



Responsibility in Medical Sociology: A Second, Reflexive Look

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Abstract

Personal responsibility has emerged as an important element in many countries' public health planning, and has attracted substantial debate in public health discourse. Contemporary medical sociology typically resists such “responsibilization” as victim-blaming, by privileged elites, that obscures important structural factors and inequities. This paper, based primarily on a broad review of how contemporary Anglophone medical sociology literatures treat responsibility and blame, points out advantages of taking responsibility seriously, particularly from the *individual's* perspective. These advantages include: empowerment; responsibility-as-coping-mechanism; moral dignity; and the pragmatic logic of doing for oneself, rather than passively awaiting societal reforms. We also offer possible reasons why sociologists and their subjects view these issues so differently, and suggest some areas for future research.

Keywords Responsibility · Neoliberalism · Medical sociology · Blaming the victim · Public health · Ideology

Introduction

Perhaps it's time for medical sociology to reconsider personal responsibility.

Over the past several decades, medical sociology's critique of the “responsibilist” emphasis on holding individuals responsible for their health has contributed much. Yet, this paper focuses on limitations of our current approach to the question. The paper is based primarily on a review of how Anglophone medical sociology literatures (broadly defined) treat blame and responsibility.

Tensions between structure and agency (or individual versus system/societal [or “root causes”] responsibility) as discrete explanations for poverty (e.g., Greenbaum, 2015; Haskins, 2009; Hennigan & Purser, 2021; Horowitz et al., 2018; Lewis, 1966;

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Patterson & Fosse, 2015; Ryan, [1971]1976; Treas, 2010; Wacquant, 2009, 2012; Wilson, 1987, 2009; Wright, 1993) and sickness (e.g., Baum & Fisher, 2014; Berg et al., 2021; Blaxter, 1995, 1997; Brown & Baker, 2012; Crawford, 1979; Knowles, 1977; Petersen & Lupton, [1996]2000; Saguy & Riley, 2005; Schirmer & Michailakis, 2011) have long characterized academic, policy, and ideological discourses (Trnka & Trundle, 2017).

Many governments, via policies often associated with fiscal belt-tightening and neoliberalist rationales, and explained by Foucault's (1991) concept of governmentality, now expect individuals to assume substantial responsibility for preventing and managing disease (Lupton, 1999; Crawshaw, 2012; Ayo, 2012; Pereira & Scott, 2017). Indeed, "neoliberalism is increasingly entrenched as a *doxa*, a self-evident and unquestionable truth about the social world, thereby gaining dominance in public and policy discourse" (Berg et al., 2021, p. 102). Accordingly, "[p]ersonal responsibility for health is widely considered the sine qua non of individual autonomy and good citizenship" (Crawford, 2006, p. 402). This approach has Western roots centuries deep (Baum & Fisher, 2014; Beck & Beck-Gernsheim, 2002; Crawford, 2006; Foucault, 1991). More recently, official and public discourses have held citizens personally responsible to fight COVID-19 by vaccinating, masking, and social distancing (e.g., Rathke, 2021).

Contemporary social scientists, including many cited above, generally consider such political, societal, and cultural expectations of individuals to be unfair and harmful. Martin (2016) has defined the idea that "'victims' are sometimes blame-worthy" as a social science "taboo" (p. 118). Often, their concerns involve the need to focus on structural inequity and other fundamental causes and contexts of illness, and the risks of victim-blaming from focusing on individuals' responsibilities. We discuss these and other factors below.

Yet this story has another side. This paper's primary goal is to reconsider medical sociology's critique of responsibility discourses—to critique the critique. Asking, "is there a baby in this bathwater?," it highlights some often-overlooked advantages of the responsibility discourse. The secondary goal is to begin to explore why we medical sociologists and those we study often view these questions so differently.

We first summarize the debates on individual responsibility, including sociologists' critique of the neoliberal "responsibilist" model¹. Next, we suggest some limitations of this critique, and highlight under-appreciated advantages of "responsibilist" discourse. We then try to explain why social scientists and those we study view responsibility for one's health so differently, while reflexively questioning the former's stance. We conclude by proposing areas for future research.

¹ A note on terminology. Bell and Green (2016) warned of conceptual slippage surrounding the term "neoliberal" and its application to debates about responsibility. Here, however, we will traverse between numerous permutations of terms from the literature, such as "neoliberalist", "responsibilist", "responsibilization", and "individualization", to refer to the discourse emphasizing personal (rather than governmental, systemic, or societal) responsibility for health. Similarly, we often use "sociology" and "social science" interchangeably.

