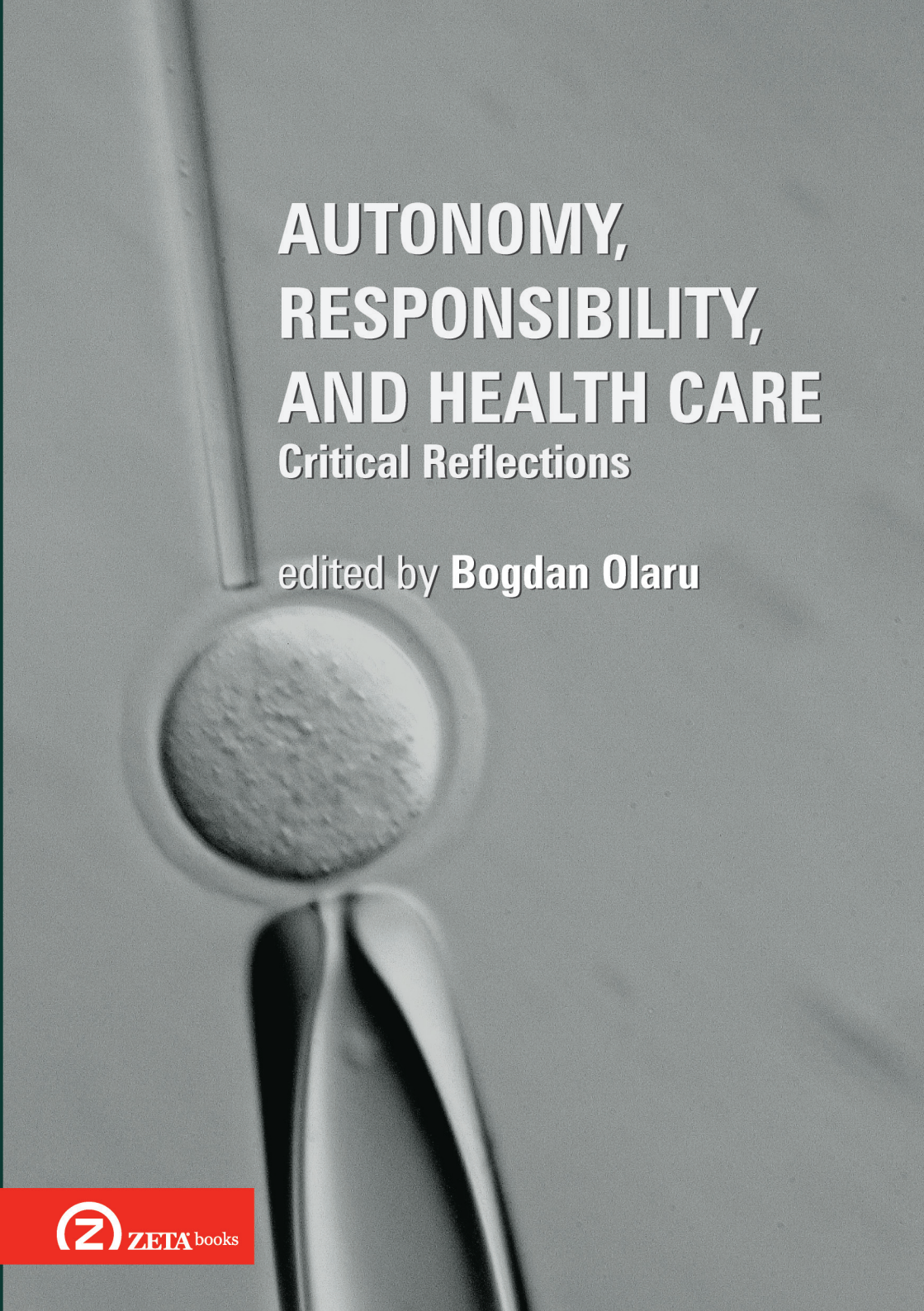
AUTONOMY, RESPONSIBILITY, AND HEALTH CARE

Critical Reflections

edited by **Bogdan Olaru**



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THE PRINCIPLE OF RESPONSIBILITY FOR ILLNESS AND ITS APPLICATION IN THE ALLOCATION OF HEALTH CARE
A Critical Analysis[1]

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1. PRELIMINARY CONSIDERATIONS

In this paper I will analyze a view that is increasingly spreading among philosophers and even physicians these days. Many of them believe that it is right to apply the principle of responsibility for illness in the allocation of health care. I will attempt to show, in as pertinent a manner as possible, that this idea is unacceptable.

The principle of responsibility for illness upholds two main claims. Firstly, the individuals responsible for causing their own diseases, whether totally or in part (that is, those who became ill due to their own deliberate lifestyle), should cover the treatment costs from their own resources, totally or partially.[2] For instance, John Roemer has recently

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1 To read the Romanian version of this paper see: Bogdan Olaru (ed.), *Current Ethical Controversies in Biotechnology: Individual Autonomy and Social Responsibility / Controverse etice în epoca biotehnologiilor. Autonomie individuală şi responsabilitate socială* (Jassy: Alexandru Ioan Cuza University Press, 2008), p. 205-244.

2 See for e.g. Tristram H. Engelhardt, "Human well-being and medicine," in: Tristram H. Engelhardt & Daniel Callahan (eds.), *Science, Ethics and Medicine* (Hastings-on-Hudson: Institute of Society, Ethics and the Life Sciences, 1976), p. 120-139; John H. Knowles, "The responsibility of the individual," *Daedalus*, 106(1977), p. 57-80; John E. Roemer, "A pragmatic theory of responsibility for egalitarian planner," *Philosophy and Public*

stated that society could or even should participate financially in covering treatment costs for the individuals suffering from a disease caused by their lifestyle (only) function of the proportion of their responsibility for that particular lifestyle. Thus, the costs of the medical care needed by a patient who was not entirely responsible for the behavior that resulted in a disease, should be compensated for the proportion of the responsibility that was all but his own (if, for instance, the individual was 80% responsible, he should cover 80% of the treatment costs, while society should cover the remaining 20%). If the individual was not at all responsible, it follows that society ought to pay for the medical services entirely. However, if "an individual were entirely responsible ... then ... he should pay the costs of the consequent diseases."[3] In view of applying this claim in practice, Roemer even proposes a 'pragmatic' formula of establishing the profile of the individuals responsible for their unhealthy lifestyle and the ensuing proportion of their responsibility.[4]

Affairs, 22(1993):2, p. 146-166, published also in: John E. Romer, *Egalitarian Perspectives: Essays in Philosophical Economics* (Cambridge University Press, 1994), pp 179-198; John E. Roemer, "Equality and responsibility," *Boston Review*, 20(1995):2, p. 3-7. This claim must not be mistaken for a more frequent one, which is not the object of this study: the claim according to which the persons who deliberately expose themselves to a high risk of illness should contribute more to the financing of the medical services (either by paying higher insurance premiums or by 'sin taxes'). For a more recent defense of this idea, see, for instance, Alexander W. Cappelen & Ole Frithjof Nordheim, "Responsibility in health care: a liberal egalitarian approach," *Journal of Medical Ethics*, 31(2005):8, p. 476-480 and Cappelen & Nordheim, "Responsibility, fairness and rationing in health care," *Health Policy*, 76(2006):3, p. 312-319.

