Responsibility and Health

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Autonomy is good for you. A strong sense of competent self-control and effective choice-making promotes both physical and psychological well-being. Loss of autonomous control—and a sense of helplessness—causes depression, increased sensitivity to pain, greater vulnerability to disease, and death. Well established by a wide range of psychological and physiological studies, the positive effects of patient autonomy (and the harms of autonomy deprivation) are well known to competent physicians, nurses, and therapists. Conscientious caregivers are thus moving beyond grudging acceptance of informed consent toward clinical respect for patient autonomy.

But as vitally important as autonomy is for both physical and psychological health, promoting autonomy carries a serious risk: the danger that along with increased autonomy will come increased emphasis on the just-deserts (or "moral") responsibility that supports blame and punishment. Autonomy is salubrious, but just-deserts responsibility—the responsibility that justifies awarding differential treatment, including special benefits or detriments—is hazardous to your health. Fortunately, autonomy does not carry just-deserts responsibility in its wake, and the therapeutic benefits of autonomy need not be weighted down by the baleful effects of just deserts.

Many regard the close link between autonomy and just-deserts responsibility as so obvious that it requires neither comment nor argument. Thus the noted psychiatrist and bioethicist Willard Gaylin wrote (and the entire paragraph is included in the quote): "Freedom demands responsibility; autonomy demands culpability."[1] The same assumption was more recently voiced by John Hardwig: "But with autonomy comes responsibility. Indeed, the effects of our choices on the lives of others is the very cradle of moral responsibility."[2] And Walter Glannon has confidently asserted: "Autonomy and responsibility are mutually entailing notions."[3] Thus by both common wisdom and philosophical principle autonomy is inseparably joined to moral (just-deserts) responsibility. If patient autonomy flourishes, then just-deserts responsibility must increase along with it.

Linking autonomy and just-deserts responsibility has profound implications. The patient is encouraged to exercise greater autonomy in considering and choosing; but if she makes the wrong choices, she must suffer the consequences. If she chooses a less than optimum treatment plan, she should grit her teeth and accept a less than optimum outcome, and not expect the medical community—or her insurer or health maintenance organization or government—to ameliorate the bad effects of her autonomous choices. Clear examples of this view are Leon Kass' recommendation that any national health insurance plan should "build both positive and negative inducements into the insurance plan,

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by measures such as refusing or reducing benefits for chronic respiratory disease care to persons who continue to smoke";[4] Walter Glannon's insistence[5] that many alcoholics bear responsibility for their liver disease and thus deserve to forfeit their chance for scarce liver transplants; and the claim by Alvin Moss and Mark Siegler that "alcoholics are responsible for undertaking a program for recovery that will keep their disease of alcoholism in remission",[6] and thus alcoholics who fail to control their alcoholism and its effects justly deserve lower ranking in the competition for scarce transplant organs. So make your own choice to delay having a mammogram; but don't request expensive treatment of the more advanced cancer that could have been detected earlier and treated cheaper through timely testing. Smoke and drink, if that's your choice; but you must live—or die—with the consequences. Thus autonomy comes at a price: the price of bearing blame for one's bad health and suffering just deserts in the form of substandard or refused treatment.

When autonomy is bound to just-deserts responsibility, then it seems obvious that patients who "bring illness on themselves" by their autonomous choices are less deserving of optimum treatment. That may appeal to rugged individualists who claim credit for their wise decisions and demand retribution for those who fall short. But on closer scrutiny the supposed linkage of autonomy with just-deserts responsibility plainly won't work, and is particularly odious when applied to medical caregiving.

The false assumption that autonomy requires just-deserts responsibility is rooted in a common confusion between types of responsibility. Just as there are varieties of fat—monounsaturated is salutary, whereas saturated fat is dangerous—so also there are varieties of responsibility: first (what we might call) the *take-charge* responsibility that patients can and should take for their own healthcare, a responsibility that contributes to a stronger sense of competent control and better health behavior and positive psychological and physiological effects; and second, the *just-deserts* variety of responsibility that causes physical, psychological, and moral problems. Although it is practically useful, psychologically beneficial, and therapeutically sound for persons to "take responsibility for" their own lives and healthcare decisions, such autonomous responsibility taking is not grounds for just-deserts responsibility.[7] The autonomous person takes responsibility and makes her own decisions, but the responsibility she takes is not just-deserts responsibility: She cannot just *take* that.[8]