Responsibility and Blame

According to Parsons' (1951, p. 440) classic sick-role model, the ill are exempt from blame for their condition (and are expected to do little but comply with doctor's orders). Yet patients *are* judged, particularly the poor (Roth, 1972; Mizrahi, 1986; Timmermans, 1998). Blame has been a frequent element in socio-cultural discourse (Leichter, 2003), especially around conditions such as AIDS (Nelkin & Gilman, 1988; Adam, 2017), lung cancer (Chapple et al., 2004), and obesity (Atanasova & Koteyko, 2017; Kirk et al., 2014; Monaghan, 2014, 2017). Duffin (2004) described the influence of blame and responsibility discourses in response to rising HIV infection. Personal responsibility has been the "bedrock message" of AIDS service organizations (Adam, 2005, p. 337). Pereira and Scott (2017) and Fraser (2004) described how public health constructed illicit drug users as responsible, both for themselves and others.

Neoliberalist discourse, comprised of political, economic, and philosophical strands, and the policies these inform, rose to prominence parallel to a separate, biomedical phenomenon. This was the Western "epidemiological transition" through which (due to improved hygiene and standard of living, combined with scientific advances) infectious, pandemic diseases were eclipsed in significance by chronic, degenerative diseases, often related to human behaviors (McKeown, 2009). This wider shift helped catalyze influential new research linking disease with personal practices (e.g., Berkman & Breslow, 1983). These factors drew more societal attention to the role of individual responsibility for disease. In his article, "The Responsibility of the Individual," Knowles (1977) famously argued that Americans sickened themselves through irresponsible behavior. The popularity of the "lifestyle" theory of disease causation (Tesh, 1988, pp. 40-48; Devische & Deveugele, 2010) has extended the potential of blaming to far wider population segments.

Additional factors included political changes, such as in the Reaganite US and Thatcherite UK, where economic retrenchment and philosophies of reduced government were used to justify retreats from many welfare state functions. There thus developed a new emphasis on citizens taking more active roles in preserving their own health, by modifying their behavior (Cheek, 2008; Galvin, 2002; McClean, 2005). In the US, this has been rooted partly in ideologies of individualism (Mechanic, 1993).

Describing contemporary preoccupation with healthy personal behavior, Beck and Beck-Gernsheim (2002), Galvin (2002), Daneski et al. (2010), Katz (1997), and Leichter (2003) contended that good health has become a form of secular morality, even a route to "secular salvation" (Crawford, 2006, p. 404). Summarizing decades of research, Epstein and Timmermans (2021) observed: "achievement of health and wellness has become a chief moral imperative as well as an inexhaustible source of normative judgments about how one should engage in the most basic activities of living..." (p. 243).

Business has played its own role. For example, fast-food advertising deflects responsibility for obesity onto customers' behavior (Herrick, 2009). Tobacco

companies deploy the rhetoric of free choice to locate responsibility for health damage with their clientele (Friedman et al., 2015).

Technology also contributes. Modern genetic testing generates information, and triggers decisions, that propel questions of responsibility and blame into whole new dimensions (Beck & Beck-Gernsheim, 2002; Hallowell, 1999; Mozersky, 2012; Shepherd et al., 2022). The rise of social media and “digital health” has created new channels through which to propagate and enact responsibility discourses and practices (Erikainen et al., 2019; Lupton, 2016, 2017; Rich & Miah, 2017). In parallel, scientific advances in neurology have stimulated “successful aging” discourses holding individuals personally responsible to prevent dementia by adopting a healthy lifestyle (Petersen & Schick Tanz, 2021).

Such factors have produced today’s “engaged patient,” more active in—and more responsible for—advocating for their health (Timmermans, 2020, p. 265).

Responsibility: Our Perspective...and Our Subjects’

Contemporary social scientists have generally been at least skeptical of, if not hostile to, blaming individuals (Sher, 2006, pp. vii–viii). For example, Ryan ([1971]1976), Wright (1993), and Greenbaum (2015) attacked earlier reliance on theories such as the culture of poverty for highlighting individual, rather than structural, failings. Similarly, social science health researchers such as Crawford (1979, 2006), Mechanic (1993), Blaxter (1995), Finerman & Bennett (1995), Petersen & Lupton ([1996]2000), Galvin (2002), Filc (2004, 2005), Herrick (2009), Ayo (2012), Brown & Baker (2012), Baum & Fisher (2014), Ravn et al. (2016), Hutchison & Holdsworth (2021), and Petersen & Schick Tanz (2021) criticized the responsibility discourse as blaming the victim while ignoring societal and governmental responsibility for inequities, the failure to curb corporations’ damage to the environment and marketing of unhealthy foods, etc. Bauman (2002) made a similar point about both unemployment *and* illness (p. xvi). Blaxter (1995) titled one article, “Why Do the Victims Blame Themselves?” Referring to health promotion, Wiltshire et al. (2018, p. 5) cited the “growing body of critical social science research that calls for interventions that do not predominantly frame change in terms of individual responsibility for health....” One *Critical Public Health* editorial jokingly suggested renaming the journal to, “*Critical Public Health: The Negative Impacts of Neoliberalism*” (Bell & Green, 2016, p. 239).

