There is no autonomy without responsibility; beyond responsibility, autonomy turns to arbitrariness which means that the person in his/her decisions does not take into consideration the interests of others. (UNESCO, 2008, p. 27)

The relationship between responsibility and autonomy is too complex to be discussed in depth here, and my aim is simply to argue that there is a *prime facie* case for the view that if a person is considered autonomous then she is also responsible. Nevertheless, mainstream bioethics and liberal political opinion acknowledges limitations to responsibility, for example in genetics (Levitt & Manson, 2007), the neuroscience of decision making (Burns & Bechara, 2007), and the language of addiction wider than drug use (Foddy, 2011), while simultaneously promoting autonomy in the same persons. If patients are not held to account for their (allegedly) autonomously enacted health-threatening behaviour, then we must look further than moral agency to enquire why.

Obligation

Williams (2008) argues that philosophers usually discuss responsibility retrospectively, that is holding responsible, or consider the features of moral agency. Strawson's (1962) account is premised on the relationship between the agent and the response, and the technique of reflective equilibrium testing intuitions about clear cases. A clear case, for example tests intuition of, say a cat knocking over a vase. Our intuition tells us that we do not hold the cat responsible because it is not a moral agent. We have different reactive attitudes, and to different extents if a small child knocks over the vase or if a passer-by twists her ankle

²⁷The UK ethics curriculum for medical students includes that students 'be able to demonstrate a critically reflective understanding of the rights and responsibilities of patients and possible justifications for limiting their rights' (Stirrat *et al.*, 2010, p. 57). There is no equivalent curriculum for UK nurses.

and stumbles into it accidentally; we reserve full indignation for an autonomous person acting recklessly, or worse, maliciously. The attitudes we feel tell us something about what we think about the agency of the person or the circumstances of the action, whether there was coercion, or constraint or just bad luck, or whether the vase was appropriately protected by its owner. The purpose of these thought experiments is to test our intuitions about moral agency, but there is another explanation for a failure to experience the reactive attitudes; the act may be morally neutral, and this seems important in an attempt to apply the reactive attitudes account of responsibility to healthcare provision. Many people would fail to feel disapprobation against smokers, not because they doubt agency (although they might), but because they think that there is nothing wrong with smoking.

We may conclude from this that the reactive attitudes approach to moral responsibility, notwithstanding Strawson's ontological claims, does not really help in understanding the social function of responsibility for health. Understanding responsibility as requiring an account is more appropriate in this context because it proceeds from moral agency to establishing what it is people are responsible for. Individuals owe an account for failing to meet an obligation, but not for acting in a morally neutral way. Responsibility for health requires obligation and this presents the major challenge to the use of responsibility in a social function, explaining the insipid telling of patient responsibilities seen in the NHS constitution and elsewhere (Royal College of Surgeons of England, 2005). The normative tension at the heart of professional health care is between respect for autonomy and responsibility.

Although the emphasis of autonomy in Anglo-American bioethics has been subjected to recent critique (e.g. Varelius, 2006; Woods, 2007; Walker, 2009), it remains predominant (Gillon, 2003; Edwards, 2009), showing little sign of revision in at least its workaday understanding. Valuing, promoting, and respecting autonomy above all else is in direct opposition with the notion of obligation. Dworkin (1988, p. 41) states:

A moral theory that stresses the supremacy of autonomy will have difficulties with the concept of obligation. As the ety-

mology suggests, to be obliged is to be bound. And to be bound is to have one's will restricted.

The result of this conflict can be seen throughout health promotion, for example in the health warnings on cigarette packets,²⁸ which are worded in terms of information giving, rather than direct appeals to the moral wrongness of smoking. Of the 14 messages printed on the back of cigarette packets, 11 are written descriptively, offering information, for example, 'smoking clogs the arteries and causes heart attacks and strokes'. Three are prescriptive: (i) Protect children: don't make them breathe your smoke; (ii) Smoking is highly addictive: don't start; and (iii) Get help to stop smoking: consult your doctor/pharmacist. At the risk of stretching the point a little, (i) merely obliges a smoker to smoke away from children, not to abstain altogether, (ii) is apparently addressed to non-smokers and (iii) obliges the smoker to get help, rather than stop. It has been argued that campaigns which set out to educate about health are, unlike other forms of education, evaluated not in terms of what people know, but in terms of how behaviour changes, because the purpose is an unacceptably morally loaded attempt to change health values to those of the educator (Allmark & Tod, 2007). The unresolved tension is between the giving of morally neutral information in support of autonomous decision making and the attempted revision of morally loaded values and associated obligations.

In the case of smoking these values lead to the view that health education should be directed at trying to get people to give up smoking, but a full rationale for the view that smoking is morally wrong is not offered. Butler's (1993) account of the moral status of smoking is based on harm to others and this also was given as the rationale for legislation prohibiting smoking in public places,²⁹ and could be offered for the child-protecting injunction printed on cigarette

²⁸The list can be found in annex 1 of Directive 2001/37/EC of the European Parliament and of the Council of 5 June 2001.

²⁹See for example House of Commons Health Committee (2005); para 41 'The justification for the principle of a ban is straightforward: workers have a right to be protected from SHS (second hand smoke).'

packets. These other-regarding considerations are consistent with Mill's harm principle, placing justified restrictions on autonomy. However, putting these to one side, while noting the beneficial effects to smokers and non-smokers of banning smoking in public places (Meyers *et al.*, 2009), we are left with self-regarding reasons not to smoke (or not to take drugs³⁰ or eat cream cakes), and it is here where the imposition of values threatens autonomous decision making. These values are based on a specific conception of health, normatively loaded but neither explained nor justified.

A further problem for 'responsibility for health' used in the sense of social policy is that even if the issue of having obligations in a general sense in the current environment of valorizing personal autonomy was accepted for other-regarding reasons, there remains the problem of identifying and justifying exactly what the obligations are and how they relate to a specific conception of health. A full understanding of 'responsibility for health' requires detailed acceptance of the concept of obligation and detailed justification for its determinative conceptions.

Holding responsible

Both the reactive attitudes and accountability versions of responsibility require engagement with our practices of holding individuals responsible. The reactive attitudes account appears to present problems for professional health care because healthcare professionals are required by their professional bodies not to have the sorts of attitudes that Strawson claims are definitive of moral responsibility, even of its vicarious expression.³¹ The ontological nature of Strawson's claims (and see Stark, 2004) is in tension with the normative and regulatory demands made of health

professionals, especially noticeable in nursing literature and regulatory documentation, for example concerning discrimination discussed earlier. Positive emotions (Scott, 2000), even love (Stickley & Freshwater, 2002), towards patients are lauded in the nursing literature; negative ones are not, although neither are fully under conscious control. Regarding the expression of emotion rather than its experience as the morally relevant feature may help, but this seems to undermine a claim that (positive) emotions are to be cultivated. The NMC (2008) Code requires that nurses 'treat people kindly', and this similarly leaves unanswered the question of whether a nurse can treat someone kindly without being a kind person.³²

The accountability version of responsibility must engage with the question of if and to whom an account is owed. Just because it is fitting that a person gives an account, it does not necessarily follow that an actual account is required or justified (Smith, 2007), but if there is a reluctance to blame patients for their behaviour, this may be because of a narrow application of what blame means. Martin (2001) starts a wider categorization of blame with the simple ascription of wrongdoing to someone who is morally accountable.

It is the NHS which has told us, the public, and its patients that we should take some personal responsibility for our health, and this is accepted by many. As the provider of potentially avoidable treatments, it seems consistent that the account is owed to the NHS. If this were the case it would fall to healthcare professionals employed by the NHS to hold people to account, but this seems to fall outside the bounds of patient-professional relationship (Kelley, 2005). That is not to say that all moral evaluation of patients' behaviour is disallowed. Positive evaluation in terms of praise could form part of therapeutic relationship, but negative evaluation, that is blame, is not. This therapeutic version of the praise-blame asymmetry is the reverse of that observed in empirical studies (Nelkin, 2007; Hindricks, 2008). It would also be difficult for a nurse to accept an account from a recalci-

³⁰In the UK a long-standing radio programme asks guests to choose what records they would take if they were marooned alone on a desert island. They are also allowed a single luxury item. If the guest chose a lifetime supply of cigarettes and the means to ignite them would or should health promoters attempt dissuasion?

³¹There are studies in the literature which have found these attitudes in nurses (e.g. Brown, 2006).

³²This is an expression of the familiar debates between act and agent-centred approaches to nursing ethics.

trant patient knowing that she may bump into him in the smoking area, a problem acknowledged in the Prime Minister's Commission.

The area where tangible consequences³³ (liability blame in Martin's (2001) categories) for failure to meet health responsibilities are most plausibly defended is in the suggestion that persons with alcoholic liver failure be denied liver transplantation, or be prioritized lower in the waiting list than those whose disease was not caused by drinking. Although it can be argued that the disease of alcoholism restricts agency, holding responsible in this manner is defended (Glannon, 1998) in certain circumstances (Brundy, 2007), or as a 'tie breaker' where other considerations are equal (Thornton, 2009). However, official guidance in the UK from the National Institute for Health and Clinical Excellence (2008) states that taking past behaviour into account is relevant only insofar as its continuation threatens the effectiveness of the proposed treatment. The forward-looking nature of the official position supports a view that it does not amount to holding responsible, instead merely being one of several criteria that predict the effectiveness of the treatment. Even in this apparently clear case where the causal link between behaviour and disease is settled and the resource is absolutely rather than relatively scarce, the notion of holding patients responsible (at least in this way) is not allowed.³⁴

Conclusion

The discourse of personal responsibility for health is prevalent in the UK and elsewhere, and is set to remain as behaviour-related ill health continues its inexorable increase. The analysis I have offered breaks down the concept into three constituent parts: the agent, an obligation, and a consequence, and I have argued that this overarching approach applies to each of the various incomplete conceptions found in the literature. Regarding responsibility for health as

³³This is of course in addition to the health consequences of undertaking the risky behaviour (Harris, 1995).

³⁴For a useful and brief paper categorizing the various arguments and counter-arguments, see Sharkey & Gillam (2010).

fulfilling a social function within professional health care is problematic in all three of these constituent parts, most significantly in its occasionally paradoxical relationship with personal autonomy, the respect and promotion of which remains the predominant moral imperative in Anglo-American bioethics. The analysis offered here remains largely at the conceptual level, and more detailed work is required in the application of the concept of responsibility for health to professional health care, both socialized and private. I suspect that this should and will result in a partial and tentative retreat from thoroughgoing respect for autonomy, but at minimum it will require a more nuanced public debate about what the healthy life consists in, how it ought to be maintained, and what obligations are owed to whom, for what reasons, and with what consequences. Currently responsibility for health is conceptually incoherent and if it is to retain its visibility in health policy, this is a situation requiring urgent remedy.

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What's Wrong with Tombstoning and What Does This Tell Us About Responsibility for Health?

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Using tombstoning (jumping from a height into water) as an example, this article claims that public health policies and health promotion tend to assess the moral status of activities following a version of health maximizing rule utilitarianism, but this does not represent common moral experience, not least because it fails to take into account the enjoyment that various health effecting habits brings and the contribution that this makes to a good life, variously defined. It is proposed that the moral status of health threatening activities should instead be defined by a version of act utilitarianism where both maximizing value and method of calculation are decided by individuals. In this account personal responsibility for health is reduced to the obligation to undertake calculations effectively, comprising of two duties; epistemic and reflective. If there is an individual epistemic duty, it is plausible to suggest that health promotion should present information in a way which facilitates it, but despite the prevalent language of autonomous choice, discussion of health promotion messages, for example, related to drinking and smoking demonstrates that this currently does not happen. Health promotion strategies should seek to encourage reflection about the harm our health effecting behaviour causes others.

Introduction

The practice of leaping from rocks or fixed man-made structures into the sea has been a recreational activity around coastlines for many years, but recent increasing frequency and fatalities¹ have brought it to popular attention. Organizations like The Royal Society for the Prevention of Accidents (RoSPA) and Royal National Lifeboat Institution (RNLI) have issued warnings and information films about the dangers and offer advice about how to minimize risks (RNLI, undated). There have been calls to ban the activity (Walker, 2007); temporary dispersal orders have been granted at least in part to prevent tombstoning (BBC, 2011a) and a youth was charged with Breaching the Peace following a tombstoning incident which necessitated lifeboat rescue (BBC, 2007). Many videos of tombstoning can be found on video sharing websites, and it has been suggested that these should be removed or accompanied by warnings (Aiken, 2009).

It is clear that many people undertake tombstoning in its various guises, while others disapprove of it, and in some cases this results in attempts to discourage, prevent or punish tombstoners. This article considers the moral status of tombstoning, and by analogy, other

forms of health threatening behaviour, beginning by analysing the reported responses to a tombstoning accident. Three versions of its moral status are identified, all utilitarian in origin and yet resulting in sharply contrasting conclusions because the utility calculations use different variables. Calls to disapprove of or to prevent tombstoning are consistent with a notion of responsibility for health based on health-maximizing rule utilitarianism that does not represent the moral reality of tombstoners. An alternative act-utilitarian approach is advanced using individually selected values and calculations. Responsibility for health, on this account, results in moral obligations in process rather than outcome, specifically two duties:² the epistemic duty and the reflective duty. These duties are outlined and their implication for public health discussed.

The Case of Sonny Wells

Aged 20 years, Sonny Wells concluded a Sunday afternoon drinking with friends by ignoring signs stating 'No diving – maximum penalty £500' and jumping 30 feet off the pier at Southsea into just three feet of water.