3 John E. Roemer, "Equality and responsibility," *Boston Review*, 20(1995):2, p. 3-7 [http://bostonreview.net/ BR20.2/roemer.html].

4 According to this formula, doctors and/or other specialists must decide first what are the relevant circumstances in determining the various unhealthy lifestyles like smoking, alcohol abuse, inadequate eating habits, leading a sedentary life, etc. These circumstances will represent the factors beyond the individual control, for which, consequently, they cannot be

legitimately held accountable. For instance, in the case of smoking, these factors might be age, occupation, sex, family environment (if the parents smoke or not), income, addiction, etc. In the second stage, the persons with unhealthy lifestyles (here, smokers) will be divided into types, each of them including persons who share the same values for all the characteristics previously described in the first stage (same age, occupation, and so on). One of these types could be, for instance, 60 year-old male steelworkers, and another type could be 60 year-old female college professors. Finally, a third stage consists of the calculation of the average number of years that the members of each type are likely to smoke. Let us assume, referring to the two examples after Roemer's model, that this number is 30 and 10, respectively. Now, both the identification of the smokers responsible for their lifestyle and the calculation of the ensuing proportion of their responsibility is made function of the position the patients have and the average number of years calculated in stage three for each type separately. To be more precise, the guilty smokers will be those who smoked for more years than the average number specific to their type. The persons who smoked for an equal number of years or smaller than the average specific to their type, on the other hand, must be considered exonerated from responsibility for the lifestyle that caused the disease since the average specific to each type is determined by circumstantial factors beyond the individual's control. Such smokers who are considered responsible are bound to be, for example, 60 year-old male steelworkers who smoked for 35, 40, or 45 years, or 60 year-old female college professors who smoked for 15, 20, or 25 years. The proportion of responsibility in the case of these smokers is a function of the additional number of years they smoked over their type average. In other words, a 60 year-old male steelworker who smoked for 35 years will have to be considered more responsible than one who smoked for 25 years, in the same way that a 60 year-old female college professor who only smoked for 15 years will be considered less responsible than one who smoked for 25 years. For a few very penetrating objections to this formula, see: Richard Epstein et al., "Social equality and personal responsibility," *Boston Review*, 20(1995):2 [http://bostonreview.net/dreader/series/equality.html]; Andrew Mason, "Equality, personal responsibility, and gender socialization," *Proceedings of the Aristotelian Society*, 100(2000), p. 235-239; Norman Daniels, "Democratic equality. Rawls's complex egalitarianism," in: Samuel

The second claim of the principle of responsibility for illness in the allocation of health care is that the individuals found responsible for causing their own disease should have low priority in the distribution of scarce medical resources when the former compete for them against patients who are 'innocent victims' of a disease.[5] For instance, Julian Le Grand invites us to imagine a situation in a hospital where there is only one emergency room. Here are brought two patients who need emergency care as a result of a serious car crash. The doctors are unable to take care of both casualties at the same time. Also, they know that one of them is the innocent victim in that crash (he was walking his

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Freeman (ed.), *The Cambridge Companion to Rawls* (Cambridge: Cambridge University Press, 2002), p. 254-255; Susan Hurley, "Roemer on responsibility and equality," *Law and Philosophy*, 21(2002):1, p. 39-64, published also in: Susan Hurley, *Justice, Luck and Knowledge* (Harvard University Press, 2003) p. 183-207; Mathias Risse, "What equality of opportunity could not be," *Ethics*, 112(2002):44, p. 720-747.

5 Julian Le Grand, "Equity, health, and health care," *Social Justice Research*, 1(1987):3, p. 257-274; Julian Le Grand, *Equity and Choice. An Essay in Economics and Applied Philosophy* (London: Harper Collins, 1991), p. 103-126; Alvin H. Moss & Mark Siegler (1991), "Should alcoholics compete equally for liver transplantation?" in: Helga Kuhse & Peter Singer (eds.), *Bioethics: An Anthology*, 2nd ed. (Oxford: Blackwell, 2006), p. 421-427; Eike-Henner Kluge, "Drawing the ethical line between organ transplantation and lifestyle abuse," *Canadian Medical Association Journal*, 150(1994):5, p. 745-746; B. Smart, "Fault and the allocation of spare organs," *Journal of Medical Ethics*, 20(1994):1, p. 26-30; Walter Glannon, "Responsibility, alcoholism and liver transplantation," *Journal of Philosophy and Medicine*, 23(1998):1, p. 31-49; Robert Veatch, *Transplantation Ethics* (Washington: Georgetown University Press, 2000), p. 311-324; Erik Rakowski, *Equal Justice* (Oxford: Clarendon Press, 1991), p. 313-332; Frank Dietrich, "Causal responsibility and rationing in medicine," *Ethical Theory and Moral Practice*, 5(2002), p. 113-131; Re'em Segev, "Well-being and fairness in the distribution of scarce health resources," *Journal of Medicine and Philosophy*, 30(2005):3, p. 231-260; David Brudney, "Are alcoholics less deserving of liver transplants?" *Hastings Center Report*, 37(2007):1, p. 41-47.

dog on the sidewalk when he was hit by the car) while the other is responsible for the crash (he lost control of the vehicle due to alcohol intoxication). Which of the injured should have priority in getting emergency medical care? According to Le Grand, the one who was the innocent victim in the crash. Things should be the same, Le Grand thinks, even when the hospital in question is a private one and when the person who caused the accident has a medical insurance whereas the victim has none.[6] In the same way, most of those who support this claim of the principle of responsibility for illness in the allocation of health care sustain that the patients who can be legitimately blamed for suffering from end stage liver disease should—since they are responsible for causing their own disease—be at the bottom of the waiting list for a liver transplant. Moreover, as the former are inclined to think, so should things go even when other rationing criteria for medical services (such as urgency) lead to the opposite verdict.[7]

The principle in question states, therefore, that both inequality of access to medical care and inequality in the treatment for their medical needs are justified in the case of the individuals accountable for causing their own illnesses. In other words: the limitation of the right to health care for these patients is legitimate.

Although I will not rule out the first claim of the principle of responsibility for illness in the allocation of health care, I will focus mostly on the second claim thereof. The main reason is that, unlike

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6 Le Grand, 1991, p. 103.