One problem with holding individuals responsible for their health involves scientific uncertainty: there is not always a reliable consensus about what citizens should do. Ravn et al. (2016)—echoing Tesh (1988)—noted science’s limitations in linking various behaviors and disease prevention. Nutrition science, for example, often shifting and contradictory, has long been a source of frustration and even ridicule (Angell & Kassirer, 1994; Reno, 1994). According to Taubes (2007, 2011) and Teicholz (2014), adherence to the dominant professional and governmental advice to decrease fats and increase carbohydrates has, itself, likely contributed to rising obesity rates. Petersen & Schick Tanz (2021) noted that media discourses on individual responsibility for dementia prevention often overstated

the strength of the supporting evidence, and risked producing “excessive responsibility demands and false expectations” (p. 2013), as well as stigma and ageism.

Yet criticism often focuses elsewhere. The tone of much of this literature reflects concerns that victim-blaming arises less from innocently sloppy thinking (or from legitimate, empirical analysis) than from powerful social actors’ self-serving displacement of their own responsibility for causing health problems onto the citizens who experience them. Accordingly, citizens’ seemingly odd persistence in accepting responsibility would amount to a form of false-consciousness, if not a complex psychological reaction to the discrimination they have encountered. Mizrahi (2016, pp. 46–48; [forthcoming](#), p. 8) has raised this point regarding what liberal sociologists consider the counter-intuitive political alignments of Sephardic Israelis.

The critique of the neoliberalist approach extends also to disease management. In her study of the web pages of women with breast cancer, Pitts (2004) described how these sites replicate offline, ostensibly-“empowering” societal discourses. These hold women responsible for “taking charge of their health” by preventing, detecting, and even defeating breast cancer. Lawn et al. (2011) made a similar point regarding services for the chronically ill, as did Brown (2021), for mental health services. Noting how weight-loss bloggers enlisted their readers to hold them accountable for their weight, Leggatt-Cook & Chamberlain (2012, p. 974) warned of, “self-surveillance, contributing to the stigmatisation of fat bodies.”

Couch et al.’s (2019) study of Australian media accounts of male obesity found that obese men frequently mentioned their own responsibility for causing and reversing their condition. The authors portrayed this approach as problematic, noting that these men failed to mention structural or environmental contributors. They described the men as complicit in self-surveillance by the “panopticon/synopticon” (pp. 85–87,89), and remarked that some of their behaviors suggested, “their internalisation of this consumer culture and of obesity self-stigma” (p. 87).

However, Mosack et al. (2005) had already taken the critique further. In describing how HIV+ intravenous drug users discussed HIV/AIDS, they quoted a respondent who reported that, when others asked, “‘Why me?’”, she replied: “‘Why you? Because you picked up the needle and did it or you had sex with the wrong person’” (p. 596). When they blamed the Lord, she responded, “‘[y]ou know damn well [laughs], the Lord didn’t give you HIV and He damn sure didn’t put that hypodermic needle in your arm’” (p. 596). Twice labelling this attitude “self-righteousness” (p. 596), the authors asserted that it represented the projection of shame, and resulted from internalized stigma combined with lifetime experiences of “racism, sexism, discrimination against people with lower incomes and prejudice against drug users” (p. 596). Perhaps. Certainly, confirming Blaxter’s (1997) demonstration that disadvantaged women attributed illness sooner to personal than to structural factors, the respondent’s comments ignored structural explanations such as poverty and inadequate services (e.g., El-Sadr et al., 2010; Rhodes et al., 2005).

Viewed from another angle, however, her remarks reflect what she viewed—or even experienced—as brutal realities about cause and effect. In attempting to “explain away” their respondent’s words, Mosack et al. wound up essentially denying her moral agency. As Mizrahi ([forthcoming](#)) warned, in a similar context:

we run the risk of emptying the subject of her subjectivity: the subject becomes a “victimizer” to be judged, or a “victim” in need of protection. Her subjectivity plays a fixed role in a structural meta-script, a component in a social structure dressed with an essential moral meaning. Hence, her own reading of the same structure is silenced or denied. (p. 9)

This raises some questions for Mosack, et al. and, more generally, for those medical sociologists who resist the placing of responsibility on individuals (even *by* those individuals) for their health-related practices. First: regardless of how we, ourselves, approach responsibility for HIV transmission, would we truly consider it illegitimate for *this (lower-income, HIV+) respondent* to view acquiring HIV as connected to personal decisions? Second: cannot individuals from disadvantaged backgrounds bear at least some responsibility, or hold others responsible for their actions? And—for that matter—third: would we not agree that disease prevention entails more than social justice, alone?