Pulled unconscious from the water and airlifted to hospital, his neck was broken in three places, and though surgical intervention restored feeling and movement to his hands, he remains paralysed from the chest down, permanently confined to a wheelchair. A week after the accident, his parents released photographs of him in the Intensive Care Unit as a warning to others (BBC, 2008a), and the following month he appeared from his bed in a video, used by Hampshire police to discourage people from tombstoning (BBC, 2008b). Further videos featuring Sonny were made by the RNLI (undated) and the Dover District Community Safety Partnership (2011).

Sonny's mother is quoted as saying that:

‘[w]e know that we can't stop all youngsters and adults from tombstoning but if we can stop just a few of them from doing it then it would have been worthwhile. If they could see Sonny they wouldn't do it. It takes him half an hour to get dressed now instead of five minutes because he has to use his teeth.’

(BBC, 2011b).

The chairman of the Dover Community Safety Partnership, which funded the video, is quoted in the same report: ‘We all must play our part in discouraging this dangerous and potentially fatal activity’. These positions can be contrasted with that presented by RNLI and RoSPA. The websites of both organizations take the markedly different line that tombstoning is a high-risk activity, and should be undertaken having taken steps to understand and minimize the risks. So, for RoSPA, the advice is:

Don't jump into the unknown. Consider the dangers before you take the plunge:

- Check for hazards in the water. Rocks or other objects may be submerged and difficult to see.
- Check the depth of the water. Remember tides can rise and fall very quickly.
- As a rule of thumb, a jump of ten metres requires a depth of at least five metres
- Never jump whilst under the influence of alcohol or drugs
- Check for access. It may be impossible to get out of the water
- Consider the risks to yourself and others. Conditions can change rapidly—young people could be watching and may attempt to mimic the activity. And, if you jump when you feel unsafe or pressured, you probably won't enjoy the experience.

(RoSPA undated)

These statements are worthy of analysis because they express views about tombstoning from the viewpoint

of those closest to it—from the parent, the tombstoner and the chairman of the local public body—rather than from professional bioethicists or politicians. The views about the moral status of tombstoning embedded within the statements are grounded in everyday experience, more closely allied to common-sense morality than moral or political philosophy. Archard (2011) argues that linkage of theory to common sense morality is inevitable, and that a defensible moral theory, which though ‘at some distance from common-sense morality’ (2011: 124) must at least be consistent with it. In arguing against the view that philosophers can be considered moral experts,³ Archard claims that the role of philosophers should properly be that of advising or coaching non-philosophers, helping them to recognize the value of a better judgement. Brassington (2013: 22) defends a role for philosophy and philosophical technique in bioethics, though recognizes that it is charged that, ‘in respect of private activity, the input of a moral philosopher is mere moralising’.

There is a significant difference between the outcome of a moral assessment and the process which arrived at it, as Archard points out, between the propositional and the performative. A philosophical analysis that refers to and builds upon reasoning by the actors concerned has the advantage of being readily understood and worthy of application; it is more coaching than moralizing. However, grounding analysis in the common-sense morality of the protagonist is not a full inductive analysis, attempting to build a theory from the comments. Utilizing a variant of reflective equilibrium neither builds nor applies theory; the aim is simply to show that established moral theory or at least more structured thinking is consistent with common-sense expressions.

The Moral Appraisal of Tombstoning

It can be argued that everything that we do is a matter for moral appraisal, at least because we could be doing something else (Seedhouse, 2009). More realistically, the view that tombstoning is an act worthy of or even requiring moral appraisal is contained within Gert's (2005: 9) ‘correct’ view of morality which, following Hobbes, is simply that morality is ‘primarily concerned with the behaviour of people insofar as that behaviour affects others’. Bernard Williams (1985: 12) makes a similar point. If this is accepted then tombstoning is a moral issue to the extent that it affects others and the

relevant question becomes, to what extent does it affect others?

In the video produced by the Dover District Community Safety Partnership, Sonny said that:

‘[i]t’s not just what it does to you; it’s what it does to your family . . . your friends, and it’s just the way everyone has to live, you know . . . I have to have people on standby, on call, in case things go wrong. It’s not just my life that’s changed, their lives changed as well because it all revolves around me.’

(Dover District Community Safety Partnership 2011)

Sonny’s father Robbie Wells is quoted 6 weeks or so after the accident as saying: ‘It’s just selfish. It’s the impact on people around you, not just the injuries; it’s the years to come’ (BBC, 2008c). The advice from RoSPA and RNLI includes that the risks for others should be considered, identifying the possibility of setting a bad example to younger people as a special concern. These quotations support the view of tombstoning as a morally appraisable activity whose harms lie in its consequences, especially insofar as they affect others.

Three Moral Positions

Illustrated by the comments above, it is possible to identify a number of different assessments of the moral status of tombstoning. The first would be that it is wrong and should be banned. Sonny passed a notice forbidding diving (BBC, 2008b) on pain of being fined a considerable amount of money, and his mother talked of ‘stopping’ people from doing it. Signs advising (or requiring—it is not always clear) patrons not to dive into swimming pools are common but this injunction does not apply to jumping in, feet first, an activity assumed to be safe enough into 3 feet of water from the edge of a swimming pool but not from a 30 foot pier. It is also not clear whether the prohibition covers diving from the location of the sign or whether it covers the whole pier, including the end furthest from the shore where, though there will be other dangers, shallow water (the circumstance that injured Sonny) is not one of them. A ban on diving is not a ban on tombstoning itself, only jumping in a specified manner (head first) from that particular part of that particular pier. Other forms of prevention, such as erecting a barrier or other means of making unsafe jumping more difficult, do not appear to have been reported. The intention to prevent people from injuring themselves has apparently been treated as justifying the passing of by-laws, but as the

foregoing nitpickery demonstrates, formulating both a law and its justification presents considerable difficulties, not least in the question of whether the harm is considered serious enough to warrant criminalization at all.

The second position is articulated by the Chairman of the Dover Community Safety Partnership who, significantly, claims that individuals should be discouraged rather than stopped from undertaking ‘this dangerous and potentially fatal activity’. Detailed inferences cannot be drawn on the basis of the limited information available, but the statement is consistent with at least two understandings of the word ‘discourage’. The first is because of the potential harm caused, that tombstoning is a moral wrong, worthy of disapproval as well as discouragement, that is a position from tolerance.⁴ The second is that discouragement is merely prudential; in this case the discouragement is similar to that which discourages high-risk financial investments. Given that the wrongness of tombstoning lies in its effects on others, I am inclined to assign the former interpretation. The third position is stated outright by RoSPA and the RNLI, and amounts to saying that there is nothing wrong with tombstoning, as long as it is undertaken safely; and if the sensible advice offered is followed, the risk of possible adverse consequences can be minimized.

These three positions arrive at markedly different conclusions, though the moral methodologies share a significant feature, that is, they agree that the wrongness of tombstoning rests in risk and occurrence of injury. It is not stated or implied anywhere that tombstoning is intrinsically wrong.⁵ These positions are all consequentialist positions. But a characteristic of the presentation of the morality of tombstoning as a consequentialist morality is that it has resulted in three different conclusions; that it is wrong and should be prevented, that it is wrong but should not be prevented and that it is permissible.

Utilitarianism, Public Health and Private Morality

It is widely recognized that the philosophical basis of public health is utilitarianism⁶ (Rothstein, 2004; Holland, 2007). But this is not to say that a single fully worked up utilitarian theory can be applied to all public health issues, calculations made and (morally right) answers revealed and, though I assume that utilitarianism of one sort or another provides theoretical underpinning of public health generally as well as the

three positions on the moral status of tombstoning, it does not follow that tombstoning is a matter for public health ethical analysis at all.

The quotations at the beginning of the article concerned what ought to be done about tombstoning rather than saying that Sonny had acted immorally, but it should not be inferred from the absence of public condemnation that tombstoning is regarded by those advocating regulation as morally permissible or that it simply is not a matter for moral appraisal. It is more plausible to infer an unstated view that tombstoning is regarded as morally wrong by those who attempt to prevent it. As I have argued, and as much as any other activity, tombstoning is a moral matter to the extent that it affects others and this assessment of private morality should be prior to any consideration that it is a legitimate matter for public health intervention. In place of inferences and suspected moralism in transferring public health ethics into the private realm (and vice versa), it is suggested that private immorality is a necessary but not sufficient condition of something being subject to public health interventions of the sort that coerces behaviour to some degree.

At least two problems present themselves with this sequencing. First, there is the possibility of genuine disagreement about moral status that can apply at the level of general rules of action, specified application of the rules and anywhere in between. A simple view that regulations preventing tombstoning are not legitimate because tombstoning is a private matter could be rejected as question begging (Coggon, 2012). An attempt to make anything the subject of public health measures could be challenged with the response that the activity is morally permissible and therefore should not be regulated. There is not much unusual in this as political (and philosophical) disagreement forms the daily backdrop to public health dilemmas, but it is enough to suggest a revision of the view that private immorality forms a necessary condition for something to be a fitting subject for consideration of public health measures. This revision would need to be of the form that a plausible defence of the view that something is immoral is required, and this must be supported by enough people so that political legitimacy for public health measures can be claimed. This might be considered imprecise but at the minimum, a defence of a moral assessment is required and this in itself would be a considerable advance.

The second problem is one of consistency of moral method. As private morality assesses the moral status of something and public morality assesses the morality, generally, of preventing that something or a response

to that something, they are doing quite different things. The moral methodology of public health ethics does not transfer into the private domain and though this may frustrate those seeking a single overarching moral theory, it is an understandable position for many who regard moral theory as secondary to moral practice (Sterba, 2005). Even if common morality is seen as being rooted in utilitarianism,⁷ the variant which I claim is predominantly used in public health causes problems when transferred to the private realm. The reason why utilitarianism arrives at such contrasting conclusions in the moral assessments of tombstoning is that two of the variables used in the calculations are different.

Acts and Rules

In the matter of health threatening behaviour, maximizing calculations within public health ethics tend to operate at the level of rules rather than acts. There is reluctance for public health bodies to label (lawful) behaviours as immoral even as they attempt to reduce or prevent them. The reluctance to moralize or to override the greater (professed) good of respecting personal autonomy provides reasons why rules rather than acts are used because it allows the view to be both implied and inferred that it is tombstoning that is wrong rather than my acts of tombstoning or me as a tombstoner.

The problem for anyone considering going to the pier in order to jump off it is that the rules that tell him that he ought not to do it are not his rules. The calculations have been formulated elsewhere by an unseen, unknown hand which has not taken his circumstances as much into account as they should have. The rule has been formulated, he might think, because people jump off the pier casually, after drinking, without checking the depth of water and the strength of the currents or who are improperly dressed or prepared. None of that applies to me—I am dressed for it, I have researched the conditions and have come with support so that if an unforeseen event occurs I will be easily rescued. I am not doing this on a whim; it is my main recreation, what keeps me going through the dreary week, the thought of gleefully flying through the air anticipating the invigorating shock of the cold briny sea. Who are you, he might ask, to tell me that I ought not to do it? His indignation will likely deepen when he realizes that he is not being told, with justification, what he ought not to do, but rather what he must not do on pain of payment of a hefty fine. He is no anarchist—he really does not want to be in the position of considering breaking what he

considers a unjust law, he just does not think it applies to him.

His utilitarian calculation (and I assume that he does one), differs in at least three ways from that used by those arguing from a public health perspective. First, it concentrates on each act of jumping, recognizing that the advice from RoSPA has been followed so that the risks have not only been minimized but also to some extent quantified. It is not an exact calculation, but the binary calculation of risk, that is, the likelihood and the severity of the general consequences can both be considered without necessarily considering the consequences of the consequences, *ad absurdum*, which has been offered as an objection to act-utilitarianism (Streumer, 2003). Second, the calculation does what the rules cannot by allowing the individual to choose what to maximize and then to perform the calculation using circumstances known only to him. When he has done these things he is able to give an answer not to the question of ‘what is wrong with tombstoning?’, but what, if anything, is wrong with me tombstoning from this place at this point in time, knowing these circumstances about my life. Third, the public health calculation concerns the outcomes of regulation and not merely a moral appraisal of the regulated act or pastime.

The Maximization of Health

Public health utilitarianism, including as applied to health threatening behaviour, maximizes health generally. This health maximization could be either from a position that health is of intrinsic value (in utilitarian terms that it is the ultimate utility to be maximized); or it could be a matter of pragmatic calculation because using an instrumental account that health is valuable only insofar as it enables or restricts other activities contributing to the overall good, however defined and measured is just too difficult to calculate in a rule utilitarian approach. I assume that it is more likely to be the former, with health promotion tending to regard health in a narrow sense, largely physical, rather than within the World Health Organisation’s famously all-encompassing definition. For example, a textbook aimed at nurses and healthcare professionals promotes not information facilitating autonomous choice, but has as a key message; ‘Getting people to change their lifestyle requires them to make unpalatable changes . . .’ [Upton and Thirlaway, 2010: 19 (emphasis added)], and regards behaviour choices evaluatively: ‘People in the UK have always drunk alcohol, sometimes sensibly⁸ and sometimes stupidly . . .’ (Upton and Thirlaway, 2010: 107).

What Does This Tell Us About Responsibility for Health?

It will not have escaped many who have read this far that the discussion about the instance of tombstoning and the associated responsibilities and views about moral status are analogous to other forms of health threatening behaviours, which constitute a significant threat to health and are subject to a range of public health measures of various sorts, including health promotion. An advantage of using cases is that they can be simple and emotionally engaging. Inferential reasoning, implied rather than stated, can take the form of ‘A did x which is commonly judged as a bad action with bad consequences; therefore a general maxim forbidding x is a good maxim’ (Adapted from Spranzi, 2012: 483). A further inferential move from the good maxim (of forbidding⁹ tombstoning) to more general responsibility for health requires an argument from analogy, a more complex and controversial technique (Macagno and Walton, 2009), common in bioethics and applied ethics.