There is an important responsibility one can take. I can take responsibility for preparing the field for tomorrow's match. I am committed to making sure the grass is cut and the lines are clearly marked, and that is my responsibility. But although I certainly have *take-charge* responsibility for the field it is something quite different to suggest that I am *just-deserts* responsible, that I justly deserve praise or blame for executing that task well or ill. Suppose game day arrives and the field is in terrible shape. The grass is high and no lines are marked. "I'm sorry," I say, "It's all my fault; having the field ready was my responsibility." Someone might reasonably reply: "Nonsense. Of course it was your responsibility, but you're not to blame; we've had constant heavy rain for two weeks." Or suppose the field is splendid, and I claim credit for its splendor. The reply might be: "Nonsense; your assistant did all the work." It will not help my case if I reply: "So what? The field was still my responsibility." It won't help, because it is obvious that I can have take-charge responsibility for

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preparing the field while having no just-deserts responsibility for the outcome. So when I *take* responsibility, I am not taking *moral* responsibility. Even if I am willing to accept blame for the sorry state of the field (or eager to claim praise for the splendid field condition) after having *taken* responsibility, it will not follow that I justly deserve blame or praise.

Responsibility for a playing field is not profoundly important; responsibility for one's own life and healthcare is. Deciding how to live, what values to champion, what career to pursue, what treatments to undergo, how to die: it is vitally important that we have take-charge responsibility for our own lives, in sickness as in health. But take-charge responsibility is not just-deserts responsibility, and insisting on the value of take-charge responsibility does not imply that we must also embrace just-deserts responsibility.

Autonomy and take-charge responsibility (in the sense of exercising effective self-confident control and making real choices) are valuable contributors to both physical and psychological well-being.[9] But we can have take-charge responsibility without any taint of just-deserts responsibility. So long as I meet minimal competency requirements, I can legitimately claim take-charge responsibility for myself. We come from very different backgrounds, but the fact that I did not draw your lucky number in the "natural lottery" of fortunate genes and early environment does not undercut my claim to full take-charge responsibility. Such factors do, however, profoundly influence how effectively I exercise my take-charge responsibility, and that brings us to the key point. Because such early influences shape my skill, diligence, and wisdom in exercising my take-charge responsibility, they undermine claims of just-deserts responsibility while leaving take-charge responsibility intact. Thus take-charge responsibility can wax while just-deserts responsibility wanes, marking them as distinctly different responsibility types.

It is a moral good and a medical benefit when patients have as much control as possible over their own treatments and environments, when they have information that enables them to consider options and make their own decisions, and when they have a sense of being confident controllers—rather than passive recipients—of their treatment.[10] Thus competent patients should exercise autonomy and have take-charge responsibility. But it is important to remember that this genuinely valuable take-charge responsibility is not just-deserts responsibility. The patient has—and should have—take-charge responsibility for her own life, including her use of alcohol. Indeed, the stronger her sense of internal control and self-efficacy (the key ingredients of autonomous behavior and take-charge responsibility) the more likely it is that she can successfully avoid or control alcohol addiction. But it does not follow that she also has just-deserts responsibility for her use of alcohol and for her failure (or success) in controlling her alcoholism, and that she therefore justly deserves to be placed lower on the list for a liver transplant.

The distinction between taking responsibility and having just-deserts responsibility is particularly important when dealing with alcoholism and the vexed question of whether alcoholics justly deserve exclusion from scarce organ transplants. It is important in this context because, first, persons who suffer alcohol-related end-stage liver disease (ARESLD) are often judged to be less deserving of transplants, and second, because the undisputed importance of the individual "taking responsibility" for combating her own alcoholism opens the door to rampant confusion concerning just-deserts responsibility. That

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confusion can afflict even the most careful and astute bioethicists, as evidenced by this passage from Alvin H. Moss and Mark Siegler:

> In view of the quantity of alcohol consumed, the years, even decades, required to develop ARESLD, and the availability of effective alcohol treatment, attributing personal responsibility for ARESLD to the patient seems all the more justified. We believe, therefore, than even though alcoholism is a chronic disease, alcoholics should be held responsible for seeking and obtaining treatment that could prevent the development of late-stage complications such as ARESLD. Our view is consistent with that of Alcoholics Anonymous: alcoholics are responsible for undertaking a program for recovery that will keep their disease of alcoholism in remission.[11]