7 However, we must make it clear that not all defenders of this claim of the principle of responsibility for illness favor this idea. Some of these authors (such as, Robert Veatch) uphold much more 'moderate' ideas (Veatch, 2000, p. 311-324; cf. also Robert Veatch, "Just Deserts?," *Hastings Center Report*, 37(2007):3, p. 4.). That is because, although they think that the principle of responsibility can be legitimately considered by doctors in the allocation of scarce medical services, they do not favor the idea that this principle should take precedence, too, as the decisive criterion in the process, as Frank Dietrich says (Dietrich 2002, p. 117).

in the case of the first claim, which aroused vehement criticism and was subsequently abandoned even by the supporters of the principle in question, the legitimacy of the second seems plausible at least at first sight. As a matter of fact, it even looks plausible to some of the authors who criticized other ideas usually promoted in the name of the principle of responsibility for illness in the allocation of health care.[8]

In order to reach our goal, I will proceed as follows. Firstly, I will try to show that the arguments used as a rule in favor of the application of the principle of responsibility for illness in the allocation of health care are not in fact sustainable. Secondly, even if these arguments were valid, the idea of allocation of health care according to the principle of responsibility for illness would still be unacceptable because, as I intend to demonstrate in Chapter 3, there are a few very strong reasons against it.

2. A CRITICAL REVIEW OF THE ARGUMENTS IN FAVOR OF APPLICATION OF THE PRINCIPLE OF RESPONSIBILITY FOR ILLNESS IN THE ALLOCATION OF HEALTH CARE

According to my research, there are five main arguments in favor of the application of the principle of responsibility for illness in the allocation of health care. I will introduce—and criticize—them below from the least plausible to the most.

1) The application of this principle would contribute to saving some important (public) funds, those spent or 'wasted' as a rule on treating persons accountable for causing their illnesses. Although Malcolm Dean, for instance, credits the British supporters of rationing for this

8 Gerald Dworkin, "Taking risks, assessing responsibility," *Hastings Center Report*, 11(1981):5, p. 29-30; Tziporah Kasachkoff, "Drug addiction and responsibility for the health care of drug addicts," *Substance Use & Misuse*, 39(2004):3, p. 489-509.

argument on account of the principle of responsibility for illness,[9] I doubt there is an author, may he be an economist, who could be serious about bringing such a reason in favor of limitation of the right to health care of the persons accountable for causing their illnesses. The idea that persons accountable for causing their illnesses should not be treated only because this would save more or less significant financial resources is, without a doubt, morally unacceptable.

2) The persons accountable for causing their illnesses committed an immoral act and, therefore, deserve (or ought to suffer) punishment for this by referring them to the principle of responsibility for illness in the allocation of health care. Although this statement is often quoted among the arguments supporting the application of this principle,[10] and despite some standpoints coming from its advocates suggesting that this is (at least) one of the reasons why they uphold it, I doubt, once more, that there is an author who would see this argument as a serious reason for the introduction of the principle of responsibility for illness in the allocation of health care. Moral(izing) sentences cannot constitute legitimate reasons for reducing the individual right to medical care even if such sentences are widely popular in our society. The right to health care is not conditioned by the individuals' moral qualities, or their virtues. It is for good reason that most of the supporters of the principle in question explicitly recant such an argument in favor of the principle of responsibility for illness in the allocation of health care (even when the medical services are scarce). In fact, even if moralizing

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9 Malcolm Dean, "Self-inflicted rationing," *The Lancet*, 341(1993):8859, p. 1525.

10 Alan Cribb, *Health and the Good Society. Setting Healthcare Ethics in Social Context*, (Oxford: Oxford University Press, 2005), p. 103-104; Stephen Wilkinson, "Smokers' rights to health care: Why the 'restoration argument' is a moralising wolf in a liberal sheep's clothing," *Journal of Applied Philosophy*, 16(1999):3, p. 267, note 8.

judgments were allowed from the moral point of view[11] and accepted as grounds for the limitation of certain individuals' right to health care, this argument would yield on the remark that the persons suffering from 'self-induced' diseases are not ferocious criminals, people who committed abominable acts deliberately and who thus deserve to be punished as severely as is suggested by the principle of responsibility. We must not overlook that if a patient receives low priority in the allocation of some scarce medical services or if, since he cannot cover the costs of the medical services he needs, they are refused to him, the situation can—and it often does—lead to the death of that patient. Neither must we forget that the legitimacy of the death penalty is questionable even in the case of murderers. Not lastly, as some critics of this argument remark, is getting ill not enough punishment already for the persons who assumed a health-threatening lifestyle? Is it not immoral for them to suffer additional punishment by limiting their right to health care?[12]

3) Responsibility for one's lifestyle is a fundamental value, one that deserves and must be asserted and promoted in society. Yet, the application of this principle in the allocation of health care would have precisely this effect. For instance, once people acknowledge the fact that their perilous lifestyle decisions can lead to significant financial losses (due to the fact that they will be forced to cover the costs of the medical services from their own pocket) or even to the dramatic diminishment of their right to benefit from certain scarce medical services, they will be more careful or 'responsible' about making such decisions.

As in the case of the other arguments presented above, this one is not sufficient proof in demonstrating the legitimacy of the principle

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11 One of the main reasons why these judgments are not allowed from the moral point of view is that they are disrespectful. For an explanation and an excellent analysis of all the vices of moralism, cf. C.A.J. Coady, *What's Wrong with Moralism?* (Malden: Blackwell, 2006).

12 Einer R. Elhauge, "Allocating health care morally," *California Law Review*, 92(1994), p. 1523.

of responsibility for illness in the allocation of health care. Not any public policy that can help promote individual responsibility in society is sustainable. Besides, like the above-discussed arguments, this one is attributed (for no good reason) to the advocates of the principle of responsibility for illness by some of their critics,[13] rather than formulated and assumed by the latter explicitly.

4) The majority of public opinion favors the use of this principle by doctors in rationing of scarce medical services. Indeed, more and more studies conducted recently seem to confirm this fact.[14] The public views seem to converge, too, with regard to the idea that persons accountable for causing their illnesses should pay from their own pocket for at least part of the medical services they need.[15]

Still, what these studies really demonstrate, as a rule, is only the fact that the public opinion favors almost unanimously the idea that

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13 Alexander Brown, "If we value individual responsibility, which policies should we favor?," *Journal of Applied Philosophy*, 22(2005):1, p. 23-44; Bruce N. Waller, "Responsibility and health," *Cambridge Quarterly of Healthcare Ethics*, 34(2005), p. 181-184.

14 Ann Bowling, "Health care rationing: the public's debate," *British Medical Journal*, 312(1996), p. 670-674; Darren Shickle, "Public preferences for health care: Prioritisation in the United Kingdom," *Bioethics*, 11(1997):3, p. 277-290; Peter Ubel et al., "Allocation of transplantable organs: Do people want to punish patients for causing their illness?," *Liver Transplantation*, 7(2001):7, p. 600-607; Eve Wittenberg et al., "Rationing decisions and individual responsibility for illness: Are all lives equal?," *Medical Decision Making*, 23(2003):3, p. 194-211; G. Schomerus et al., "Alcoholism: Illness beliefs and resource allocation preferences of the public," *Drug & Alcohol Dependence*, 82(2006):3, p. 204-210.