The concept of responsibility for health forms a significant part of public health ethics. Discourse is frequently concerned with the notion of *personal* responsibility for health, and while philosophical analysis can bring clarity to the confused concept, much of the debate is political in nature. Despite its many ambiguities the concept personal responsibility for health forms part of the NHS constitution,¹⁰ and is accepted by a large number of people (King’s Fund, 2004). There are three parts to responsibility for health (Snelling, 2012): (i) a moral agent having (ii) responsibilities, and (iii) liable to be held responsible in failing to meet them. This article discusses the second part, responsibilities and in doing so makes some assumptions about the nature of moral agency (the first part) and virtually ignores the third part (being held responsible).

Dworkin (1988) suggests that there is an essential contradiction between autonomy and obligation, and this is certainly the case where autonomy can mean simply the supremacy of personal choice and taking responsibility for health can mean doing what you are advised to do. However, the concepts of autonomy and obligation are not necessarily in conflict; the problem is that in this model obligations are defined by others. Obligations understood within an individual moral assessment augment rather than contradict personal autonomy, forming the process of moral decision making rather the outcome, externally derived. The obligations are, principally, private obligations and as the

objections of the imagined tombstoner show, these are formulated in terms of acts rather than rules. In the private domain our responsibility is to use act utilitarianism effectively and this amounts to two duties: the epistemic duty and the reflective duty. These inter-related obligations form our responsibilities for health.

Epistemic Duty

The epistemic duty is a duty to seek knowledge, to gather evidence and at least on certain topics, a duty which stands in need of very little justification (Levy, 2006). The epistemic duty requires moral agents to enquire about the likely effects that their behaviour has on their health and its purpose is to enable and facilitate the reflective duty.

Reflective Duty

(i) Harms

The reflective duty requires an individual to place his health threatening action(s) in the context not only of his own life but also the lives of others affected by them. This includes family and friends but also the wider community if the behaviour has a financial or opportunity cost where there is socialized medicine. Several levels of reflection require consideration under this duty. The highest level requires deep reflection about the meaning of the good life and although the reflective duty encourages this, it certainly does not require it. It does require, however, some consideration of the effect that health threatening behaviour has on others. The harms that should be considered fall broadly into three categories:

- (i) Direct harms resulting from the activity itself including injuring someone by jumping on him while tombstoning, or exposing others to second hand tobacco smoke.
- (ii) Indirect harms caused not by the activity but by resultant ill health. These can be suffered (a) by those immediately affected by poor health or death, like family members who are disadvantaged financially or who are harmed emotionally, and are also suffered (b) by society generally through a number of mechanisms including in some cases opportunity costs *in lieu* of treatment.¹¹

Reflective Duty

(ii) Benefits

It should be noted first of all that there is claimed to be wide benefit in facilitating autonomous choice, and this is a reason why respect for autonomy has become so dominant in society generally and particularly so in bioethics. Gillon (2003) among others makes this point in defence of respect for autonomy being regarded as 'first among equals' in the principlist scheme. He explains that enjoyment of eating fatty food results in an autonomous decision to carry on eating despite knowing and agreeing that giving them up would 'be better for me' (Gillon, 2003: 310). He seems to mean here better for his health rather than better for him generally but it appears to be on the latter grounds that he determines to continue his indulgence of these 'delectable' foods. The reflective duty encourages clarity over the issues of benefit to avoid the error of conflating what is good for health and what is good more generally. As these more general benefits cannot usually be described as 'health benefits', they are seldom taken into account by health maximizing health promoters. When he was Secretary of State for Health, Dr John Reid caused a furore when he was reported as saying 'As my mother would put it, people from those lower socio-economic categories have very few pleasures in life and one of them they regard as smoking' (BBC, 2004). It is of interest that he is reported as saying that the rationale for his reluctance to disapprove is that individuals should not be patronized, but nevertheless it is a rare acknowledgement that people derive pleasure from smoking and drinking and eating; and in some cases this pleasure is more deep rooted, forming a part of character, desired or otherwise. See, for example, Oliver Reed's quotation that 'I don't have a drink problem. But if that was the case and doctors told me I had to stop I'd like to think I would be brave enough to drink myself into the grave'¹² (Sellers, 2008).

What might be considered an extreme case of the tensions between risk and pleasure is provided by the adventures of Andrew McAuley, who left his wife and small child on the Australian shoreline in December 2006 and paddled into the sea fulfilling a long held ambition to kayak unaided to New Zealand. Two months later he drowned, agonizingly close to reaching his goal. His widow, Vicki McAuley, wrote a book detailing their life together as well as the planning and execution of the expedition. After paddling out of the bay, Andrew McAuley talks to a bow mounted camera:

'I'm really worried I'm not going to see my wife again, and my little boy. And I'm very

scared . . . I'm very scared. I've got a boy who needs his father . . . and a wife who needs a husband, and I'm wondering what I'm doing here. I'm wondering why I'm doing this, I really am. And I don't have an answer. People ask me why, and I love adventure.'

(McAuley, 2010: 6)

These examples of lives defined by adventure or hedonism do not extend to the millions of people smoking and drinking and eating more than recommended, but they do illustrate that these habits and many others which threaten health can contribute to a good life variously defined because they are enjoyable and self-chosen; something that health promotion aimed solely at changing behaviour fails to recognize. Kekes (2008: 10) states the case eloquently:

Moralists forget that morality involves not merely a set of commands and prohibitions, but also the pursuit of an enjoyable life. No reasonable person can deny that we all have responsibilities, but it is just as important to recognize that enjoyment must be part of any life that could reasonably be called good.

Reflective Duty

(iii) Calculations - Act or Rule?

A problem for the comparison of tombstoning with the more general targets of health promotion is that health promotion is formulated as rules, whereas the tombstoner more readily uses acts in his preferred utilitarian calculations. Although there are clear differences in how to calculate right action between acts and rules, Brad Hooker (2000b), who has advanced a detailed account of rule utilitarianism, concedes that in ordinary morality, not only are the outcomes often the same between act and rule utilitarianism, but also the versions agree on how, generally speaking, people should go about their day-to-day moral thinking. As Upton (2011: 435) points out, we do best by careful deliberation on acts which require it, but that generally the familiar rules 'with which we have grown up' serve as an effective starting point. Such deliberation results in the distance between act and rule utilitarianism being less significant in practice than might be expected, confirming that a kind of amalgam version is useful and workable as an action guide despite the apparently fatal objections to both theories operated alone.

It is difficult to be clear about what constitutes an act for the more common targets of health promotion. For smoking, and moving from the general to the specific,

the act could be (at a pinch) being a smoker or (just) smoking or smoking a cigarette or even taking a drag from a cigarette. It would be absurd to require a utility calculation before each drag or each cigarette, and in any case they would be identical and could lead to fallacious reasoning similar to the fallacy of the heap of sand or the fallacy of the beard (Clark, 2002): this drag on this cigarette will not cause me any long term harm, therefore neither will the next, nor the next . . . therefore smoking will not cause me any long term harm. Advocating act utilitarianism for smoking so that it is analogous to tombstoning requires the act to be conceptualized more generally, as the act of being a smoker; that is the thing (like a single act of tombstoning) that is harmful to health. This will apply to established smokers but a different calculus would apply to those who have never smoked or those who have smoked and given up but are vulnerable to restarting. In these cases the act of lighting or smoking a cigarette may lead to the individual (re)turning from a being non-smoker into a smoker (that is, the thing that is harmful) and so the smoking of a single cigarette or perhaps a few cigarettes over the course of an evening assumes a greater significance here than for the established smoker. Arriving at a theoretical preference for the level of analysis is ambiguous between and within the practical cases of tombstoning and smoking, but accepting, with Hooker (2000b) that in practice the approaches are similar, leaves the basic tension unresolved. What is needed is a theory that can account for both levels of evaluation.

R.M. Hare's Dual Level Account

Hayry's view (in 1994) was that R.M. Hare's dual level account in his book *Moral Thinking*, offered the best solution to the debate between act and rule versions of utilitarianism. Generally, we can be guided by the intuitive rules that constitute the first level of moral thinking, formed by experiences and moral emotions, but conforming to a version of general rule-utilitarianism. The second level, acts, requires critical thinking that has selected the set of *prima facie* principles for use in intuitive thinking, and also can be employed when the intuitive principles conflict. There is potentially some confusion as to the extent to which the *prima facie* rules need to be universalizable. If they are universal rules then the formulation will be of the sort that 'people should not smoke', whereas an individual is more likely to formulate a rule in terms of whether 'he should smoke',¹³ or perhaps even (recognizing that this is problematic for utilitarianism) that 'he is permitted to smoke.' Hare's critical level equates act utilitarian calculations with that

kind of rule utilitarianism ‘which allows its rules to be of unlimited specificity and which therefore is not distinguishable from act-utilitarianism’ (Hare, 1981: 43). For practical purposes it does not really matter at the critical level whether the agent specifies universal rules so that they apply to his circumstances, or takes an outright act-utilitarian approach, but both of these approaches stand in opposition to the rules generated by orthodox health promotions which are much more general in orientation.

What to Maximize and How

Having reflected on the wider risks and the benefits of the act or the behaviour under consideration, utilitarian moral theories require that a calculation be undertaken, placing the positive value of the act or behaviour against the potential harm that injury or death brings to those affected. The maximized value can be variously chosen; health, welfare, utility, preference or happiness and while difficulty in calculation is acknowledged as a significant problem with all utilitarian theories, weighing up pros and cons of decisions, and not only in the moral domain, is a fundamental part of everyday life. It is clear what is meant when we say that all things considered this or that decision is better even though we would be hard pressed to show our detailed working out.

A problem with this is that if the decision making process cannot be articulated, neither can it be scrutinized. In law, decision making processes can be challenged via judicial review which can find that decision making processes considered irrelevant criteria or failed to consider criteria which they ought to have done, but no appeal process exists in the reflective duty. It would be difficult to separate an objection, from a person whose objections matter, that the wrong conclusion (that I go tombstoning) has been reached, from an objection that the reflective process is inadequate (that the interests of my family have not been given sufficient weight). This might be a matter for discussion and potentially, blame, but ultimately it is a matter for the individual, similar to the question of what property should be maximized. Only a person at the centre of the decision knows his own thoughts and feelings and is much more able than a disinterested observer to judge the likely¹⁴ consequences of his action on those who are affected by it. An attempt to prescribe a decision making process is vulnerable to the same moralizing critiques as prescribing actions, though the defence of moral expertise is probably stronger here. The reflective duty requires a process of calculation and recognizes that there are many ways to perform it. The choice

and justification of maximizing property and decision making procedures are matters for the actor and he is accountable for them.

At the centre of her grief at losing her husband and father to her child, Vicki McAuley was quoted a week after his death as saying:

‘These are a few words that I’d like to say to my most wonderful man. To have the courage to pursue your dreams and believe that anything is possible is a rare gift . . . You are our hero. You live for adventure. You’ve just had one incredible adventure this time, and we were with you all the way . . . Ant, you have taught me how to live.’

(Chandler 2007)

It would be easy to characterize his behaviour as selfish or reckless, and many would. But Vicki McAuley has not because she alone really knows what it meant to him, and what it would have meant for him to forgo his ambition. His epistemic and reflective duties were performed, and though the result was catastrophic, the decision was, as far as process is concerned, moral. Strawson’s (1962) reactive attitudes account of responsibility defines the moral status of an act in terms of its provoked response, amply demonstrated in the anger of Sonny’s parents and Vicki McAuley’s pride; Andrew McAuley met his responsibilities and Sonny Wells did not.

Policy Implications

Autonomy is (purportedly) valorized within Western health care systems and autonomous decisions need information, recognized by the need for sufficient information for valid consent for care and treatment. However, illustrated by the ready adoption of behavioural insight (Cabinet Office, 2011; Yeung, 2012), current practice within health promotion is not to facilitate the epistemic duty, but rather to present information in a way designed to persuade people to change their behaviour. Unlike the process of gaining consent for treatment, the value of behaviour change, predicated upon the value of health, overrides the value of facilitating autonomous decisions. As Allmark and Tod (2007) have pointed out, health education, unlike other forms of education is evaluated not in terms of what people know but whether behaviour has changed.

For example, the strategy to reduce drinking is skewed away from education and towards behaviour change. Putting to one side the fact the evidence upon which the recommendations are based will be almost 20 years old by the time a review is completed (House of

Commons Science and Technology Committee, 2011) current guidance, though written for a public audience, is difficult to interpret. A key document is ‘Your drinking and You’ (NHS, 2012), which gives the lower risk guidelines as ‘No more than 3–4 units on a regular basis’. Clarification is offered for the word ‘regular’: ‘Regular in this context means drinking in this way every day or most days of the week’. It is unnecessarily unclear why the daily allowance is given as 3–4 U with no indication as to whether it is 3 or 4 U. Of the 22 other countries used as comparisons in the House of Commons Report, only Japan, the USA and Portugal (unofficially) use a range rather than a single daily amount. The definition of regular could mean 4, 5, 6 or 7 days a week. None of the other countries has this ambiguity, and only Poland uses anything other than a daily or a weekly allowance. The guidance (2012:2) goes on to state that if you are drinking just above the guidelines,

- Men are twice as likely to get cancer of the mouth, pharynx or larynx (part of the neck and throat), while women are 1.7 times as likely.
- Women increase their risk of breast cancer by around 20%.
- Men and women are both 1.7 times as likely to develop liver cirrhosis.
- Men are 1.5 times as likely to develop high blood pressure, with women 1.3 times as likely

For even higher consumption the same categories, adjusted for increased likelihood are given. It is impossible for anyone to make any sort of risk assessment based on this information because the likelihoods of developing the diseases highlighted are given in relative rather than absolute terms.¹⁵ The figures are virtually meaningless, and in addition the consequences of developing the diseases are not given—my blood pressure may be higher, but what does this mean for my health? Calculation of risk requires both understanding of the likelihood and the consequences of an adverse event occurring.