In this passage, Moss and Siegler have confused the two very different senses of "responsibility," sliding from premises concerning take-charge responsibility to a conclusion based on just-deserts responsibility. We do indeed want alcoholics (and cancer patients and those with high blood pressure) to take responsibility for their illness and its treatment. The alcoholic (like the cancer victim and the hypertensive) who effectively "takes responsibility" for her illness has a much better chance of successfully controlling it: She seeks out promising treatment programs, exercises greater fortitude in sticking with difficult treatment regimens, her active involvement in her own treatment increases her confidence and sense of control, and she anticipates and effectively copes with problems. If she fails to take and exercise responsibility, then her recovery prospects are severely threatened, whether she is afflicted by alcoholism or heart disease or skin cancer. In that sense, it is vitally important that alcoholics "are responsible for undertaking a program for recovery." But it is something very different to suppose that alcoholics should be "held responsible" and justly blamed and awarded their "just deserts" (of reduced opportunities for transplants) for their failures to effectively take responsibility.

Take-charge responsibility should be supported—and claimed—whenever someone is capable of exercising such responsibility. Even those who are not very good at take-charge responsibility should have every opportunity to exercise it: By practicing take-charge responsibility, one may get better at it. Of course it is essential that those who are encouraged to take responsibility are supported in their efforts and have adequate resources for exercise of take-charge responsibility. It does not benefit a patient's confidence, responsibility, or health to be pressured into "taking responsibility" when the patient has not received sufficient information and support to develop a strong sense of self-efficacy:[12] a sense that she can effectively exercise control over her treatment choices. But with the right support, patients should be encouraged to "take responsibility" whenever possible: It is good for both their mental and physical health. And that is all the justification required for take-charge responsibility. Thus *taking* responsibility should be supported and encouraged, but obviously it does not follow that patients should be blamed (held *morally* responsible) for either their failure to take responsibility or their ineptitude at exercising the responsibility they take.

Claims and ascriptions of just-deserts responsibility require a foundation that is very different from the psychological and therapeutic considerations that establish the desirability of take-charge responsibility. If it is *just* that this

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individual be treated in a special manner—whether specially beneficial or specially detrimental—then such treatment must be fair. We do not give those with brown eyes special benefits while imposing deprivations on those with blue eyes. That would be unfair, because whether you have brown or blue eyes is simply a matter of luck and not something on which we can base just deserts. But what about the individual who failed to take responsibility for treating his disease of alcoholism? Does he justly deserve inferior treatment to the person who is genetically vulnerable to disease? Or consider the stressed executive who skips exercise and lives on high-fat fast food. Her coronary problems are the result of her own choices and habits; does she justly deserve to be placed lower on the transplant list than the individual with a congenital heart disorder?

It might initially seem so, but only if we avoid scrutinizing the cases in greater depth. Consider Albert, who chooses a junk food diet—and junk food lifestyle—over healthier alternatives, and compare him to the "more deserving" Mohammed, who exercises and avoids fatty foods. Of course both "choose" to live the way they do: No one held a gun to Albert's head and forced him to wolf down a cheeseburger and fries. Some insist that we should look no further: Albert and Mohammed made their own choices, they were not coerced, and so they have full just-deserts responsibility and no more questions should be asked. Alice chooses to stick with an alcohol treatment program, whereas Barbara chooses to drop out, and so both are justly deserving of the beneficial and detrimental consequences of their own decisions. But it is only myopic shallowness that makes this justification of just-deserts seem at all plausible. For when we probe deeper into such choices we discover a causal history that shatters any illusion of fair "just deserts."

Albert is intemperate, irresolute, unreflective—and he makes bad decisions and develops bad habits. True enough, but why? When we look deeper we find that Albert became irresolute because he lacked early experiences that shaped fortitude. Perhaps he was given everything whether he made an effort or not, as overindulgent parents rewarded him for slipshod effort; or possibly he was given impossibly difficult tasks, and he learned that effort is useless.