15 R. Blendon et al., "Bridging the gap between expert and public views on health care reform," *Journal of the American Medical Association*, 269(1993):19, p. 2573-2578; K. Stronks et al., "Who should decide? Qualitative analysis of panel data front public, patients, healthcare professionals, and insurers on priorities in health care," *British Medical Journal*, 315(1997), p. 92-96.

alcoholics or smokers should contribute more to the financing of health care system and/or should have a lower priority in the allocation of scarce medical services (liver transplant, for instance). But it is not very clear whether the public opinion sustains such policies regarding smokers and alcoholics for the reason invoked by the advocates of the principle of responsibility. Quite on the contrary, this view coming from the public does not seem to emerge primarily from the belief that these people are responsible for causing their own diseases, but rather from the shared perception that smoking, alcohol abuse or other health-threatening behaviors are 'vices' or socially undesirable acts, which are to be sanctioned or punished through such policies. This was the implication of a particular study which concluded that people who tend to give low priority to alcoholic or smoking patients in the allocation of scarce medical resources often make the same decision even in the case of those patients acknowledged to have become ill from causes other than their lifestyle. Consequently, the authors of this study remark, "people's attitudes toward transplanting patients with a history of controversial behavior should not be understood merely as resulting from a view that those patients [...] do not deserve organs because they are personally responsible for becoming ill. Instead, many people may want to divert resources from patients simply because they engaged in socially undesirable behaviors."[16] Under the circumstances, the idea that the public opinion sustains the application of the principle of responsibility for illness in the allocation of health care becomes problematic. It is more correct to interpret these empirical results as indicating the fact that the public opinion favors the application of a different (and unacceptable) principle, the principle of moral or social

16 Peter Ubel et al., "Social acceptability, personal responsibility, and prognosis in public judgments about organ transplantation," *Bioethics*, 13(1999):1, p. 68.

value of the patients,[17] and not as a sign of support for the principle of responsibility for illness in the allocation of health care. The fact that the public opinion is not in favor of limiting the right to health care for those people, too, who got ill as a result of deliberate practice of certain professions which, though health-threatening, are useful or necessary to society, endorses the same interpretation as well.

Moreover, this argument is undermined by a well-known problem: is it a position justified solely because it is shared by the majority of the public opinion? Does asking the public opinion represent a legitimate way to try the validity of a view? Certainly not.

5) The principle of responsibility represents a fundamental—if not the ultimate—demand of distributive justice. Its application in the distribution of medical services and the costs thereof could constitute, therefore, the warranty of a truly just, or fair health care system.

This is, indeed, the only argument explicitly advanced by the advocates of the principle of responsibility for illness in the allocation of health care, and the only one constantly invoked in all the apologies for this idea. In addition, it is the only argument which, if correct, constitutes a very strong reason indeed for the application of this principle in the allocation of health care.

The idea that the principle of responsibility represents the basic demand of distributive justice is supported by an entire current of thinking from today's political philosophy, namely, the current that is usually designed (more or less adequately) as 'luck egalitarianism'. It is not by chance that most of the authors promoting the principle of responsibility for illness either are luck egalitarians themselves[18] or authors who invoke works by the latter in support for their own claims.[19]

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17 A principle according to which the persons of a questionable moral quality or low social value must have low priority in the allocation of scarce medical services.

18 Roemer 1993, Roemer 1995, Rakowski 2001.

19 Glannon 1998, Dietrich 2002, Segev 2005, Brudney 2007.

In the interpretation of the luck egalitarians, the principle of responsibility states that, from the point of view of fairness or distributive justice, a person's right to be compensated by the other members of society for the disadvantages he is facing (or a person's right to be granted a particular social service) depends on the proportion of his responsibility in causing those disadvantages (or the need for that social service). A person legitimately considered (totally or partially) responsible for him suffering from certain disadvantages or for having certain needs—in the sense that they represent consequences of some actions resulting from his own choices or personal decisions—loses (totally or in part) his moral right to receive compensation for those disadvantages or needs.[20] In other words, compensation for disadvantages or alleviation of this person's needs do not represent a demand of distributive justice—although it could constitute, of course, a demand pertaining to other principles or moral, political, or economic values.[21] Only the persons who are not responsible for bringing disadvantages or needs onto themselves have legitimate claims to compensation in the name of social justice. Compensation or alleviation constitutes such a claim. Consequently, as G. A. Cohen explains, "When deciding whether or

20 This idea represents the core of what Thomas Scanlon has recently called *forfeiture view* on responsibility, a view by which "a person who could have chosen to avoid a certain outcome, but who knowingly passed up this choice, cannot complain of the result: *volenti non fit iniuria,*" T.M. Scanlon, *What We Owe to Each Other* (Cambridge: Belknap Press, 1998), p. 259; s. also T.M. Scanlon, "The significance of choice," in: Sterling McMurrin (ed.), *The Tanner Lectures on Human Values*, vol. 8 (Salt Lake City: University of Utah Press, 1988), p. 192-195.

21 For instance, Julian Le Grand explains, although an individual injured in an accident he caused loses, at least in part, according to the principle of responsibility, his right to the medical services he needs, there are reasons other than fairness in favor of the allocation of these services, e.g. compassion or even efficiency (the person in question may be a highly productive member of the community). Cf. Le Grand 1987, p. 261.

not justice (as opposed to charity) requires redistribution, the [luck] egalitarian asks if someone with a disadvantage could have avoided it [...]. If he could have avoided it, he has no claim to compensation, from an egalitarian point of view."[22] For example, if a person "became blind through deliberate and fully informed participation in a dangerous sport that often gives rise to injuries that results in blindness, it becomes questionable whether compensation is owed for the handicap."[23]

In the most frequent expression, which is based on a distinction introduced by Ronald Dworkin, luck egalitarianism is defined as the conception that distributive justice requires compensation for inequalities, disadvantages, or needs resulting from brute bad luck, but not for those coming from option bad luck. By 'brute luck', Dworkin understands just the (bad) luck that does not root in any previous deliberate action, choices or will of the person affected by it, whereas 'option luck' is that which follows a risk assumed deliberately: "Option luck is a matter of how deliberate and calculated gamble turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined. Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles."[24] Examples of brute luck could be: someone born defficient in the talent or skills necessary to practice better paid professions, or born with a genetic disease, or severely disabled as a result of a medical error; someone who became ill before he got the chance to make an insurance for that particular disease, and so on. Examples of option luck are

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22 G.A. Cohen, "On the currency of egalitarian justice," *Ethics*, 99(1989):4, p. 920.

23 Richard Arneson, "Liberalism, distributive subjectivism, and equal opportunity for welfare," *Philosophy and Public Affairs*, 19(1990):2, p. 187.

24 Ronald Dworkin, "What is equality? Part 2: Equality of resources," *Philosophy & Public Affairs*, 10(1981):4, p. 293, republished in: Ronald Dworkin, *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge: Harvard University Press, 2000), p. 65-119.

someone's financial loss following gambling, injuries or diseases caused by voluntary exposure to the risk of getting them, etc.