Information in smoking cessation material is similarly skewed. Although there is evidence that mass media campaigns have some success in smoking cessation (Bala *et al.*, 2008; Farelly *et al.*, 2012), the evidence about how the messages are presented is inconclusive. It has been recommended that preference should be given to negative messages (Durkin *et al.*, 2012) and there is some evidence to suggest that emotionally evocative advertisements work better than descriptive ones (Durkin *et al.*, 2009). Farelly *et al.*'s (2102) study lumped together emotional and/or graphic anti-smoking

advertising and found this category more effective in quitting behaviour than comparison advertisements. The most recent UK advertisement¹⁶ graphically shows a tumour growing on the side of a cigarette as it is being smoked, and while this obviously reinforces the proven links between smoking and cancer at the group level, like the alcohol information discussed earlier, it does nothing to facilitate epistemic duty and therefore reflective duty, because risk cannot be calculated.¹⁷ Other recent advertisements have invited smokers to consider the effect their habit has on others, for example, from 2009, the ‘scared and worried’¹⁸ campaign showed a boy explaining to camera what he was not worried about, but concluded with a shot of him with his father smoking a cigarette on a fishing trip: ‘... but I am worried about my Dad smoking. I’m worried that my dad will die’. In an emotionally challenging way, this advertisement invites the reflective duty, more consistent with the responsibilities for health outlined in this article, highlighting that the wrongness of the father’s smoking is in the pain expressed in the boy’s visible concern. In a similar vein, an advertisement from Australia¹⁹ shows a young boy aged about 4 years, standing alone in a train station having been separated from his mother. His concern turns to distress and as his tears begin the narrator says: ‘if this is how your child feels after losing you for a minute, just imagine if they lost you for life.’

Although of interest, the reworking of mass media campaigns alone will not satisfy facilitation of responsibility for health as conceptualized by the epistemic and reflective duties. It would require a wholesale shift from ‘getting’ people to change their negatively evaluated behaviour to giving them information to enable an autonomous decision and encouraging them to consider the interests of others as they make it. The most that can be hoped for is that the Government and its agencies embark on a fuller justification of its strategies. This may mean a renewed commitment with explanation of the operationalization of the concept of autonomous decision making and ways of encouraging a more morally reflective life, though this is clearly a much bigger issue than health promotion.

This is not to say that regulation and restrictions on unhealthy food availability or tax regimes that increase the price of alcohol and cigarettes are necessarily unethical. Though something being a fitting matter for private moral assessment is insufficient for it being a proper subject for public morality, this does not mean that the public has no interest in behaviour affecting individual health. But at the very least the essentially private nature of these behaviours requires public health authorities to provide a full explanation for policy interventions seeking

regulation. Something within the sphere of our individual influence being bad not for us, but our health, narrowly defined, is not sufficient. Our behaviour causing direct harm to others probably is enough; though causing indirect harm probably is not. Financial reasons alone present further difficulties in calculation in a system of socialized medicine and these provide better reasons for some measures (tax) than for others (bans).

Conclusions

(i) What is Wrong with Tombstoning?

The account that I have offered is more aligned to the approach to tombstoning advocated by RoSPA and RNLI, and the analysis of this article shows that it is because it focuses upon and facilitates the epistemic duty. Whether individual cases of tombstoning can be regarded as morally permissible depends on whether the framework of facilitation offered has been followed, and whether there has been adequate reflective attention given to the facts. If they have, tombstoning is morally defensible. I say defensible rather than permissible because the reflection is subject to evaluation and therefore disagreement and so should be regarded as a necessary rather than sufficient condition. A search for ‘people are awesome’²⁰ via the video sharing website YouTube further illustrates this. With very few exceptions, the people undertaking all manner of daredevil feats, tombstoning, base jumping, tightrope walking and extreme cycling are properly prepared and equipped, and it is assumed that what might be called this ‘professional’ approach implies that they have given the activity serious consideration. It is easy to accept the invitation to marvel at the skill, courage, enjoyment and sheer verve of the acrobats. People really are awesome. Contrast this with a search for ‘ultimate fails’.²¹ Among the assorted pratfalls, confused pets and distracted walking into glass doors are many examples of people falling off bikes and skateboards and hurting themselves. Like Sonny Wells, most ‘victims’ are ill prepared. There are few helmets or protective pads and failure often is the result of laughingly inadequate preparation though onlookers’ initial mirth often fades with the realization that serious injury may have resulted. What is wrong with tombstoning? Nothing at all, potentially.

(ii) Responsibility for Health

A change in emphasis from responsibility for health as following public health advice to a model of

responsibility which instead requires private process is closer to the espoused predominant value of respecting autonomy. It will require the giving of information about health in a more neutral way to facilitate the epistemic duty. The major challenge is in the reflective duty, which becomes the principal personal responsibility for health. It will remain the case that decision making will be influenced by factors outside individual control, but these will be reduced by a more reflective approach to deciding what our individual good life consists in and how this impacts on those who share our lives. Our responsibilities, that is our obligations, will be more clearly identified but not by the state in various guises. It probably is the case that most of us do have moral obligations in respect of our health and that they are largely unfulfilled. Insufficiently challenged weakness of will in the consumption of tobacco and alcohol and all manner of health threatening habits possibly are, for many of us, immoral. And though the end results are similar, the key difference between this conclusion and the similar, if unstated, one of orthodox health promotion, is that this account of responsibility for health is one of individual process rather than collective outcome. The only duties we all have in respect of our health are the epistemic and reflective duties, though other autonomy-compatible responsibilities will follow for many.

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Conflicts of Interest

None declared.

Notes

1. The Royal Society for the Prevention of Accidents (undated) state that in the 5 year period 2004–2008, there were 139 incidents which required rescue, including 12 fatalities.

2. To paraphrase Goodin (1995), responsibilities are to utilitarianism what duties are to deontology. I have used the word duties because duties denote actions.
3. But see Gordon (2014), for a response.
4. This would be a paradigm example of tolerance generally understood as ‘putting up with what you oppose’ (McKinnon, 2006: 3). Toleration requires disapproval and a failure to stop something when you could, but a more modest version might include a failure to attempt to stop that of which you disapprove.
5. It could be argued that there is something intrinsically wrong with tombstoning separate from its consequences, that it is simply in itself, a worthless thing to do, but this will not be considered further here.
6. I do not wish to get bogged down in a dispute about whether the term ‘consequentialism’ should be used instead of the term ‘utilitarianism’. There is considerable overlap between the terms and standardly utilitarianism is the paradigm case of a consequentialist theory. Foot (1985) regards consequentialism as what is wrong with utilitarianism, and Jacobson (2008) argues that there is such a thing as non-consequentialist utilitarianism. In his entry in the Stanford Encyclopaedia of Philosophy, Sinnott-Armstrong (2012) states that ‘...there is no agreement on which theories count as consequentialist...’ and though its broad meaning is known, shorn of specifying adjectives the naked term ‘utilitarianism’ is virtually useless as an action guide. I have used the term consequentialist to suggest that the wrongness of tombstoning rests in its consequences and thereafter I have used the term utilitarian as it is more likely to denote maximizing processes as I suspect that the term ‘utilitarian’ is more readily understood than the term ‘consequentialist’. Certainly, the term bioutilitarian appears in the bioethical literature but the term ‘bioconsequentialist’ generally does not.
7. See Hooker (2000a) on Sidgwick’s Common-sense morality and Greene (2013) for a review of the empirical evidence for dual level utilitarianism.
8. The word ‘sensible’ also appears in UK government documents, for example, Department of Health (2010: 10).
9. To be clear, this is a moral maxim; forbidding means that tombstoning is wrong. It does not follow that it should be prevented or that sanctions should follow its performance.
10. Under the heading ‘Patients and the public – your responsibilities’ the wording was initially: ‘You should recognize that you can make a significant contribution to your own, and your family’s, good health and wellbeing, and take some personal responsibility for it’. In the public consultation just concluded, the word ‘some’ is removed so that it reads ‘...and take responsibility for it’. The explanation is that this is a ‘technical amendment—minor drafting change’, (Department of Health, 2012), though a more significant reading could be made.
11. This might be more difficult to apply than might be thought. In a systematic review of the literature between 1997 and 2007, Allender *et al.* (2009) could find only two studies which calculate the financial cost of smoking-related UK healthcare costs. Updating the figures, they suggest that these costs amount to £5.17 billion in 2005–2006, compared with a figure from the 2009 budget of £8.1 billion raised in tobacco taxation and a total NHS budget of £86.4 billion (H M Treasury, 2009). Similarly, alcohol taxation raises £9 billion from alcohol receipts (Collis *et al.*, 2010) and alcohol harm costs the NHS approximately £3.5 billion annually (National Treatment Agency for Substance Misuse, 2013).
12. His bravery deserted him in 1987 when he gave up drinking for a year because of kidney problems, but nevertheless he died at the age of 61 years from a heart attack, an acute episode of a disease known to be associated with high levels of alcohol consumption. There is a line between autonomous choice and autonomy-restricting addiction, and Oliver Reed probably stepped over it. This very important point is not considered here.
13. Universalized, this might take the form of everyone in circumstances that are the same as mine should smoke (or is permitted to smoke).
14. Likely rather than actual consequences. A critique of all forms of utilitarianism is that consequences are very difficult to predict. Empirical research can diminish the strength of the critique. See Lang (2008) on the cluelessness objection.
15. A point given wider discussion in Fitzpatrick’s (2001) celebrated polemic
16. Available at <http://www.bbc.co.uk/news/health-20805059> (accessed 26 March 2014)
17. For a discussion on how these messages can foster autonomy see Barton (2013)
18. Available at <http://www.theguardian.com/society/video/2009/feb/18/worried-smoking-children> (accessed 26 March 2014)
19. Available at <http://www.youtube.com/watch?v=SfAxUpeVhCg> (accessed 26 March 2014)
20. For example, <http://www.youtube.com/watch?v=hhKXsLFKYqc> (accessed 26 March 2014)

21. For example, <http://www.youtube.com/watch?v=Ujwod-vqqqA> (accessed 26 March 2014)

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Challenging the Moral Status of Blood Donation

Paul C. Snelling

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Abstract The World Health Organisation encourages that blood donation becomes voluntary and unremunerated, a system already operated in the UK. Drawing on public documents and videos, this paper argues that blood donation is regarded and presented as altruistic and supererogatory. In advertisements, donation is presented as something undertaken for the benefit of others, a matter attracting considerable gratitude from recipients and the collecting organisation. It is argued that regarding blood donation as an act of supererogation is wrongheaded, and an alternative account of blood donation as moral obligation is presented. Two arguments are offered in support of this position. First, the principle of beneficence, understood in a broad consequentialist framework obliges donation where the benefit to the recipient is large and the cost to the donor relatively small. This argument can be applied, with differing levels of normativity, to various acts of donation. Second, the wrongness of free riding requires individuals to contribute to collective systems from which they benefit. Alone and in combination these arguments present moral reasons for donation, recognised in communication strategies elsewhere. Research is required to evaluate the potential effects on donation of a campaign which presents blood donation as moral obligation, but of wider importance is the recognition that other-regarding considerations in relation to our own as well as others' health result in a range not only of choices but also of obligations.

Keywords Blood donation · Organ donation · Altruism · Obligation · Television advertisements

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Introduction

It is a commonplace that health, variously understood, is a good thing and that work to protect, maintain and restore it is therefore also good. The responsibility, that is the obligation, to meet the demands this principle requires falls to a number of individuals and organisations. In the UK, despite the discourse of ‘personal responsibility’ for health, moral, legal, and professional obligations to patients and the public rest principally with health professionals within socialised medicine. Where the notion of personal responsibility is referred to it is predominantly directed at individuals’ own health, offering self and other-regarding reasons for action. Self-regarding reasons take the form, to borrow Kantian terminology, of hypothetical imperatives; if you want to be healthy, you ought to undertake this action (or omit that action). Categorical imperatives are seen where reasons to protect an individual’s health are other-regarding, seen for example in health promotion messages which emphasise harm to others, commonly children, that ill health or early death of the individual brings.¹ Outside caring and professional relationships, the notion of legal and moral responsibility for others’ health is rarely seen,² and where it is, it requires omissions. Legislation to ban smoking in public places was justified in order to protect the health of others [34],³ recklessly infecting someone with HIV is a criminal offence [10],⁴ and more mundanely, patients are exhorted not to attend GP surgeries if they think that they are infected with swine flu.⁵

The question of moral responsibility to act for other’s health is seldom addressed and I shall use the example of blood donation to argue that this responsibility is plausible in certain circumstances. Within the broader category of tissue and organ donation, it is possible further to distinguish types of acts and their moral statuses, from the obligatory to the supererogatory, and though the rule of rescue [60] and family responsibilities apply and complicate in some instances of donation, they are seldom seen in one of the commonest donation acts: blood donation. Using publically available documents and communications material, this paper both analyses the moral status presented and offers an alternative normative account. I argue that hitherto, blood donation has been regarded in the UK and elsewhere as altruistic and supererogatory. I suggest that this position is wrongheaded, and instead that blood donation should be regarded as morally obligatory for two reasons. First the principle of beneficence makes donation obligatory where large

¹ A recent NHS advertisement has a boy explaining what he is not worried about. ‘But I am worried about Dad smoking. I’m worried that my Dad will die.’ Available at <http://www.youtube.com/watch?v=BmUtR8DcMAc&feature=related> (This and all urls last accessed on 9th August 2012).