Albert also makes rash, unreflective decisions, whereas Mohammed chooses judiciously; but deeper psychological research has revealed a factor called "need for cognition": It is a stable characteristic, distinct from cognitive ability, and varies from individual to individual.[13] The need for cognition motivates both engagement in and enjoyment of effortful cognitive activity.[14] Some people are "cognitive misers." Confronted with situations in which most people would think long and hard, their reflection is meager. They have little intrinsic motivation to engage in careful cognition, do not enjoy it, and are generally less practiced and less effective. In contrast are the "chronic cognizers," who enjoy thinking, require little external stimulus to engage in cognitive efforts, and think at more length and greater depth.

Thus Mohammed, who is an eager cognizer, continues to deliberate and inquire, whereas Albert—a cognitive miser—ceases deliberation and acts. In both cases the choice is their own. But why is Mohammed a more profound and willing cognizer and Albert a cognitive miser? Possibly cognitive motivation is related to genetics; more likely, it is the result of early influences:

> Children who learn, through observation and experience, that they can cope with their problems through reason and verbal influence rather

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> than through physical force or flight should tend to develop higher levels of need for cognition because of the demonstrated import of good problem-solving skills in charting a course through the hazards of life.[15]

Albert comes from an environment in which judicious reflection was discouraged. If he contemplated whether to have cake or fruit for dessert, his greedy siblings snatched both and Albert got neither. If he reflected on whether to choose trumpet or trombone, his impatient father stormed out of the music store and Albert was left out of the band. When he reflected on whether to throw the ball to second base or try to get the runner at home, his little league coach berated him: "Just throw the damned ball!"

So Albert, who has been shaped as a cognitive miser, now makes bad, ill-considered, impulsive choices, and they are his own choices. But does he deserve blame for being such a sloppy and impetuous thinker? Albert's cognitive superficiality is the result of a formative situation that did not reward early careful cognizing; or perhaps rewarded it in the wrong manner, through rewards that led him to regard careful cognizing as under the oppressive control of others. But surely Albert's unfortunate environmental shaping—obviously not of his own making—fails as grounds for punitive just deserts, just as Mohammed's more favorable environment cannot support justly deserved rewards. Mohammed will be better at taking responsibility, and thus will be more effective at treating his alcoholism or hypertension. Albert, the intemperate cognitive miser, is lousy at taking responsibility, and does not seek out (or does not stick with) effective treatment. But neither competence nor ineptitude at taking responsibility can justify differences in just deserts.

Determining why Mohammed becomes a careful cognizer and Albert a cognitive miser may be complex and controversial, but the present point is simple. If we reject the view that such cognizing is a matter of inexplicable miraculous choice, then careful examination of their cognitive histories soon leads to formative factors that undermine claims of just deserts. Albert and Mohammed make their own choices concerning how much to deliberate,[16] but their just-deserts responsibility for those choices is another question altogether.

Of course some people have bad childhoods and overcome them. But why does one person have the fortitude to triumph over bad conditions and the other does not? When we push a step deeper, it is obvious that the different results are due to different environmental factors, and such positive or negative environmental shaping is a matter of good or bad fortune and not something for which it is *fair* to give special treatment, not something that can support claims of just-deserts responsibility. Or possibly fortitude is primarily shaped by genetics, rather than early environment, but that is even less plausible as grounds for just deserts.

Or perhaps neither environment nor genetics shaped Albert and Mohammed: Their choices were miraculously independent of their genetic and environmental and causal histories. Or as Roderick Chisholm described it:

> If we are responsible . . . then we have a prerogative which some would attribute only to God: each of us, when we really act, is a prime mover unmoved. In doing what we do, we cause certain events to happen, and nothing and no one, except we ourselves, causes us to cause those events to happen.[17]

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This moves from the frying pan of shallowness to the fire of mystery. Superficiality is poor company for medicine, but mysteries are worse. If there is an outbreak of AIDS, we do not stop with shallow explanations: They died because their immune systems shut down. Medical science requires digging deeper: *Why* did their immune systems shut down? Competent researchers will not be satisfied until they have traced the causes deep into their roots, and those roots are not inexplicable mysteries. Just-deserts responsibility requires mysteries or myopia; either way, it is fundamentally incompatible with medical science.