The main argument of luck egalitarians in support of the idea that principle of responsibility is a fundamental demand—or even the ultimate demand—of distributive justice is, unsurprisingly, that responsibility for the consequences of one's own actions is the cost, or the 'other side' of one's freedom or autonomy. Individual autonomy and responsibility are inseparable. It is natural, therefore, that only the individual—and not the other members of society as well—be the one to foot the bill (or appropriate the benefits) of his autonomous actions. In other words, individuals cannot demand for compensation from society for the unfortunate consequences of their own decisions, for which they alone are to blame. As Ronald Dworkin thinks, for instance, "people should pay the price of the life they have decided to lead, measured in what others give up in order that they can do so."[25]

The idea that the principle of responsibility is indeed a demand of distributive justice is, however, opposed by very solid counter-arguments. One of the most widely debated of the latter is that the principle grants legitimacy to 'repugnant conclusions' from the moral point of view, an unacceptable aspect for a principle that is desired to constitute an adequate demand of distributive justice. Such a conclusion is, for example, that individuals who got ill or injured (and who do not have a health insurance) as a result of their own carelessness or negligence, and cannot cover the costs of the medical care they need from their own resources, should not be attended to.[26]

This argument roused a huge reaction from the ranks of defenders of luck egalitarianism, bringing forth an entire wave of responses.[27]

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25 Ronald Dworkin 1981, p. 294.

26 Elizabeth Anderson, "What is the point of equality?," *Ethics*, 109(1999):2, p. 295-296.

27 David Sobel, Richard Arneson & Thomas Christian, "What is the point of equality?," *Brown Electronic Article Review Service*, 1999 [http://www.brown.edu/Departments/Philosophy/bears/symp-anderson.html];

The most convincing reply seems to have come from Shlomi Segall. According to him, this conclusion does not affront in fact our sense of justice, but other different values such as, compassion, charity or solidarity. That is, what this argument demonstrates so convincingly is not in fact the idea that the principle of responsibility is not an adequate demand of distributive justice, but only the idea that—unlike what some luck egalitarians seems to believe—justice or fairness are not exclusive values that doctors (or society) must observe in the distribution of medical care (or other social services, or resources).[28]

There is yet another crucial argument against the idea that the principle of responsibility is an adequate claim of distributive justice, one to which the luck egalitarians have taken their time to respond. Namely, the principle of responsibility grants legitimacy to other 'repugnant conclusions' which, unlike the above stated, oppose not only moral values such as charity and solidarity, but our very intuition regarding distributive justice. So, a principle leading to such conclusions cannot constitute a legitimate claim of distributive justice. One of these conclusions is, for example, that people who got ill as a result of practicing health-threatening professions of their own deliberate choice (e.g. firemen, miners, and policemen) must pay from their own pocket for the medical care they need, or have low priority in the distribution of scarce medical services when these are requested by people who did not get ill

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Ronald Dworkin, "Sovereign Virtue revisited," *Ethics*, 13(2002):1, p. 113-118; Ronald Dworkin, "Equality, luck and hierarchy," *Philosophy & Public Affairs*, 31(2003):2, p. 190-198; Alexander Brown, "Luck egalitarianism and democratic equality," *Ethical Perspectives*, 12(2005b):3, p. 293-339; Carl Knight, "In defence of luck egalitarianism," *Res Publica*, 11(2005), p. 55-73; Nicholas Barry, "Defending luck egalitarianism," *Journal of Applied Philosophy*, 23(2006):1, p. 89-107; Karen Voight, "The harshness objection: Is luck egalitarianism too harsh on the victims of option luck?" *Ethical Theory and Moral Practice*, 10(2007):4, p. 389-407.

28 Shlomi Segall, "In solidarity with the imprudent: A defense of luck egalitarianism," *Social Theory and Practice*, 33(2007):2, p. 177-198.

following a health-threatening lifestyle.[29] A similar conclusion is that persons whose earnings are insufficient for a decent living due to their deliberate decision to sacrifice their career in order to raise their children are not entitled to compensation from the other members of society.[30]

The only response at hand for luck egalitarians to counterbalance the idea that the principle of responsibility legitimates such conclusions is that anyone in a health-threatening profession or who puts raising children above a well-paid job is not even partially responsible for his decision. Yet, this response is hardly plausible. Under the circumstances, it seems fair to me to say that, as a matter of fact, not even this last argument for the application of the principle of responsibility for illness in the allocation of health care is acceptable.

3. SHOULD THE PRINCIPLE OF RESPONSIBILITY FOR ILLNESS IN THE ALLOCATION OF HEALTH CARE BE PUT INTO PRACTICE? ARGUMENTS FOR A NEGATIVE ANSWER

If the critical observations from the previous chapter are correct, there already is a serious reason to give a negative answer to this question. The reason is that there is no legitimate argument to support the application of this principle in the allocation of health care. I will attempt to show next that the answer is based also on the fact that we have strong reasons not to apply this principle in the allocation of health care. One of them is that the application of the claims of this principle would lead to discrimination among the patients who come from underpriviledged social categories. Since, unlike the well-off patients, they do not have the necessary resources to cover the costs of the medical services they need for the treatment of 'self-inflicted'

29 Anderson 1999, p. 296.

30 Andrew Mason, "Equality, personal responsibility, and gender socialization," *Proceedings of the Aristotelian Society*, 100(2000), p. 235-239.

illnesses, these people would be practically excluded from the allocation of these services (at least where the principle of responsibility for illness is taken in its first sense).[31] It would be the same, too, if the principle were applied in its second sense, according to which the persons who are not responsible for their illness must have priority over those responsible for causing their own disease in the situation of scarce medical services. This is because most people with health-threatening lifestyles are from underpriviledged social categories. Thus, they would be the most affected victims of this principle.

A solution to this challenge comes from Alvin H. Moss and Mark Siegler, two physicians who advocated the application of the principle of responsibility in the case of liver transplant (to be more precise, in favor of reducing the right of certain alcoholics to candidate for a transplant). Moss and Siegler believe that the principle cannot be applied legitimately in the case of (alcoholic) patients who are poor because these patients cannot be safely considered responsible for their unhealthy lifestyle and, thus, for their ensuing illnesses. For instance, since they do not normally have the (knowledge and financial) resources necessary for the treatment of alcohol addiction, these patients cannot be blamed sensibly for causing their cirrhosis. Only the patients diagnosed with alcoholism and who had the financial resources to pay for treatment that would have prevented them from developing cirrhosis, can be legitimately delayed in their right to liver transplant. Consequently, the two authors argue, far from lapsing into disccrimination against the poor, the application of the principle of responsibility for illness in the allocation of scarce medical resources would actually lead to the diminishment of the right of the well-off to candidate for it.[32]

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31 Amy Gutmann, "For and against equal access to health care," *Milbank Memorial Fund Quarterly*, 59(1981):4, p. 542-560.

32 Alvin H. Moss & Mark Siegler (1991), "Should alcoholics compete equally for liver transplantation?," in: Helga Kuhse & Peter Singer (eds.), *Bioethics: An Anthology*, 2nd ed. (Oxford: Blackwell, 2006), p. 421-427.