² I do not include the obligation to pay taxes which funds, in part, other people’s health care.

³ Smoking, Health and Social Care (Scotland) Act 2005; Health Act 2006. Justification for the legislation was the harm principle as reported in the House of Commons Select Committee report [46], but see also Coggon [20, 21] for a discussion of the ban applied to prisoners in Rampton Hospital where prisoners’ own health was also a factor.

⁴ See *R v. Dica* 3 A11 ER 593.

⁵ The advice contained in the NHS leaflet was ‘Do not go into your GP surgery or local accident and emergency department unless you are advised to do so or you are seriously ill, because you might spread the illness to others. Ask a flu friend to go out for you.’ Available at http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_177903.pdf.

health gains by recipients are accrued from relatively small costs from donors, and second, fairness and particularly the wrongness of free riding obliges those who would accept blood to give, or to offer to give it. The implication for advertisements and public awareness is discussed, but perhaps the most significant implication of this analysis is to increase the emphasis of the notion of obligation, challenging the predominance of individual autonomy in western bioethics.

Analytical Framework

The analytical framework utilised in this paper draws upon two distinctions from the work of David Hume. First, the separation between the descriptive and the normative, the is and the ought, is maintained as far as possible, though in places the absolute distinction is difficult to maintain. Second, though not as celebrated as the is/ought distinction, Hume [47] also distinguished practical from theoretical philosophy.⁶ ‘Theoretical’ philosophy is concerned with explaining human nature, whilst the aim of practical philosophers is to explain to people what they ought to do, making

...us feel the difference between vice and virtue; they excite and regulate our sentiments; and so they can but bend our hearts to the love of probity and true honour, they think, that they have fully attained the end of all their labours [47, p. 5].

In this quotation, practical philosophy is aligned more with the normative than the descriptive domain. The key feature is the difference between a reasoned philosophical exploration of the moral status of something, in our case blood donation, and the way that this is presented to those making donation choices. Theoretical philosophy, *inter alia*, open-mindedly selects and defends a theoretical approach, applies it to an issue, anticipates objections and considers alternatives. In contrast, A Humean practical philosopher presents arguments and conclusions seeking to persuade, to ‘excite the sentiments’, and ‘bend the heart’ of those to whom the message is directed. So in the analytical framework, the normative has at least two dimensions, the theoretical and the practical. Initially at least it is assumed that these two parts are consistent, allowing a normative position to be inferred from practical presentation, and also that a fully reasoned normative position should result in practical presentation reflecting this view. The framework applied to blood donation addresses these issues;

1. *Descriptive*. This is primarily an account of why people donate and why they do not, analogous to Hume’s theoretical philosopher.⁷

⁶ He actually uses the terms ‘easy’ and ‘abstruse’.

⁷ I do not mean to suggest that individuals choose to donate or not to donate for reasons which are exclusively moral [71]. The issue is highly complex, influenced by many social and psychological factors. The Theory of Planned Behaviour suggests that moral values are influential in determining the attitudes and subjective norms preceding an intention to donate [36], but it would be as significant an error to see donation exclusively in terms of moral reasons as it would be to ignore them altogether.

2. *Normative—theoretical.* This consists of an account of the normative status of blood donation; whether it is required, or supererogatory or merely prudential.⁸
3. *Normative—practical.* Communicative strategy principally takes the form of media advertisements. Embedded within the advertisements are messages; some subtle and some not so subtle about the moral status of blood donation. By their nature, the advertisements are a blunt tool, addressed to all; donors, lapsed donors, and non-donors. Communication with registered donors is more individually directed, by letter, text and via social networking media, and insofar as the purpose of television advertisements is to raise awareness widely, it is most usefully directed at non-donors, offering predominantly moral reasons for action, persuasive rather than deliberative in nature.

Application of these constituent parts differs between nations but there are also similarities, coordinated by the World Health Organisation (WHO), and I will use their documentation in particular as it is consistent with, but wider than UK⁹ policy. To be clear; the paper concerns blood donation practice in the UK, though the analysis is transferable to some extent. The analysis is presented in two parts, each starting with what I take to be the ‘official position.’ First, descriptive claims are discussed and those made by the WHO are presented. It is argued that this position predominantly regards donation as altruistic, and this claim is tested and critiqued against a brief review of the empirical literature on donor motivation. Second the presented moral status of blood donation is analysed. A full normative account is not offered by blood collection agencies in the UK, and so it is inferred from UK communication material which presents blood donation as an act of supererogation. An alternative account of blood donation as moral obligation is outlined, supported and illustrated by examples of communication material from blood donation in India and organ donation in the UK, both of which are plausibly transferable to blood donation.

Part 1: Description

The ‘Official’ Position

In 2010 WHO published a framework for action with the aim of ensuring that 100 % of donations are voluntary, phasing out paid and replacement donations [94]. In using this document as my primary source, it is necessary to quote at some length;

A voluntary non-remunerated blood donor gives blood, plasma or cellular components of his or her own free will and receives no payment, either in the

⁸ Some, notably those of the Jehovah’s Witness faith, regard blood donation as morally forbidden, but I do not consider that here as I am interested in blood donation within a system of therapeutic use of blood and blood products which those who regard its use in this way stand outside.

⁹ There are separate organisations covering England, Scotland, Wales and Northern Ireland, though the English organisation also covers North Wales. Unless stated, references are to websites and documents from the (English) National Blood Service, part of the NHS Blood and Transplant Authority.

form of cash or in kind which could be considered a substitute for money [94, p. 14].

The rationale for the emphasis on voluntary donation is primarily safety;¹⁰

Voluntary donors are recognized to be the safest donors because they are motivated by altruism and the desire to help others and by a sense of moral duty or social responsibility. They have no reasons to withhold information about their lifestyles or medical conditions that may make them unsuitable to donate blood. They are not placed under any pressure by hospital staff, family members or the community to donate blood and they entrust their blood donations to be used as needed, rather than for specific patients. The only reward they receive is personal satisfaction, self-esteem and pride [94, pp. 18–19].

Having identified voluntary donation as a consequentialist instrumental good, that is it is safest, the WHO goes on to claim altruism is what might be considered a fundamental principle;

A blood donation is a “gift of life” that cannot be valued in monetary terms. The commercialization of blood donation is in breach of the fundamental principle of altruism which voluntary blood donation enshrines [94, pp. 19–20].

It is claimed that donors give for altruistic reasons and out of a sense of social responsibility;

Voluntary blood donors donate blood for altruistic reasons and receive no reward except personal satisfaction in helping to save lives and improve the health of individuals they will never meet. While they choose to donate their blood out of a sense of social responsibility, recognition of the importance of their individual donations and appreciation by the blood service and wider community help to create a sense of belonging to a special group of people [94, p. 92].

But there is also recognition that donors have self-interest in giving;

Voluntary blood donors themselves benefit from health education and encouragement to maintain healthy lifestyles as well as regular health checks and referral for medical care, if needed. Provided that they receive good donor care when they donate blood, they feel personal satisfaction and self-esteem which provides a sense of social engagement and belonging that is recognized and valued by the community [94, p. 20].

¹⁰ This argument is derived from Titmuss' [90] important work. Three arguments for the preference of voluntary donation are (1) Commercial supply reduces voluntary donation in the 'crowding out effect' (2) paid blood is inherently unsafe, and (3) there is a risk of exploitation and harm to poor donors who sell blood through economic necessity. Empirical evidence for these positions is scant [33]. For a more detailed examination of Titmuss's work, see Sykora [88], and for a critique see Rapport and Maggs [74].

These quotations are representative of compliant organisations. For example the UK blood transfusion service states simply that ‘All blood donors in the United Kingdom are non-remunerated volunteer donors’ [92], and the International Society for Blood Transfusion (ISBT) has the requirement for voluntary donation as part of its Code of Ethics, and the promotion of altruism as one of its aims (ISBT, undated). In the EU, directive 2002/98/EC of the European Parliament and of the Council required member states to encourage voluntary donation.¹¹

The ‘Official’ Position: A Critique

There is a tendency both to conflate altruism with voluntary unremunerated donation, and to present it as a simple binary choice between the unremunerated and remunerated. Both of these tendencies significantly oversimplify, and the predominance of the claim to altruism is at the expense of two further positions which are nevertheless identified in the WHO [94] report. First that blood donation is prudential and self-interested; that donors’ sense of satisfaction and the receipt of other benefits is and should be reasons to donate (*Voluntary blood donors themselves benefit from health education and encouragement to maintain healthy lifestyles as well as regular health checks and referral for medical care, if needed* (p. 20)).

Second, that blood donation forms part of a moral duty or social responsibility (*...motivated by altruism and the desire to help others and by a sense of moral duty or social responsibility* (p. 18)). A closer examination of this phrase reveals an important moral distinction. I will suggest that the tone of communication and the environment in which blood donation operates presents a predominant discourse of supererogation, by definition a non-obligatory act (*...altruism and the desire to help others*). However the second part of the sentence, preceded by the word ‘and’ suggests that donors also have a sense of duty or responsibility and both of these words involve the notion of obligation. The sentence appears self-contradictory. One possible explanation is that even though blood donors are the subject of the sentence, what is meant is that some blood donors see donation as supererogatory and some see it as obligatory. But if this is the case there is plenty of untaken opportunity to make it clear, and the WHO document refers to donors throughout as a single homogenous group. Noting again the descriptive nature of the claims and the absence of an unambiguous statement of the moral status of blood donation, a more plausible explanation is that the position is muddled and contradictory.

Free Will or Legitimate Pressure?

In the light of extensive and continuing philosophical debate about the concept, it is noteworthy that the expression ‘free will’ is used; it adds nothing to clarify the term ‘voluntary’ or the claim that donors ‘...are not placed under any pressure’, and may

¹¹ The full text of article 20 of directive 2002/98/EC is ‘Member States shall take the necessary measures to encourage voluntary and unpaid blood donations with a view to ensuring that blood and blood components are in so far as possible provided from such donations.’ (see Farrell [32] for a review of blood safety in the EU).

obscure them. The ISTC code of ethics [50] talks not of pressure but of the absence of coercion, more defensible normatively and empirically. In comparison, procedures to obtain valid consent for examination and treatment (see Department of Health [DH] for example which uses the term ‘freely’), include the criterion that consent must be given ‘without undue influence¹² being exerted’ [25, p. 11]. Blood donation organisations, for example the American Red Cross (undated), actively encourage the recruitment of other donors, influence from friends is given as a reason by a significant proportion of donors [82], and research has been undertaken to seek the best method of encouraging donors to recruit friends [55]. In making these observations about the language of statements made by different organisations, it is not claimed that subtle and contestable differences between the concepts influence, pressure and coercion were uppermost in the thoughts of either the writers or their intended audience, nor is it suggested that there is anything necessarily unethical about recruiting friends or allowing peer group and other pressure to influence potential donors. But there is a tension between the stated official position that blood donation is voluntary (of their own free will) and altruistic, and the recognition that undefined forms of pressure are effective, desirable and morally acceptable. Conceptually the claim to altruism appears simplistic; can it be supported by empirical research findings?

A Very Brief Review of Empirical Literature

I do not offer a full discussion of the many empirical studies which assess donor behaviour and motivation. There are a number of reviews [8, 27, 38, 41, 58] which discuss factors influencing behaviour. What these and other studies show is that the area is much more complex than Titmuss’ altruistic model proposes, and this has been apparent for some time. In 1976, for example, Condie et al.’s study [22] showed that social pressure and degree of free rider tendency were more important motivators than altruism, and though much of the research since then has shown higher levels of altruism in donors, there are a number of methodological problems and potential biases in the research which is undertaken largely within systems assuming altruistic donation [14].

Methodological problems reported by Bednall and Bove [8] include a reliance on self-reported surveys which have the potential for social desirability bias. In contrast, an Iranian study [56] used physicians to decide on a single predominant donating motivation based on donor interviews and found that although altruistic reasons were the biggest group at 39.1 %, almost as many (38.6 %) were primarily motivated by self-regarding reasons, including perceived health benefits. In this study, undertaken in a religious society, religious beliefs accounted for 11.4 % of donations. In the US, Gillum and Masters [39] hypothesised that since blood donation is perceived as an altruistic behaviour, and religions commonly advocate pro-social behaviour, there would be a correlation between religious observance and

¹² Stewart and Lynch [86, p. 600] report the legal case of Mrs U where undue influence requires ‘...something more than pressure’, but it is unclear whether the DH is using the phrase in a legal or everyday sense.

blood donation. The data, when controlled for socio-demographic factors, provided scant evidence for their hypothesis.

Steele et al. [84] noted that studies use different definitions of altruism and measure it in different ways. In their study, instead of asking donors why they donate, a large sample (12,064) of donors recruited at blood donor sessions completed previously validated scales for altruism, empathetic concern, and social responsibility motivation. There was no significant difference in altruistic behaviour score between regular donors and those who subsequently lapsed. Older people had progressively higher scores on the altruistic measures, contrary to Maghsudlu and Nasizadeh [56] who found that older people were more likely to donate for self-regarding reasons. Surveys often report different results than field experiments which test actual rather than declared behaviour. For example, surveys have predicted that incentives such as free cholesterol testing will increase donation rates, but this has not been confirmed experimentally [40, 87].

In Canada, Hupfer [48] found that students identified more closely with an advertisement emphasising self-interest rather than altruistic messages and in one of the few UK papers, Ferguson et al. [35] found in three studies that motivation was more benevolent than altruistic, benefitting both donor and recipient,. They claim that, though subtle, the shift in emphasis is important because self-interest has not been highlighted in recruitment campaigns. Steele et al. [84, p. 51] concluded that ‘it may be time to try to appeal to self-interest as younger donors appear to respond positively to appeals that emphasize how donating blood may help them personally’.