It is desirable for people to "take responsibility" for their own health. Some do it well and others ill, but the more practice they have, the better they are likely to become. And those who can effectively and confidently enjoy a sense of control over the major forces and events in their lives (including their own healthcare) are generally healthier, both physically and psychologically. But when we shift from take-charge responsibility to *just-deserts* responsibility, the benefits of responsibility become harms. One of the main problems stemming from just-deserts responsibility is the veil it drops on important social and environmental causal factors. To maintain the illusion of just deserts we must avoid examining the environmental and social factors that shape us, for better or worse, in ways we neither choose nor control. And just-deserts responsibility not only encourages the neglect of environmental factors, it rationalizes that neglect. If we are just-deserts responsible for our behavior, then we must be capable of rising above such environmental factors through our choices. Such a wondrous capacity for transcending environmental influences makes the choice environment irrelevant. Laura lives in a society that treats women as incapable of intelligent choice, her family pushes her into the role of passive drudge, her religion preaches her inferiority, her economic situation squeezes her severely, her job requires mindless acquiescence, and her political system offers no real choices. But none of that matters: She is just-deserts responsible for her own life because she has the power to transcend all those influences through her own choices. Thus belief in just deserts blocks effective understanding of the causal factors that enhance or undercut valuable take-charge responsibility.

In addition to blocking our understanding of how effective take-charge responsibility is nurtured or destroyed, just-deserts responsibility makes another contribution to the failure of genuine take-charge responsibility: When people attempt to *take* responsibility for—attempt to take control over—influences they are in fact helpless to control, then the result is learned helplessness and the demise of take-charge responsibility. Individuals are expected to control their stress, make their own choices and run their own healthy lifestyles. They are considered just-deserts responsible for doing so; thus any barriers to their effective action must be concealed, and when those hidden barriers cause them to fail, then their ineffectual behavior engenders helplessness and lost confidence, not a strong sense of control. In short, it is desirable that people have confident control and exercise take-charge responsibility for themselves and their medical care. But they are not just-deserts responsible for failing or succeeding at that critically important goal, because their success (or failure) is the result of their abilities to exert control and make decisions, and those abilities are a function of the environment in which they were shaped and not of their own works. That undercuts just-deserts responsibility, but it enhances take-charge responsibility by focusing attention on the conditions that inhibit

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or strengthen the effective exercise of take-charge responsibility. From the opposite perspective of just-deserts responsibility, if an individual fails to exercise control and effective planning and intelligent choice making, then "it was up to her to succeed or fail, it's her own credit or fault," and no notice can be taken of the cultural conditions that stultify choice making and foster helplessness and passivity.[18]

Just-deserts responsibility obscures crucial social environmental factors, factors that shape effective autonomous self-control in some and undercut confident take-charge responsibility in others. Thus, clinging to just-deserts responsibility undermines the effective enhancement of healthy take-charge responsibility. But supporters of just-deserts responsibility dispute that claim. Some champions of just-deserts responsibility suggest that we should continue to hold people just-deserts responsible because it shapes better behavior. Perhaps we can't show that holding people just-deserts responsible for smoking is morally justified in terms of fairness and justice, but holding people just-deserts responsible—whether they "really deserve it" or not—will cause them to smoke less. As Robert Morison argued:

> Society does in fact hold most individuals responsible for their acts. . . . The knowledge that one will be held responsible should be one of the very important variables that are summoned into consciousness before the individual makes a choice. The ultimate decision may still be regarded as determined, with the sense of responsibility being one of the determinants.[19]

But in fact, not only do just deserts fail in terms of fairness and justice, they also gutter when it comes to practical usefulness. As already noted, just-deserts responsibility befogs our view of the critical social and environmental factors that shape both autonomy and heteronomy. Furthermore, assigning rewards and punishments according to "just deserts" often entrenches undesirable behavior and atrophies the autonomous behavior we wish to promote. Consider two students, Katrina and Hanna. Katrina is brilliant: She consistently makes the highest grades in the class, reaps all the awards, and receives heaps of praise—and she accomplishes this effortlessly. In fact, she works at far below her true capacity—she studies very little and makes desultory efforts—and is still richly rewarded. Meanwhile Hanna devotes enormous time and energy to her studies, but the results are consistently mediocre. She receives little praise and few rewards, and eventually her heroic efforts are extinguished from lack of reinforcement. Katrina, whose trophy case is bulging, is rewarded for half-hearted efforts, and her lethargy becomes deeply entrenched. So just deserts is a grossly inefficient—often counterproductive—pattern for shaping desirable behavior.