However, discrimination against the poor is not the only reason against the application of the principle of responsibility for illness in the allocation of health care, a reason to be counterbalanced by the supporters thereof. Other two reasons of this kind are: 1) that the role of one's lifestyle in causing his disease is not quite clear (the physicians are unable to determine with certainty that a patient got ill as a result of his lifestyle and not because of another factor liable to triggering that disease), and 2) that this principle cannot be applied without violating a fundamental human right, the right to privacy. Even the champions of this principle admit the pertinence of these arguments when it comes to the vast majority of patients suspected of having caused their own diseases (e.g. the smokers who suffer from respiratory diseases or lung cancer, HIV patients, heavily overweight persons with diabetes, etc.) But unlike those who consider these arguments generally valid,[33] the adepts of the principle of responsibility for illness claim that the cirrhotic patients awaiting a liver transplant are a quite different situation. In their case, the doctors can say exactly whether or not the cirrhosis was the result of alcohol abuse: "Alcohol-induced liver damage is a special case, first, because the cause of the illness is clearly identifiable."[34] In addition, doctors can establish whether an alcoholic patient is responsible for inducing his disease without violating his right to privacy: "A second special feature of liver transplantation is

33 Haavi E. Morreim, "Lifestyles of the risky and infamous," *Hastings Center Report*, 25(1995):6, p. 5-12; C. E. Atterbury, "Anubis and the Feather of truth: judging transplant candidates who engage in self-damaging behavior," *Journal of Clinical Ethics*, 7(1996):3, p. 268-276; Scott D. Yoder, "Personal responsibility for health: discovery or decision?," *Medical Humanities Report*, 19(1998):3 [http://www.bioethics.msu.edu/mhr/98sp/s98responsibility.htm]; Scott D. Yoder, "Individual responsibility for health: decision, not discovery," *Hastings Center Report*, 32(2002), p. 26-31.

34 Frank Dietrich, "Causal responsibility and rationing in medicine," *Ethical Theory and Moral Practice*, 5(2002), p. 119.

the easy availability of the relevant information in any given case of liver damage. The symptoms reliably indicate whether it was caused by alcohol abuse or not. Furthermore, the doctors in attendance are usually well-acquainted with a patient's case history. There is no need for troublesome investigations to find out whether the potential recipient of a donor liver is an alcoholic."[35] Under the circumstances, the author of these arguments believes, the application of the principle of responsibility for illness in the allocation of liver transplant is both possible and legitimate.

I find these arguments unconvincing. Firstly, according to specialists, the diagnosis of alcoholic liver disease is far from absolute: "Even liver biopsy, the cornerstone for diagnosis of alcoholic liver disease, is fallible."[36] Besides, "it is impossible to conclude that alcohol use alone causes liver failure in even the heaviest drinking alcoholic patients."[37] Not lastly, alcoholic liver disease can occur even in patients who did not have a history of alcohol abuse.[38] Alcoholic liver disease is not therefore an accurate indicator of alcohol *abuse* in a patient's history. Under the circumstances, it becomes very difficult to understand in what way doctors could know this for sure without resorting to 'troublesome investigations' on his lifestyle and without violating thus his right to privacy. Moreover, as we have seen already, and as the advocates of the principle of responsibility for illness admit themselves, not all alcoholics—but only a part of them—can be blamed reasonably for the fact

35 Dietrich 2002, p. 120.

36 Michael R. Lucey, & Thomas Beresford, "Alcoholic liver disease: to transplant or not to transplant?" *Alcohol and alcoholism*, 27(1992):2, p. 105.

37 Thomas Beresford, "The limits of philosophy in liver transplantation," *Transplant International*, 14(2001):3, p. 176-177.

38 Carl Cohen & Martin Benjamin, "Alcoholics and liver transplantation," *Journal of the American Medical Association*, 265(1991), p. 1300; Lucey & Beresford 1992, p. 105; Martin S. Mumenthaler et al., "Gender differences in moderate drinking effects," *Alcohol Research & Health*, 23(1999):1, p. 55-64.

that they have cirrhosis. In other words, many can have solid excuses for their alcohol addiction, or for not having treated it. These excuses, which the opponents of the application of the principle of responsibility for illness in the allocation of health care insist on, include genetic predisposition, the fact that (most of) these choices are made at ages when individuals cannot be legitimately considered responsible for their deeds, the fact that these decisions are influenced by an unfavorable social or family environment, the low social and economic status, inadequate education, reduced ability to analyze and understand the risks of alcohol abuse, cultural background, a period of intense suffering, severe mental disorders, etc.[39] It follows that, in order for a patient

39 Amitai Etzioni, "Individual will and social conditions: toward an effective health maintenance policy," *ANNALS of the American Academy of Political and Social Science*, 437(1978):1, p. 62-73; Daniel Wikler, "Persuasion and coercion for health: ethical issues in government efforts to change life-styles," *The Milbank Memorial Fund Quarterly. Health and Society*, 56(1978):3, p. 303-338; Daniel Wikler, "Who should be blamed for being sick?," *Health Education and Behavior* 14(1987), p. 11-25; Charles J. Dougherty, "Bad faith and victim blaming: the limits of health promotion," *Health Care Analysis*, 1(1993): p. 115-116; Henk A. M. J. Ten Have & Michael Loughlin, "Responsibilities and rationalities: should the patient be blamed?," *Health Care Analysis*, 2(1994), p. 119-127; J. W. Lynch et al., "Why do poor people behave poorly? Variation in adult health behaviors and psychosocial characteristics by stages of the socioeconomic lifecourse," *Social Science and Medicine*, 44(1997):6, p. 809-819; Sarah Marchand et al., "Class, health, and justice," *The Milbank Quarterly*, 76(1988):3, p. 449-467; Meredith Minkler, "Personal responsibility for health? A review of the arguments and the evidence at century's end," *Health Education and Behavior*, 26(1999), p. 121-141; Willem Martens, "Do alcoholic liver transplantation candidates merit lower medical priority than non-alcoholic candidates?," *Transplant International*, 14(2001):3, p. 170–175; Mike W. Martin, "Responsibility for health and blaming victims," *Journal of Medical Humanities*, 22(2001):2, p. 95-114; P. Alleman et al., "Transplantation for alcoholic liver disease: the wrong arguments," *Swiss Medical Weekly* 132(2002), p. 296-297; Howard

to lose his right in a legitimate way to a liver transplant, alcohol abuse is not enough reason. Doctors must also be able to prove the fact that the patient can be legitimately made responsible for this (that there is no excuse on his side). This, however, is impossible in the absence of information as accurate and as detailed as possible about the circumstances that affected his decision to drink excessively or made him ignore the possibility of treatment for his disease.[40]

Even if doctors were 'well-acquainted' to a patient's drinking history (and so, they were not forced to carry out 'troublesome investigations' into his private life to be sure), it is far from obvious, as the advocates of the principle of responsibility seem to think, that they would do the right thing using this information to lower the patient's priority in meeting his medical needs. On the contrary, there are a few extremely important ethical considerations against this idea. As a matter of fact, a third reason against the application of the principle of responsibility for illness is that it is incompatible with the nature and ethics of the medical profession. As it has been remarked, if doctors were allowed to act in the manner prescribed by the advocates of the principle of responsibility for illness, the immediate consequence would be the breach in the relationship of confidence between doctor and patient,

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M. Leichter, " 'Evil habits' and 'personal choices': Assigning responsibility for health in the 20th century," *The Milbank Quarterly*, 81(2003):4 , p. 603-626; Daniel Wikler (2004), "Personal and social responsibility for health," in: Sudhir Anand, Fabienne Peter & Amartya Sen (eds.), *Public Health, Ethics, and Equity* (Oxford: Oxford University Press, 2004), p. 109-134; Bruce N. Waller, "Responsibility and health," *Cambridge Quarterly of Healthcare Ethics*, 34(2005), p. 181-184.