Research in this area has tended to be quantitative [3], though it is recognised that qualitative studies can be useful in examining complex behaviour. For example, In a Spanish study, Belda Suarez et al. [9, p. 1445] used discourse analysis and found that donors perceived themselves to be the same as other donors and non-donors, and only a minority attributed to themselves higher awareness and kindness; an image ‘fostered by the institutions responsible for promoting donation’. It is argued that presenting messages in this way may discourage some individuals from donating.

There are a great many difficulties and challenges in researching donor motivation, but for now I simply want to make the point that the empirical evidence is contradictory and complex, and fails to support the ‘official’ position, which acknowledges mixed motivations but is clear that predominantly donation is and should be altruistic.

Part 2: Normative

The separation between the empirical and the normative seems quite straightforward in terms of factual claims and empirical research findings, though it presents greater problems in an analysis of the moral status of blood donation. This is because there is little in the way of ‘theoretical’ discussion from blood collection agencies. There is, however, ‘practical’ presentation of the moral issues involved in blood and other tissue and organ donations, and here I analyse some aspects of these, inferring the ‘theoretical’ moral position from the practical presentations.

The ‘Official Position’: Supererogation Inferred

The Donor Management Manual produced by DOMAIN (Donor Management in Europe¹³) states that;

The effect on recruitment will most likely increase when the recruitment messages focuses on these factors.

- Donating blood is a good thing to do
- It generates social approval
- It can be easily accomplished: ‘yes, I can be a blood donor’

[24, p. 90]

The strategy appears without an evidence base, but the prevailing view, that blood donation is a good, generating social approval is presented. The most recent UK¹⁴ television advertisement is described below.

A man stands at the gate of a primary school waiting for his daughter. They see each other and smile. An on screen legend fades in: ‘*Motorway pile up. Thursday 7.52 pm*’.

A woman is having her hair cut. In close up she is laughing. An on screen legend fades in: ‘*Chemotherapy starts Monday 10am*’.

A man holds an infant in his arms then gently places him in a cot. In a wider angle shot it is apparent that there are two cots in the room but the second cot is empty. An on screen legend fades in: ‘*Liver transplant. Next Tuesday 7am*’.
The man wistfully plays with the mobile above the empty cot.

Narrator; Give blood and you can save someone’s life. Today. Please don’t leave it to someone else. Type your postcode into blood.co.uk.’

The screen fades to the NHS blood transfusion service logo over their strapline. ‘Do something amazing.’

The events that require blood transfusion are situated in the near future, and so potential donors can help the individuals by their actions.¹⁵ The everyday nature of the stories could also be designed with the aim of suggesting to the audience that they themselves might need blood. But the strap line ‘Do something amazing’ supports the WHO position that blood donation is altruistic and praiseworthy.

Supererogation, both as a concept within and outside normative ethical theories is underdeveloped and problematic. Urmson’s seminal essay ‘Saints and Heroes’

¹³ DOMAIN is a European project that focuses on good donor management. Funded by the European Union, 18 blood organisations from 18 countries are members, including the four UK organisations.

¹⁴ Available at <http://www.blood.co.uk/video-audio-leaflets/tv-radio-ads/>). This advertisement is not currently being aired but it remains available on the blood transfusion website.

¹⁵ The previous campaign in the UK used celebrities who identified individuals who had helped them or a relative in the past. For example the chef Gordon Ramsay, says that ‘without this man I would have died from a ruptured spleen.’ (available at http://collection.europarchive.org/tna/20090605173026/http://blood.co.uk/pages/video_06.htm).

recognised that the tripartite categorisation of moral acts into the forbidden, the obligatory, and the permissible is ‘totally inadequate to the facts of morality’ [93, p. 60], unlike regulation which operates exclusively within these categories [68]. The problem, for morality if not regulation, is that the category consisting of permitted acts includes those of very different types, united simply by the properties that they are neither forbidden nor obligatory. The category includes acts that are amoral or trivially moral as well as morally good acts which exceed that demanded by obligation; the heroic act.¹⁶

Formally, the necessary properties of a supererogatory act are given by Mellema [61, p. 3]. An act is supererogatory if

1. It is an act whose performance fulfils no moral duty or obligation
2. It is an act whose performance is morally praiseworthy or meritorious
3. It is an act whose omission is not morally blameworthy.

The relationship between the term and its necessary conditions is circular [45] and the conditions apply to individual acts of donation more than donation in a general sense. Those whose donation requires overcoming needle phobia or forgoing something of value might, for example, be regarded as particularly praiseworthy. The principal concern here is whether blood donation is presented as morally obligatory or not and since this question forms part of an environment of supererogation the status of other elements are also of concern. There is little that addresses the normative question directly and so I propose to infer it from documents and presentations that are available and in doing so I offer two justifications for the logical sleights of hand which follow. First I return to Hume’s two types of philosopher and suggest that the practical philosopher need not adhere rigidly to logical rules for his purpose is to engage with an audience to whom the rules are largely unknown. Second I can dilute my claim a little so that instead of saying that the ‘official’ position is that blood donation is not obligatory, I can say that this position is consistent with the evidence rather than it is demonstrated by it. So with caveats in place, and with the intention to acknowledge the sleights of hand as they occur, how do the necessary features of supererogation apply to blood donation in the UK?

The first and third conditions share the important feature of being defined in terms of what they are not rather than what they are. There is no evidence that blood donation is considered obligatory, and none either that failure to donate is blameworthy. The sleight of hand here is to accept the absence of evidence for something as evidence of the absence of something. However, it would be surprising if there was a clear statement of a moral position in official documents because this is not their purpose, but also because there is a clear normative tension in UK healthcare practice between any notion of obligation and the predominant moral imperative to respect and promote personal autonomy [81].

¹⁶ The webpage of the united States organisation ‘Blood centres for the Pacific’ is www.bloodheroes.com and the system of small rewards for donation in the form of tee shirts and restaurant vouchers is known as ‘hero rewards’.

The second condition presents a more difficult challenge. The criterion is positively stated and so some evidence must be offered that donation is praiseworthy. I do this by offering evidence that donation is praised, and that donors are regarded as an appropriate recipient of gratitude, ‘generally the mark of supererogation’ [45, p. 65]. The sleight of hand here is to suggest that because an act is praised, it is praiseworthy. Gratitude can be appropriately offered for things that we are required to do¹⁷ and care is required when inferring praiseworthiness that the stated praise and gratitude do not fall within the category of gratitude offered for an obligatory act.

Gratitude is a positive emotion ‘one feels when another person has intentionally given or attempted to give, one something of value’ [5, p. 139], and can be regarded in at least two ways [59]. First as an appropriate response to beneficent behaviour to the extent that it might be considered that this response is required in order to avoid being thought ungrateful and second as a motivator of pro-social behaviour. Recipients of blood might be expected to feel gratitude but unlike the gratitude felt and expressed by patients for the personal care they receive from staff caring for them [63], or the gratitude felt towards known donors [37] this cannot be expressed to the individual.¹⁸ However, gratitude can be felt and expressed by recipients to the pool of donors, and this forms part of the regimen of gratitude fostered by blood donation organisations.

In the UK, a video¹⁹ posted on the webpage of the NHS Blood and Transplant Authority (NHSBT) starts by offering thanks from the organisation. A maroon background is seen on screen with a bright red heart shape in the centre, with the capitalised legend ‘DEEPLY VALUED’. The commentary states: ‘Thank you for coming today and for giving blood and platelets. Your contribution is important and deeply valued.’ A later section shows a mother sitting with her daughter describing transfusions required following childbirth. She contrasts those who give to family members, which might be expected or required, against those who donate to strangers. She says ‘I think that they’re really special people’, echoing the language of the WHO report. A further section shows the chief executive of the organisation talking to a donor of 140 units;

Thank you so much for coming along today. I understand you’ve made nearly 140 donations? That is fantastic. I’m so grateful because it’s through people like yourselves (sic) that Blood and Transplant is able to save so many lives, and without you we would not be able to do our job.

During the writing of this paper, I was in communication with NHSBT. I received a helpful e mail giving requested information. At the foot of the e mail the writer thanked me for the nine donations I have made, having clearly looked me up on a database. This is an example of the role of vicarious gratitude as an intended

¹⁷ Driver [28] argues that it is possible for an obligatory act to be considered praiseworthy, and gives some examples to show that some obligatory acts are more praiseworthy than others that are supererogatory.

¹⁸ This is in contrast to acts of donation where the recipient is known or later identified, for example living kidney donation.

¹⁹ Available at <http://www.blood.co.uk/video-audio-leaflets/tv-radio-ads/>.

motivator of pro-social behaviour, more likely to induce a return to Ledbury Community Centre than pointing out that nine donations in 30 years of adult life is a pretty meagre return.²⁰ This is not a trivial point as it contributes to the general *milieu* of gratitude. Though the emotional gratitude expressed by recipients in the video is clearly of a different sort to that expressed by my e mail interlocutor and the Chief Executive, it would be a thin account of gratitude expression which regarded it solely in terms of a calculation to encourage repeated donation. A more plausible account is to regard the emotional response felt by recipients and the vicarious gratitude expressed as genuine responses to acts of perceived supererogation, expressed simply in the tag line of NHSBT: ‘Do something amazing.’

An Alternative Normative Position

In this section an alternative account of the moral status of blood donation is advanced in two arguments; those from beneficence and justice. Examples of television advertisements utilising these arguments support the case that they are already familiar, though to different audiences or differently applied.

The Argument From Beneficence

The principle of beneficence is familiar to healthcare professionals because of its inclusion as part of the principles based approach to bioethics [7]. One perceived strength of the principles is that they can be derived from any of the major moral theories. This theoretical hedging is also a source of critique from Clouser and Gert [19] who argue that the theoretical source of the principle of beneficence is Mill and utilitarianism. An act of beneficence is an act that helps others, but Beauchamp and Childress [7] are clear that not all acts of beneficence are obligatory and though they take care to root their system in common morality, its purpose is to guide action within the special relationships that healthcare professionals have with those in their care. This relationship can make benevolent acts obligatory that would be supererogatory in common morality, and the same might be said for other special relationships, for example within families. As the blood donation video described earlier acknowledges, I am (ordinarily) obliged to care for and about my family in ways that I am not for my neighbour or a stranger [80]. This seems to present a problem for an attempt to define blood donation or any other beneficent act towards strangers in terms of obligation. Peter Singer has attempted to reset the normative bar in a field that is similar in many ways; charitable donation to developing countries. The formal expression of his argument is;

- First premise: Suffering and death from lack of food, shelter and medical care are bad
- Second premise: If it is in your power to prevent something bad from happening, without sacrificing anything nearly as important, it is wrong not to do so

²⁰ And at the risk of expressing ‘shallow gratitude’ [6] for the modest success of writing this paper, I am happy to thank and acknowledge him in return.

- Third premise: By donating to aid agencies, you can prevent suffering and death from lack of food, shelter, and medical care, without sacrificing anything nearly as important
- Conclusion: Therefore, if you do not donate to aid agencies you are doing something wrong [79, pp. 15–16]

The premises can be rearranged so that they apply to blood donation. The first can be restated as ‘suffering and death from lack of donated blood are bad’. The second can remain as it is and the third can be similarly amended. The consequentialist calculation juxtaposes the benefit of donation against cost. In applying these premises, Singer [79] recognises that the second is vague, but his discussion concerns a relatively small monetary sacrifice in return for a large gain in health for the poorest in developing countries. For example, he quotes a figure of approximately \$250 per life saved in a programme to prevent diarrhoea [79, p. 89].

Some advertisements from across the world are robust in presenting an opportunity to help an identified individual as morally obligatory. For example, from India, a series of advertisements produced by BBC Media Action²¹ includes one about a girl with thalassemia.²² The advertisement does not specifically mention weighing of costs and benefits, but it obviously invokes an appeal to beneficence.

Daytime in a coffee shop. A man, about 30 sits alone reading a magazine. A girl, aged about 8, pretty, round faced with long black hair approaches. (After the initial greeting the script is reproduced from subtitles).

- Girl: ‘Hello Uncle’
- Man: [*Smiles, puts down his magazine and turns to face the girl*]. ‘Hellooooo.’
- Girl: ‘I wanted to say thank you to you.’
- Man: ‘Thank you! For what?’
- Girl: ‘Actually, you see I have thalassemia.’
- Man: [*looks away, perhaps for a parent?*] ‘Oh.’
- Girl: And every month an aunty or uncle like you give (sic) blood and help me.’ [*the camera cuts to the man’s face. His smile is dropping*] ‘But I don’t know who they are. So, I say thank you to everyone. So thank you!’
- Man: ‘But I have never donated blood.’
- Girl: [*she wrinkles her nose*] ‘Hmmm’. [*Pause. Then she smiles*] Never mind. Next time? Bye! [*she turns and walks away*]
- Man: ‘Bye’. [*His smile fades further and he watches pensively as the girl approaches another table*]
- Narrator: Donate blood from the age of 18. You can save someone’s life.

²¹ BBC Media Action is BBC’s International charity. It ‘is using media and communication to provide access to information and create platforms to enable some of the poorest people in the world to take part in community life, and to hold those in power accountable’ http://www.bbc.co.uk/mediaaction/what_we_do/governance_and_rights

²² Available at <http://www.youtube.com/watch?v=fhoPEUXFcT4>.

The screen fades to a picture of a hanging bag of blood, with the bulleted legend: ‘You can donate blood every three months. Make sure it is a licensed and registered blood bank. Does not cause weakness.’²³

The final scene is of the girl now being held up by the man who is standing in front of a building. They are wearing different sets of clothes, so presumably this is after a donation. The man is looking at the girl.

Girl: [*smiling*] ‘Try it!’