That problem cannot be solved by limiting just deserts to effort-making instead of final accomplishment. Akim and Patrick are rehab patients at the same center. Akim is energetic, self-controlled, highly motivated, confidently competent; Patrick, by contrast, tends toward helplessness, and he lacks a strong sense of self-control and self-efficacy. Akim, on his most lethargic days, is likely to exert more effort than does Patrick at his most ambitious. But in order to shape greater self-confidence and fortitude in Patrick, it will be essential to positively reinforce (reward) his faltering attempts to exercise even rudimentary control. Rewarding Akim's effort-making—his stronger effort,

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which is more "justly deserving" of reward than Patrick's—may actually weaken Akim's resolve, as Akim begins to sense that his effort-making is under the surveillance and control of others.[20] So even in areas of effort-making, assigning reinforcements according to "just deserts" is not an effective means of shaping strong, resolute, self-confident behavior. Just deserts are neither just nor expedient.

Rather than just deserts shaping strong self-confident fortitude, there is a significant danger that its effects may be precisely the opposite, not just a considerably less than optimum means of fostering positive take-charge behavior, but in fact a force that promotes lethargy and helplessness. Psychologists have found that in difficult situations—and patients are not uncommonly in difficult situations—where there is a possibility of achieving success but also a strong possibility of failure, people often engage in "self-handicapping": they act in ways that increase their likelihood of failure, but that also allow them to reduce their responsibility for the failure.[21] (For example, "I never really gave myself a chance to succeed at that job; I missed too many days at work.") Success would be great, but trying and failing is so terrible—there is no one to blame but yourself—that it is safer to self-handicap for failure and have excuses that deflect blame. Thus rather than blame and just deserts being an effective motivator, they often provoke the self-handicapping that contributes to failure.

There is a final reason why "holding people (just-deserts) responsible" and giving them (or allowing them to suffer) their "just deserts" does not shape good behavior. Typically the bad consequences that are "justly deserved" by the smoker or overeater or heavy drinker occur much too late to change the damaging behavior. Letting the smoker die a "justly deserved" painful death from untreated cancer is unlikely to shape the unfortunate smoker toward healthier habits.

Of course the chronic smoker whose cancer has metastasized may be a poor candidate for an organ transplant on grounds independent of just deserts. If life-saving organs are scarce and the patient's disease is such that an organ transplant will be of very limited help in extending life, then we may legitimately transplant the scarce organ to a patient who can better benefit, a more promising, but not more deserving, candidate. Peter Ubel, Robert Arnold, and Arthur Caplan[22] have noted that retransplant patients have a significantly lower survival rate than do comparably ill primary transplant patients, and they effectively argue that such a difference is just and reasonable grounds for giving preference to primary transplants. Such an ordering may be justified on the basis of fairness and justice, but it has nothing to do with just deserts: The unlucky transplant recipient who suffers acute allograft rejection is obviously not less deserving than is the candidate for a primary transplant. Whatever the moral legitimacy of such rankings, they should not be used as a ploy for slipping in blame and just deserts. In discussing their survey of public attitudes concerning transplant allocation, Peter Ubel, Jonathan Baron, and David Asch noted that their survey results indicate that some people (who do not want to directly include social desirability judgments in their transplant allocation criteria) will look for other reasons to deny transplants to those (drug addicts, alcoholics) they deem socially undesirable. As Ubel, Baron, and Asch warned: "For those (like us) who think that social desirability judgments do not deserve a role in health care allocation, this study reminds us to look beyond arguments based on prognosis or responsibility for illness to see if people making those

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arguments are also making social desirability judgments."[23] Before placing smokers or drinkers lower on the waiting list, one must ask: If new data showed that recovered smokers and alcoholics enjoy a better survival rate, would you be willing to place them at the top of the list? Rationing scarce medical resources according to just deserts is not made legitimate by subterfuge.

Even if just-deserts responsibility were justified in principle, for the reasons noted above it would be counterproductive to employ blame and just deserts in the medical caregiving context. But there is yet another reason for rejecting just-deserts responsibility in medicine. As medical professionals have long emphasized—and the law has long agreed—confidentiality is essential for a good therapy environment. I must be able to confide in my medical caregiver, confide in ways that may go beyond the confidences I share with close friends. If my physician is judging my moral worth and whether I justly deserve special care or only minimal care (or perhaps no care), then I must be cautious with my confidences, and discretion will be more prudent than disclosure. A confident, open, and trusting relationship between caregivers and patients requires that caregivers be advocates, teammates, nurturers, supporters, confidantes—not judges.