40 The fact that it requires the collection of data as accurate and correct as possible about the circumstances that influenced the lifestyle of the persons who got ill as a consequence thereof (and it leads to the violation of their right to privacy) is, in fact, one of the decisive hindrances to the application of the Roemerian calculation formula for the proportion of responsibility (see footnote 3 above), usually overlooked by his critics.

vital for the success of the medical care act. If the patients knew that their doctors could use the relevant information about them in order to establish if they deserve or not high priority in treatment (or should cover, at least in part, the costs of the medical services they need), the patients would lie or be more discreet in giving relevant information on the history of their disease, which would, in turn, jeopardize the accuracy of the diagnosis and treatment generally.[41] This is one of the main reasons why their professional ethics force doctors to play the role of unrestricted advocates for their patients and forbid them to become their 'judges' or use the information about their patients for purposes other than the strict medical practice.[42] One of the basic principles of the doctor-patient relationship is that of beneficence, which engages the doctor into acting solely in the interest of (all) his patients, regardless of the degree of responsibility in some of them in causing their own diseases. In other words, the only criteria the doctor can observe in rationing scarce medical services are medical criteria (urgency, need, and prognosis). The decision of lowering liver transplant priority for an alcoholic is justifiable only based on these criteria.[43] Not by accident, the official guides of medical ethics forbid, as a rule, particularly the application of the principle of responsibility for illness in rationing medical care and sustain the exclusive use of medical criteria.[44] And not by chance, again, many doctors have come up with arguments

41 Einer R. Elhauge, "Allocating health care morally," *California Law Review*, 92(1994), p. 1523.

42 Suzanne Van Der Vathorst, Carlos Alvarez-Dardet, "Doctors as judges: the verdict on responsibility for health," *Journal of Epidemiology and Community Health*, 54(2000), p. 162–164.

43 Kevin Schwartzmann, "*In vino veritas*? Alcoholics and liver transplantation," *Canadian Medical Association Journal*, 141(1989), p. 1262-1265.

44 CEJA (Council on Ethical and Judicial Affairs), "Ethical considerations in the allocation of organs and other scarce medical resources among patients," American Medical Association, 1995, p. 8-9 [http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_ka93]; NIHCE (National Institute for

pertaining to the ethics of their profession in order to reject the ideas promoted in the name of the principle of responsibility for illness.[45]

One of the arguments that further justifies the idea that only medical criteria can be used legitimately in rationing scarce medical resources was provided by Robert Goodin.[46] According to him, the application of this principle in the allocation of medical services is simply "out of place" The allocation of medical services is part of those situations when it is morally unacceptable to apply the criterion of responsibility. In such cases, especially in life and death matters, "needs are trumping deserts" when we have to pick a prioritization criterion, and this not just in the sense that needs must always prevail over merits in assessing someone's right to repair his disadvantage, but also in the sense that merits are simply *cancelled* by needs. Consequently, the principle of responsibility can *never* constitute a legitimate criterion in the allocation of health care, not even "in the last resort," when the patients' situations are quasi-equal from the point of view of the medical criteria. In such a case, the only (morally) justified manner of selecting the patient who will have priority in attending to his medical needs is the aleatory selection (such as lottery or flipping the coin).[47]

Health and Clinical Excellence), "Social Value Judgements—Principles for the development of NICE guidance," 2005, p. 22-23 [http://www.nice.org.uk].

45 M. I. Khalid, "Denying treatment is indefensible," *British Medical Journal*, 306(1993), p. 1408; Nizam Mamode, "Denying access more costly," *British Medical Journal*, 306(1993), p. 1408; Matthew Shiu, "Refusing to treat smokers is unethical and a dangerous precedent," *British Medical Journal*, 306(1993), p. 1048–1049; S. Bhattacharya, "Higher complication rate not confined to smokers," *British Medical Journal*, 306(1993), p. 1409.

46 Robert E. Goodin, "Negating positive desert claims," *Political Theory*, 13(1985):4, p. 586-587.

47 This moral intuition is shared, in fact, even by one of the defenders of luck egalitarianism, who admits that, "in extending medical treatment, especially emergency treatment, society should be responsibility-blind." (Segall 2007, p. 195). An argument similar to Goodin's which also sustains this

So, a fourth reason why the principle of responsibility for illness should not be applied in the allocation of health care is that its application would not observe the demands of morality. However, this idea is not sustained only by Goodin's argument. I consider here the fact that the persons with heath-threatening lifestyles (e.g. smokers or alcoholics) have a bigger contribution to the financing of health care system than persons with healthy lifestyles. The so-called 'sin taxes', for instance, recently introduced in Romania too, represent an important and quite popular method of supplementing the funds for these services.[48] So, the idea that it is fair that these people should have low priority in the allocation of medical care is impossible to justify. Are they not entitled to equal medical care by (at least) this additional contribution, even in the event that they are 'personally responsible' for their diseases (without being asked to pay for this care from their own pocket, as Roemer says)? If only because of this supplementary contribution, they are entitled to attendance to their medical needs that is equal to that for non-smoking and non-drinking patients, even when the medical resources or services are scarce. It is true that, probably in order to prevent this sort of criticism, the adepts of the principle of responsibility for illness favor its application only in the case of absolute scarce medical services.[49] But, as has been remarked, the individuals with health-threatening lifestyles

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conclusion is that medical services represent, due to their decisive importance in ensuring a 'normal functioning' of the individuals, a 'special' category of goods which must not be allocated according to the claims of the principle of responsibility. Cf. Eli Feiring, "Lifestyle, responsibility and justice," *Journal of Medical Ethics*, 34(2008), p. 34-35.

48 In Romania, according to Minister Eugen Nicolaescu's statements, the 'sin taxes' contributed €170 mill. in 2006 and €350 mill. in 2007 (acc. to N.G., "Românii vicioşi salvează bugetul sănătăţii / Romanian Vices Save Health Budget," *Ziarul Online*, July 25, 2006 [http://www.ziarulcn.com/article/aid/37340/romanii-viciosi-salveaza-bugetul-sanatatii].

49 The absolute scarce medical services are those services the availability thereof does not depend primarily on the amount of money allocated for pro-

have a major contribution to the availability of these services as well. More exactly, many organ donors are people who died in accidents caused by alcohol intoxication or by the fact that they assumed other major risks to their health.[50] Under the circumstances, even the idea of limiting only these patients' right to candidate for allocation of absolute scarce medical services is indefensible.