Man: [*Turns to face camera*] ‘It feels good’.

I am not suggesting that presentation of blood donation in this way is a central feature of the campaign. Other advertisements in the series present other perspectives, not least reassurance that blood donation does not cause weakness. The sleight of hand here is to attempt to transfer this advertisement from India to the UK, where blood transfusion services are very different. India aspires to voluntary unremunerated blood donation, but about 45 % of blood for transfusion is collected from family or replacement donors [65], and there are a number of web-based organisations which assist patients and their relatives in their search for suitable donors.²⁴ It is estimated that 50 % of blood comes from paid donations, and only 5 % of voluntary donors are repeat donors [70]. Ramani et al. [73, p. 259] state that ‘...blood-transfusion services in India are a highly-fragmented mix of competing independent and hospital-based blood-banks, serving the needs of urban populations.’ The Central Drugs Standard Control Organisation website²⁵ reports that there were 2,517 licenced blood banks as of July 2011, of which 973 were government operated and 1,544 were private, and Pal et al. [70] estimated that in total, 34 % of blood banks were unlicensed. The advertisement would have been seen only by those with access to television and who had a number of options for donation, including being paid and being directly asked by the girl’s relatives. This makes donation motivation and the relationship between donor and recipient significantly different than in the UK. However, the non-financial costs and benefits of donation are similar, and the arguments implied and emotions shown in the advertisement are applicable elsewhere, albeit with slight modification, and so the advertisement is worthy of analysis.

There are similarities and differences between the UK and Indian advertisements. Costs to donors are not discussed in detail, so it must be assumed that these are understood by potential donors at least in broad terms; the mild pain and inconvenience and possibly feeling slightly unwell are placed against the benefit gained by the recipient, which is always significant and frequently lifesaving. Both invite donation to save an identified person’s²⁶ life. The Indian advertisement thanks

²³ Thanks to Dr Sabita Menon for the translation.

²⁴ For example, see <http://www.friends2support.org/>.

²⁵ Using data from the Ministry of health and Family Welfare. <http://cdsco.nic.in/html/BloodList.html>.

²⁶ And of course it is no accident that the individual is an appealing child. Singer [79] discusses studies which show that the propensity to donate money is increased when the focus is on one rather than many beneficiaries, and of course the opposite effect was well known in perhaps apocryphal quotation attributed to Stalin; ‘The death of one man is a tragedy. The death of millions is a statistic.’

the donor (albeit mistakenly) retrospectively while the UK one looks to future donations. In the Indian advertisement, there is identification and focus on the donor, absent from the UK advertisement which focuses exclusively on recipients. Interestingly the final words in the Indian advertisement, spoken by the man are self-regarding, a reference to well-known phenomenon that individuals feel a sense of satisfaction after donation.²⁷ The significant difference is the suggestion from India, framed in the wrinkle of an innocent nose that failure to donate, for this individual, is blameworthy, that is donation is something he ought to have done.

The very notion of supererogation is a problem for consequentialism.²⁸ If greater overall benefit is obtained by donation, then that is what we ought to do. If greater overall benefit is obtained by not donating then we ought not to do it. The supererogatory position presented by the UK advertisement, that donation is neither obligatory nor forbidden cannot easily be reconciled with consequentialist calculations, even of the everyday sort implied. Because of its everyday nature, theoretical precision in the definition of what is being maximised and how is not necessary especially as the balancing is clearly significantly asymmetrical; the asymmetry between costs and benefits also addresses a common objection to consequentialism, that it demands too much [62, 66]. Application of a broadly consequentialist approach regards blood donation as morally obligatory, recognised in the Indian if not the UK advertisement.

The Argument From Justice: The Wrongness of Free Riding

Famously, Hart [44] and Rawls [75] argue, from fairness, that there is an obligation to contribute to collective goods that we benefit from, that is we ought not 'free ride' on the collective actions of others. The free rider argument is invoked elsewhere within bioethics, for example in the debates between Harris [43] and Chan and Harris [18] in favour, and Brassington [11, 12] against, concerning obligation to support and participate in medical research, and also by John [53] in the question of vaccination. Subtly different versions are applied in individual circumstances according to costs of contribution, and the nature and extent of benefit. An advertisement in the UK utilises the free riding problem in presenting organ donation as obligatory.²⁹

A woman about 45 years sits comfortably on her legs in an armchair. Her teenaged son is on the sofa next to her. She looks at him and smiles then turns her attention back to the television which is out of shot and from where comes the sound of laughter. The boy is also laughing. The camera focuses on his

²⁷ An advertisement feature from Florida includes an interview with a doctor who suggests that blood donors have a reduced risk of cancer. The suggestion is that blood donors tend to be individuals who also consult their doctors more often, but the clear implication is a causal effect between giving blood and reduced chance of contracting cancer. Even if a more generous interpretation is allowed, this film remains a direct claim of the personal benefits of blood donation. (available at <http://www.youtube.com/watch?v=8MNmeLaVLdM>).

²⁸ And for Kantianism (see [4]).

²⁹ Available at http://www.uktransplant.org.uk/ukt/adverts_and_video/adverts_and_video.jsp.

elbow; he absentmindedly scratches it and when he removes his hand an intravenous cannula is revealed.

Commentary: *If someone you love is offered a lifesaving organ, what would you do?*

The boy's breathing becomes laboured and he coughs. A drip stand appears behind the sofa and a bag of intravenous fluid appears connected to the cannula. The mother watches the television apparently unaware of the transformation.

Commentary: *Nothing?*

The boy's hand rests on the sofa arm. Its colour changes from pink to grey. The fingers become clubbed.

Commentary: *Nearly all of us would take an organ but most of us put off registering as a donor.*

In close up, his healthily bright eye becomes, after a weary blink, bloodshot and dilated. He sinks back in the sofa rubbing his face unveiling oxygen cannulae and the paraphernalia of acute illness behind him; oxygen bottle and bleeding monitors. His mother turns to him and her smile fades.

Commentary: *If you believe in organ donation, prove it.*

Screen legend: Three people who need a transplant die every day.

Commentary: *Register now.* [on screen is a screen capture of www.organdonation.nhs.uk The cursor moves to the on screen button marked 'register now']

Organ donation provides a singular case of the free riding problem. Specifically the contribution requested by the advertisement is simply that individuals sign up to the organ donation register, but despite the provisions of the Human Tissue Act 2004,³⁰ which state that removal of organs for transplantation is lawful if the deceased gave appropriate consent (for example via the organ donation register), in practice permission is required from relatives [49], and see [78]. Where consent of the patient to post mortem donation has not been given because, for example, in common with 70 % of the population, the organ donor register has not been signed, he can avoid being considered a free rider if his relatives consent to donation on his behalf.³¹ Alternatively if while alive the potential donor has avoided free riding by signing the register, this can be overridden by his relatives refusing donation and in this case the accusation of free riding might be more justly aimed at the relatives. Genuine free riding in this case would be restricted to those who would accept an

³⁰ And the Human Tissue (Scotland) Act 2006.

³¹ The free riding of the dead person is retrospective, that is the claim is that he would have accepted an organ.

organ but have ensured that their wish not to donate an organ is known and therefore likely to be acted upon.³²

It has been argued to derive an obligation to contribute from the fact of obtaining a benefit commits the is/ought fallacy [42], and further standard objections to the wrongness of free riding are provided by Nozick [67]. The strongest objection is to systems enforcing contribution, but this is not the case either for blood or organ donation.³³ A further objection is the cost to an individual in doing his share must be outweighed by the benefits of the actions of others. The cost/benefit ratio differs between organs, blood and other acts of donation, and benefits are stratified. Almost everyone benefits to some extent from the system of blood and organ donation. Though only recipients receive life saving benefits, these are dependent on the existence of the system of potential benefits and so they require the lesser benefit to many, and the lesser benefit to the many exists only so that greater benefit to a few recipients is possible. So when calculating benefits to the individual of the collective system, it makes no sense to consider only actual benefits to the many. The gain to individuals must be assumed to be derived from potential rather than actual benefit, and since this is significant, the cost/benefit objection is met. Nozick also objects that it is wrong to give benefits to patients and then demand payment; that is moral obligations cannot accrue in lieu of unrequested benefits. It is the case that individuals do not ask for the potential benefit of blood or organ receipt, but this is not so where individuals seek and consent to receiving organs or blood. Nozick's objections to the principle of fairness, particularly the need to avoid free riding can be answered.

Despite the singularity of its application to organ donation, it is clear that the free rider argument is used in the advertisement. Though the actual words are expressed in the hypothetical, 'if you believe in organ donation...' this is nearly everyone. The normativity is unambiguous; you *ought* to donate your organs. There are differences between the application of the free rider problem to organ donation and blood donation, not only in the calculations for cost and benefit but also in process, principally because of the nature of contributing an organ post mortem and the decision making processes involved. Blood donation is closer to standard accounts of free riding [23], complicated by stratified benefit. However, there do not appear to be any material features of the system of blood donation to distinguish it from the system of post mortem organ donation such that the free riding argument applies to the latter and not the former.³⁴ If this is the case, then it is concluded that if the need

³² It is this latter provision which forms the minimal normative expectation in the NHS Constitution (DH [26] 'You should ensure that those closest to you are aware of your wishes about organ donation').

³³ A thin version of this would be presumed consent, currently in force in some countries and being introduced in Wales [30]. True enforceability would mean removal of organs even in the face of refusal to consent from relatives and prior to death from the deceased. This is seldom suggested; but see Fabre [31].

³⁴ In order to prevent free-riding Jarvis [52] offered the 'modest proposal' that only those individuals signed up as organ donors should be eligible to receive them. A more modest version of this modest proposal, that those willing to donate should be prioritised for receipt [29, 91] avoids the potential to waste organs, and has attracted, in the US, some public support [83], and was enacted in Israel in 2008 [54].

to avoid free riding is a reason to make organ donation morally obligatory, it must also make blood donation morally obligatory.³⁵

Arguments Extended

In contrast to the ‘official’ position, I have examined two familiar arguments that blood donation is a morally obligatory act. The first based on the duty to assist others applies to all adults, and the second, based on the moral obligation to avoid free-riding applies only to those who would accept blood. Both of these arguments rely, though in different ways, on weighing up costs and benefits. For the broadly consequentialist beneficence argument, this calculation includes benefits for others, and for the free-riding argument, in order to meet Nozick’s objections, the calculation is restricted to self-regarding benefits. Both of these arguments can be applied to donation of other tissues. For beneficence, acts become less obligatory and increasingly supererogatory as the costs and risks to the donor increase. The free rider argument will not apply where the donor has no chance of ever being a recipient, for example, sperm donation. The level of normativity can be represented on a table (see Table 1) where acts are more obligatory at the top and more supererogatory descending down the table. The table is for illustrative purposes only and the ordering is open to challenge, but as a heuristic device it is helpful in stratifying calculations. It is consistent with the view [69, pp. 207–208] that supererogation ‘...is measured by that which is required: *in supererogatory action the ordinary measures of duty rather than the categories of duty are exceeded.*’³⁶ On this account, different acts of donation amount to different amounts of the same thing, rather than different kinds of things. The question is at what point on the scale does donation change from being obligatory to supererogatory. At present, the ‘official line’ appears to be drawn between post mortem organ donation and blood donation, and the argument of this paper is that it should be drawn lower, at least under blood donation, and probably a lot lower than that, and especially where the need to avoid free riding applies.³⁷

There remains the question of the specific features and extent of the obligation to donate blood. Clearly, ought implies can, and so the obligation cannot apply to those who have received blood³⁸ or, for example, have had a tattoo in the last 4 months.³⁹ The obligation is to give blood if you can, or to offer to give blood. To say that you

³⁵ There is heightened interest in the concept of solidarity, and the arguments from beneficence and justice that I have offered could be presented within this framework. Further analysis is warranted elsewhere (see [72, 76]).

³⁶ Emphasis in original.

³⁷ In the US in 1978, a man dying from leukaemia asked a judge to compel his cousin to donate bone marrow to save his life, and in refusing the request the judge left the cousin in no doubt that his refusal was ‘morally indefensible’ [85]. Regarding the act of donation of bone marrow as an obligation presents some difficulties, not least because, as in this case, of the complications of the Rule of Rescue [60] and family obligations.

³⁸ The full list is available at <http://www.blood.co.uk/can-i-give-blood/who-cant-give-blood/>.

³⁹ It would be going too far to suggest that you ought not have a tattoo because it interferes with your opportunity to donate.