In sum, it is difficult to support just-deserts responsibility anywhere, but even traditional believers in just deserts and righteous retribution should have doubts about their application to medical care. After all, many of the "autonomous decisions" that have the greatest impact on health are made before reaching the "age of accountability." Tobacco companies target young people for nicotine addiction long before the victims reach adulthood. A barrage of slick advertising for soda and candy and sugar-loaded cereals is aimed at children, and special "children's meals"—high-fat burger and fries, high-sugar soda, and choke-free toys for toddlers—are designed to shape children's dietary preferences at tender ages. And finally, it may at first glance seem fair to blame the heavy-smoking, low-exercising, high-cholesterol-consuming heart patient—"It's his own fault that he has heart problems; he shouldn't be eligible for surgery, much less a transplant"—until we note that others live precisely the same lifestyle but survive to a ripe old age in perfect health. They all act the same, but one is fortunate to have a genetic constitution that resists heart disease, whereas the other does not; so how can it be "fair and just" that the heart attack victim suffers and the others escape such problems? More to the point, how could it be fair to deny the unlucky ones care?

An impediment to effective caregiving and a hazard to health, just-deserts responsibility promotes shallowness, threatens the relation of trust between patient and caregiver, and undermines patients' efforts to be active, competent, confident participants in their own treatment and rehabilitation. Just-deserts responsibility is not take-charge responsibility; to the contrary, just-deserts responsibility is an obstacle to the exercise of effective take-charge responsibility. Nurturing take-charge responsibility requires understanding and promoting the social and environmental conditions that enhance effective decisionmaking and personal control and confident choosing; just-deserts responsibility obscures those crucial environmental factors. In contrast to injurious just-deserts responsibility, take-charge responsibility—including confident control of genuine choices—is of great benefit to patients and nonpatients, nurses and doctors, Ashanti traders and New York bus drivers, foraging chimpanzees and hospitalized humans. Good medicine must nurture patient autonomy and take-

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charge responsibility (and promote the understanding of the key causal factors that enhance and inhibit take-charge responsibility) just as it promotes any other proven contributor to good health, while combating the plague of just-deserts responsibility.

Notes

1. Gaylin W. *The Killing of Bonnie Garland*. Hammondsworth, England: Penguin Books; 1982 at p. 338.
2. Hardwig J. SUPPORT and the invisible family. *Hastings Center Report* 1995;25:S23–5 at S24.
3. Glannon W. Responsibility, alcoholism and liver transplantation. *Journal of Medicine and Philosophy* 1998;23:31–49 at p. 45.
4. Kass L. Regarding the end of medicine and the pursuit of health. *The Public Interest* 1975;40:11–42 at p. 31.
5. See note 3, Glannon 1998.
6. Moss A, Siegler M. Should alcoholics compete equally for liver transplantation? *JAMA* 1991;265:1296–8 at p. 1297.
7. Although philosophers typically confuse "taking" responsibility with "just-deserts" responsibility, at least some medical researchers have recognized the importance of keeping them distinct. For example, Gonzalez, Goeppinger, and Lorig noted:

   > *Accepting responsibility* is a coping mechanism that applies more to business than illness. Although some illnesses may be due in part to one's past actions, trying to get someone to accept responsibility is probably counterproductive and only adds to blaming the victim. On the other hand, taking personal responsibility is extremely important when trying to encourage preventive practices or self-management of a chronic disease.

   Gonzalez VM, Goeppinger J, Lorig K. Four psychosocial theories and their application to patient education and clinical practice. *Arthritis Care and Research* 1990;3:132–43 at p. 137.
8. See note 3, Glannon 1998:45. Glannon is a clear example of sliding from autonomous choices for which one *takes* responsibility to claims concerning the establishment of *just-deserts* responsibility.
9. Waller BN. Patient autonomy naturalized. *Perspectives in Biology and Medicine* 2001;44:584–93.
10. Waller BN. The psychological structure of patient autonomy. *Cambridge Quarterly of Healthcare Ethics* 2002;11:257–65.
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