Perhaps the strongest reason against the application of the principle of responsibility for illness in the allocation of health care is that it would be inevitably discriminatory. This principle legitimates the limitation of the right to medical care of several categories of patients other than those usually considered by the advocates of the principle (alcoholics and/or smokers sometimes). These categories include, for instance, the persons who got ill or injured as a result of practicing professions that threaten their health (including doctors who work in an environment with a high degree risk of contamination), as a result of 'workaholism', excessive exercise, trying to save someone's life (e.g. in a fire), and so on. But none of us would consider as justified the idea of limitation of the right to health care in the case of these categories of patients. As a matter of fact, the adepts of this principle do not sustain such an idea either, although they should, for the sake of consistency in their argumentation. The fact that they do not shows that another frequent accusation against them may be reasonable. They are accused of actually not supporting the principle of responsibility for illness, but

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viding them, but on the availability of non-financial resources (e.g. transplant organs).

50 Tarek I. Hassainen et al., "Does the presence of a measurable blood alcohol level in a potential organ donor affect the outcome of liver transplantation?," *Alcoholism*: *Clinical and Experimental Research*, 15(1991):2, p. 300-303; Harry Bonet et al, "Liver transplantation for alcoholic liver disease: Survival of patients transplanted with alcoholic hepatitis plus cirrhosis as compared with those with cirrhosis alone," *Alcoholism*: *Clinical and Experimental Research*, 17(1993):5, p. 1102.

really nurturing a masked affinity for the principle of moral or social value of patients. In other words, the true reason why they advocate the limitation of the right to medical services of alcoholics (and/or smokers) whose illness was caused by their lifestyle is the fact that their lifestyle is 'vicious' and/or without social value.[51] But such moral(izing) sentences or judgments on the social desirability of certain types of behavior cannot constitute legitimate reasons for the limitation of someone's right to health care.

Finally, a last reason against the application of this principle in the allocation of medical services is that it contradicts the demands of the principle of equality of opportunities for the individuals in society. Equality of opportunity is one of the basic principles for the idea of a human right to health care. Or, in the absence of equal access to medical services and of equal treatment of medical needs, individuals cannot benefit from equal opportunity to pursuit their life plans. In fact, as Yvonne Denier remarks, "fair equality of opportunity is a *forward-looking* concept. It provides the moral basis for a fallback framework

51 Steven Schenker, Henry S. Perkins & Michael F. Sorell, "Should patients with end-stage alcoholic liver disease have a new liver?," *Hepatology*, 11(1990):2, p. 314–319; Carl Cohen & Martin Benjamin, "Alcoholics and liver transplantation," *Journal of the American Medical Association*, 265(1991), p. 1299-1301; Arthur L. Caplan, "Ethics of casting the first stone: personal responsibility, rationing, and transplants," *Alcoholism: Clinical and Experimental Research*, 18(1994):2, p. 219-221; Arnold J. Verster, "Caring for unhealthy lifestyles," *Canadian Medical Association Journal*, 151(1994):5, p. 509; Haavi E. Morreim, "Lifestyles of the risky and infamous," *Hastings Center Report*, 25(1995):6, p. 5-12; Peter Ubel, "Transplantation in alcoholics: separating prognosis and responsibility from social biases," *Liver Transplantation and Surgery*, 3(1997):3, p. 343-346; Stephen Wilkinson, "Smokers' rights to health care: Why the 'restoration argument' is a moralising wolf in a liberal sheep's clothing," *Journal of Applied Philosophy*, 16(1999):3, p. 255-269; Tziporah Kasachkoff, "Drug addiction and responsibility for the health care of drug addicts," *Substance Use & Misuse*, 39(2004):3, p. 489-509.

that contributes to all persons' receiving a fair chance in life. Because of this, it would be unfair to cut off fair equality of opportunity in the future because of past behavior. Although it sounds paradoxical, holding people responsible for their ends means that in assuming the presence of fair institutions, we are acting as if they can exercise their underlying moral power to *form* but also to *revise* their conceptions of the good and valuable."[52]

4. CONCLUSION

If the critical observations and the arguments presented in this study are correct, the idea of the application of the principle of responsibility for illness in the allocation of health care is unacceptable. The use of this principle is not acceptable, either, in what concerns the allocation of scarce medical services or in the situation when none of the medical criteria (urgency, need, and prognosis) can help a doctor to establish which patient must have priority in attending to his medical needs. Not only are the usual arguments for the application of this principle unsustainable, but also a few other extremely powerful reasons go against this idea. If these latter reasons are indeed valid, then the idea of the application of the principle of responsibility for illness in the allocation of health care should be rejected even by those who still believe, despite the critical observations presented here, that at least some of the arguments in favor of it are sound (e.g. the argument that the principle of responsibility is a legitimate demand of distributive justice).

However, while rejecting this idea, I have not rejected the one that, as the adepts of the principle of responsibility for illness say, it is correct to give low priority in the allocation of scarce medical services to

52 Yvonne Denier, "On personal responsibility and the human right to healthcare," *Cambridge Quarterly of Healthcare Ethics*, 14(2005), p. 232 (the author's emphasis).

persons with health-threatening lifestyles (e.g. alcoholics or smokers). The reason is that we can endorse such an idea with an argument other than that these patients (or some of them) are personally responsible for their diseases. It refers to the fact that the chances these patients have to benefit from the allocation of scarce medical services are much slimmer than in the case of the people with healthy lifestyles.[53] However, I am not qualified to analyze the validity of this argument. I will not finish, though, before I make it clear that even this argument was rejected by the authors who are in the position to do so.[54]

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53 C. E. Atterbury, "The alcoholic in the lifeboat: Should drinkers be candidates for liver transplantation?," *Journal of Clinical Gastroenterology*, 8(1986):1, p. 1-4; M. J. Underwood & J. S. Bailey, "Should smokers be offered coronary bypass surgery?," *British Medical Journal*, 306(1993), p. 1047-1048.

54 David A. Van Thiel et al., "Liver transplantation for alcoholic liver disease: A consideration of reasons for and against," *Alcoholism: Clinical and Experimental Research*, 13(1989):2, p. 181-184; Thomas Beresford, "Alcoholics and liver transplantation. Facts, biases, and the future," *Addiction*, 89(1994), p. 1043-1048; F. Kee et al., "Expanding access to coronary artery bypass surgery: who stands to gain?," *British Heart Journal*, 73(1995), p. 129-133; Robert G. Batey, "The case for liver transplantation in end-stage alcoholic liver disease," *Drug & Alcohol Review*, 15(1996):2, p. 183-188; G. P. Pageaux et al., "Alcoholic cirrhosis is a good indication for liver transplantation, even for cases of recidivism," *Gut,* 45(1999), p. 421-426; T. Cowling et al., "Comparing quality of life following liver transplantation for Laennec's versus non-Laennec's patients," *Clinical Transplantation*, 14(2000), p. 115–120; M. R. Roberts et al., "Survival after liver transplantation in the United States: a disease-specific analysis of the UNOS database," *Liver Transplantation*, 10(2004):7, p. 886–897.