Table 1 Costs and benefits of acts of tissue donation

Act	Costs to donor	Benefits to recipient	Free rider argument?	Notes
Samples for research	Very little-time, perhaps or minor tissue extraction. Or perhaps no cost at all	New drugs and treatments improve treatments	Yes	
Cadaveric organ donation	Thinking about mortality 10 min to sign register with regular updating, and discussion with relatives	Organ donation saves (heart) and improves (cornea) many identified lives	Yes. Presented in advertisements	17,751,795 people on organ donation register ^a Official NHS position—obligatory. Consent rate 65 % ^b 1.4 m donors in 2010 ^c 2 m units donated
Blood donation	About an hour of donors time Slight pain around needle site Occasional transient feeling slightly unwell	Many lives saved and morbidity improved Wide indirect benefit from knowing that blood is available if needed	Yes.	
Platelet donation	More frequent donation than blood. Requires connection to apheresis machine. Takes approximately 90 min	Lifesaving and life prolonging	Yes	14,500 platelet donors ^d
Bone marrow donation (stem cell donation)	Registering as a donor If required, daily injections for 5 days followed by collection via blood. A few days time needed for donation. Occasionally a minor procedure under general anaesthetic	To an individual recipient—chance of cure from an otherwise fatal disease	Yes.	More than 770,000 on registers. 750 donations to unrelated recipients in 2009 ^e
Egg donation	Minor procedure involving general anaesthetic, some pain	Potentially life changing to childless couples	No	1,258 donors in 2010 ^f
Sperm donation	Weekly visits to clinics, tests, interviews Possibility of offspring contact after 18 years	Potentially life changing to childless couples	No	480 donors in 2010 ^g

Table 1 continued

Act	Costs to donor	Benefits to recipient	Free rider argument?	Notes
Live organ donation	Major operation Possibility of needing both kidneys later (e.g. trauma to remaining kidney) Risk of death in operation (1 in 3,000 for kidney donation ^b)	Potentially lifesaving to identified recipient	Not at present. A narrower argument from reciprocity may apply	1,045 living donations in 2010. 60 altruistic donations (including paired donations) ¹

This table is for illustrative purposes only. It has not included benefits to donors, such as the 'warm glow' of altruism. Donation of bone marrow and live organs to relatives may have special value to donors

^a March 2011 figure <http://www.organdonation.nhs.uk/ukt/statistics/statistics.asp>

^b http://www.nhsbt.nhs.uk/annualreview/pdf/nhsbt_annual_review_2010-2011.pdf

^c http://www.nhsbt.nhs.uk/annualreview/blood_components/

^d June 2012. Personal communication from Gareth Humphries, NHSBT

^e http://www.nhsbt.nhs.uk/pdf/uk_stem_cell_strategic_forum_report.pdf Existing registers are to be amalgamated into a single register managed by the Antony Nolan trust

^f <http://www.hfea.gov.uk/3411.html> includes both those who donate all their eggs in a treatment cycle (non-patient egg donors) and those who share their eggs with up to two recipients (egg share donors)

^g <http://www.hfea.gov.uk/3411.html>

^h http://www.organdonation.nhs.uk/ukt/how_to_become_a_donor/living_kidney_donation/pdf/living_kidney_donation.pdf

ⁱ http://www.nhsbt.nhs.uk/annualreview/organ_donation_transplantation/focus_living_donation.asp

ought to give blood is to suggest a number of distinct obligations [95]. Since it is more than sixteen weeks since I last gave blood, ought I travel to Gloucester to give again, or can it wait until the mobile unit comes to my small town next month? What if on that day I cannot attend because I have promised to take my neighbour to visit her sick relative? I would say that it is clearly a moral ought rather than a non moral ought, but beyond that there is no need for further analysis here. There are many contingencies and the normativity of each potential act of donation must be evaluated in the light of its circumstances. My analysis concerns being a blood donor generally rather than considering each opportunity or act of donation.⁴⁰ Following Zimmerman [95]⁴¹ the obligation is best regarded as *prima facie*, but in any case the importance of the arguments presented rests in their conclusion that blood donation is obligatory at all rather than in any specific sense.

Advertisements, Nudges and a Threat to the Framework

The most important purpose of an advertising campaign is to increase and maintain the numbers of donations. Eligible individuals can, of course, decline to give blood, but the temptation to make it clear that they are not acting in a morally acceptable way must be tempered by the possibility that this will be widely regarded as moralistic rather than moral, reducing rather than increasing donation. In this case it would be a plausible position, though apparently paradoxical, to maintain that on consequentialist grounds blood donation is morally obligatory, but that advertisements should continue to present it as supererogatory. This would present some problems for the analytical framework utilised in this paper.

First, the assumption that there is, or should be, consistency between the theoretical and practical expression of the moral status of blood donation is challenged questioning the normative inferred from the descriptive. However a critique of this method and findings does not invalidate the ‘alternative’ moral status of blood donation which can stand outside the framework if necessary. A more serious critique would be that focussing on the most effective presentation renders an analysis of moral status of donation redundant. Nagel [64] perceived ethics as a branch of psychology, but even if the relative importance of moral philosophy was to retreat in the face of insights from psychology and neuroscience, it does not follow that philosophical analysis is of no value at all.

In other fields, negative marketing has been found more likely to result in self-protection and inaction (for example, [13]) and studies cited earlier suggested that advertisements should emphasise self-regarding rather than other regarding reasons to donate. The role of psychological framing is influential; popularised by Thaler and Sunstein’s [89] book, ‘Nudge’ which has become ‘an instant classic’ [21, p. 12], Behavioural Insight has become an important part of UK public health policy

⁴⁰ This analysis will differ for different acts of donation. Signing up to the bone marrow donation register will be of little value if I find a trivial reason not donate on the one occasion in 20 years when I am asked to make good on my intentions.

⁴¹ Who followed Ross [77].

[15, 16],⁴² claiming some success in, for example, required choice for organ donation, and reducing missed appointments by simple behavioural interventions [16, 57].⁴³ Despite the claims made for framing, a recent review by the Cochrane Library [1] found very little evidence of its effectiveness.

Further research into the practical applications of framing and nudging applied to blood and organ donation may yield interesting and useful insights. However, though important, the significance of TV advertisements and other public presentation is not restricted to the narrow matter of procuring the most blood.⁴⁴ Placed in the wider context of the role of autonomy and choice related to health enhancing and threatening behaviour, highlighting the normativity of blood donation could serve to emphasise the general notion that health is a legitimate matter for public concern, and that other-regarding considerations in relation to others' health as well as our own result in a range not only of choices but of obligations. As I have shown, presenting donation in this light is already a feature of blood donation advertisements overseas, and organ donation advertisements from the UK.

Conclusion

Western bioethics reveres personal autonomy and its facilitation above all else. However, if the concept of responsibility for health is to be meaningfully operationalized in an age of alarming increase of lifestyle induced ill health, the notion and extent of obligation must be defined, justified and defended. This remains problematic for self-regarding reasons for action, more so for normative consideration of other-regarding acts which are seen as mere supplicants at the feet of the personal autonomy god. I have argued that individuals have other-regarding responsibilities for other's health, where the cost is small and the benefit large, and where the imperative to avoid moral free riding is clear. Blood donation is a paradigm example of pro-social behaviour which has hitherto been regarded and presented as altruistic and supererogatory. However, application of arguments from beneficence and justice challenge this established moral status, recognised in part by somewhat inconsistent communicative strategies. Offering blood for donation for the benefit of others is a moral obligation, and in the absence of evidence of an

⁴² According to the Cabinet Office [16, p. 4] the cabinet office team has 'strong links' to Professor Richard Thaler, co-author of 'Nudge'.

⁴³ There are however, differences in the stated motivations between its theory and practice. The UK Government's aim is to find 'intelligent ways to encourage, support and enable people to make better choices for themselves' [16, p. 9], which sits uneasily with Thaler and Sunstein's [89 p. 40] view that 'framing works because people tend to be somewhat mindless, passive decision makers.'

⁴⁴ There are seldom media stories explaining that treatment has to be curtailed because of insufficient supply, so it is assumed that despite occasional pressure the current system, including the advertisements, meets the needs placed upon it, though blood donation organisations would doubtless prefer the problem of having too many donors rather than too few [17]. As I write this there is some concern about the potential for shortages over the olympic summer resulting in more targeted approaches to individual donors.

unintended deleterious effect, this should be made visible and unambiguous in public discussions, documents and advertisements.

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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 the 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 behavior, 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 also 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.

Keywords: responsibility, professional ethics, nursing, blame.

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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; (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-affecting behaviours. Moral agency, or at least the capacity for autonomous decision making, is assumed in professional health care, and yet it 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 well-being, and take personal responsibility for it.¹ (National Health Service, 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

¹The 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.

role in our moral experiences, blame is underexamined 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-affecting 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 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

²In the United Kingdom, 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 (Keogh, 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.

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, while recognizing 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 an 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 (1963) celebrated paper, *Freedom and Resentment*, developed by many (notably Wallace, 1994), conceptualized blame as a range of reactive attitudes we feel in response to others' acts, omissions, or character. We feel indignation or resentment if someone wrongs us, and more objectively, we disapprove if the wrongdoing does not directly affect us. Martin's (2001) 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' (2001, 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 & 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 blame 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 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 & 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, Callahan (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 & 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 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, pp. 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. For example, in the literature of health promotion, 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 (National Institute for Health and Care Excellence, 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

³See also Schafer & Ferraro (2011).

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 relate to a process of assessment, 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 United Kingdom, a nurse⁴ was recently honoured for whistle blowing 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 (i.e. being fully morally 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-affecting 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 & 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 characterized 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 compatibilists' regard this as the ability to decide on the basis of reasons (Sie & 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 & Wouters, 2010) and the view that, particularly when future and current desires are concerned, different versions of

⁵It could be that the response would be different if it was a dependent rather than an infrequent drinker.

⁶See Rumbold & Wasik (2011) 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.

⁴<http://www.bbc.co.uk/news/health-25549054>.

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 & 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 and 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) 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 well-being approach, it might not be if it contributes to well-being in other ways.

⁷For example, <http://www.who.int/suggestions/faq/en/>.

Simple binary distinctions nearly always oversimplify but are useful heuristic devices and can identify the polar extremes of a continuum while acknowledging that the truth (if there can be one) lies in between. However, for both positions, the moral appraisal of health-affecting 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. 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. For example, it may 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 well-being 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 with 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.

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. For example, Scanlon (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 incompatibilism,

a position that is reversed when concrete emotional examples are used in experiments (Nicholls, 2011). It is also argued that incompatibilist intuitions are explained by errors in popular understanding of what determinism is (Murray & Nahmias, 2014), which, when addressed, result in compatibilist 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 & 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 & 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-affecting behaviour. I imagine that my (adult) son has jumped 30 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 minimized (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.

I think that I would feel some disapproving emotions upon hearing of his behaviour, but even after

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

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. However, 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 had not 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? Robbenolt'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 publicize the dangers; his mother spoke of 'stopping' (British Broadcasting Corporation, 2011) others from doing what Sonny had done, and his father spoke of Sonny's 'selfishness' (British Broadcasting Corporation, 2008a) in seeking his postdrinking 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 moralism⁹ (Taylor, 2012).

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 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 universalizable 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.

⁹In a similar vein, Watson (2013) discusses judgmentalism but points out that nonjudgmentalism can be considered a vice.

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

¹⁰In the United Kingdom, 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 & Bennett, 2012).

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. However, this may not be possible; Scanlon defines blame 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).

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 realize 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 consistency¹² within if not between relationships. The concern that I would feel would proceed to a stronger and considered remonstrance that for his sake and mine, he should not repeat the behaviour unless he has undertaken reflective calculations on risk and

¹¹I do not claim that the relationship between a father and his adult son is or should be symmetrical.

¹²This 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/>.

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. However, it probably would not be justified if stronger expressions of sanction blame were used – if I used surveillance to monitor his activity, 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 materialized, and so further sanction blame would serve no forward-looking purpose in changing my son's behaviour. It might be argued, similarly to Callahan 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 Callahan seeks prevention of obesity through individuals wishing to avoid stigma, whereas the

stated intention of both Sonny and his father is to educate others (British Broadcasting Corporation, 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 generalized 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, 2011). 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: 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 socialized nature of most health care in the United Kingdom, 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 (e.g. 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 deprioritizing treatment to individuals (normally categorized into groups) deemed to be responsible for their poor health¹⁵ though currently policy is that this cannot be considered. 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 prioritized minimally or even denied treatment, but care is always taken to defend decisions on the basis of

¹³According to the Health and Social Care Information Centre (2012), 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.

¹⁴Fees 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).

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

¹⁶For example, in the United States, Gollust & Lynch (2011), and see Bowling (1996).

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 likely 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 while attempting to retain priority for clinical need (Donaldson, 2010), and the recent strategy document from National Health Service Blood and Transplant (NSBT) (2013) recommends a national discussion about prioritizing prior registered donors for receipt of organs (Jarvis, 1995), as is already law in Israel (Lavee *et al.*, 2010).

Blaming and health care practice: health care 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 holds negative attitudes to groups of patients, for example to substance misusers (Howard & Chung, 2000a, 2000b), obese people (Poon & Tarrant, 2009; Mold & 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.

¹⁷See, for example, http://news.bbc.co.uk/1/hi/england/southern_counties/4717764.stm, and see Salih & Sutton (2013) for a review.

- You must not discriminate in any way against those in your care.
- You must treat people kindly and considerately.¹⁸

(Nursing and Midwifery Council, 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 United Kingdom 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. (General Medical Council, 2013, p. 19)

As if to emphasize the importance, this is restated 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.

However, 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 while 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 prioritized and valorized above all else is insufficient, and it provides a challengeable initial premise from which procedurally correct but nevertheless similarly criticizable conclusions follow, and stands in tension with a further valorized principle in health care, 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

¹⁸Of interest is the corresponding clause in the General Medical Council document 'Good Medical Practice' which is 'you must be *polite* and *considerate*' (my italics) (General Medical Council, 2013, p. 16).

¹⁹Addressing 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' (Nursing and Midwifery Council, 2004).

²⁰See, for example, the NMC's Guidance for the Care of Older People (Nursing and Midwifery Council, 2009).

²¹This argument is strikingly similar to Clouser & 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.

accountable to health care professionals. Justified blame of sorts does contribute to close relationships as I have described, but the albeit emotional and caring relationship that can characterize 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 apologize for his actions, any apology would be offered to me because I (and certain others) would be harmed in light of the harm to him, but it would make no sense for him to apologize 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 is not *that* asymmetrical, and it seems perfectly reasonable for nurses to feel the resentment that would characterize an assault outside professional health care. Much of the incidence and literature about violence to health-care 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' (National Health Service, 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.

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

Conclusion

To deny that people cannot be held responsible for their health-affecting 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 a variety in relationships and accounts of the good life, and this means that there can be no universalizable rules beloved by overzealous 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-affecting 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 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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