We revisit such questions below. Meanwhile, our review of the contemporary medical sociology literature demonstrates that individuals’ narratives often depict them as more comfortable accepting and attributing blame and responsibility than are those who study them. Indeed, stories are well-suited to individual judgments and assignments of blame and responsibility (Tilly, 2008, pp. 21–22). Thus, Blaxter’s (1995, 1997) above-referenced poor or working-class individuals sooner blamed themselves, than they did societal inequity, for their illnesses.

To be sure, individuals do not always embrace responsibility. Crawshaw (2012, pp. 204–205) documented how unemployed men stated that they lacked the resources fully to adopt the practices expected by the “responsibility” discourse. Harper & Rail’s (2012) and Dolan’s (2014) respondents also resisted attributions of blame. Nordtug (2022) found that parents often felt overwhelmed by the onerous burden of their perceived responsibility for decision-making about their children receiving the human papilloma virus (HPV) vaccine, and thought health and media professionals should share in this burden.

More common, however, are data such as those from Rier’s (2007a, b, unpublished) study of sixteen online support groups for HIV/AIDS. Across the multi-year data set, participants often quite readily accepted personal responsibility for their condition. They also conducted vigorous debates about the ethics of HIV seropositivity disclosure, in which they often demanded that others accept responsibility for contracting or transmitting HIV.

By contrast, reviewing contemporary sociological writing on attributions of responsibility (such as the majority of papers cited above) indicates a consistent pattern in which researchers: a) noted that individuals accepted at least some responsibility for their actions, and b) framed this as a problem. Often, this was because, from the authors’ perspective: 1) individuals ignored structural, societal, and environmental causes; 2) via self-surveillance, they conspired in their own domination by the governmental responsibility discourse; and/or 3) they were underprivileged, hence lacked the resources to assume responsibility.

But what if we reversed Blaxter (1995) question? Not, “why do they blame themselves?,” but, “why do sociologists generally resist their subjects’ acceptance

of some responsibility?" Rather than assuming individuals' attribution practices to be problematic, this paper reconsiders sociologists' opposition to attributions of individual responsibility among those we study, and suggests some costs of this attitude.

Limitations of the Critique of the Responsibilist Discourse

Framing: Is Everybody Poor?

Among the most frequent, and significant, criticisms of the responsibility discourse (e.g., Baum & Fisher, 2014) is the unfairness and futility of applying it to the disadvantaged. But such framing, whatever its value for protecting the underprivileged, ignores an important point often overlooked in our concerns over blaming the victim: not everybody *is* poor. Some have adequate access to physicians and gyms, do not live in food deserts, are not constrained by racism.

For those more fortunate individuals, it is not unreasonable to expect some degree of personal responsibility. There is no equation formally to apportion moral responsibility by standard deviations above the poverty line. Still, were the literature more thoroughly to consider the question, most sociologists would likely agree that some form of gradient exists. That the contemporary medical sociology discourse seldom does directly raise this particular question ends up masking a relevant instance of the value of individual responsibility.

Responsibilization vs. Paternalism

One of medical sociology's most important contributions, especially in the 1970s and 1980s, was to question the paternalistic mid-twentieth century view of the doctor-patient relationship enshrined in the Parsonian sick-role (Parsons, 1951). There is an interesting tension between the contemporary critique of responsibilization and the last few generations' critique of Parsonian paternalism. As physician-sociologist Armstrong (2014, pp. 169–170) noted, patient agency was no conspiracy of the medical profession, but rather resulted from (*inter alia*) bioethics' emphasis on patient autonomy. He observed that it is precisely agency "which separates the passive patient of 1958 from the active one today" (p. 172). Indeed, the public, themselves, helped move us from there (Parsonian paternalism) to here (the empowered, post-Parsonian, "responsible" patient), via social movements such as: feminism and self-help (e.g., Boston Women's Health Book Collective, [1971]1979); environmental activism (Brown, 1992; Brown & Mikkelsen, 1990); AIDS activism (Epstein, 1996; Indyk & Rier, 1993); and consumerism (Haug & Lavin, 1981). These arose partly because, given observed limitations of the traditional paternalistic model, and a wider context of social changes eroding public trust in establishment institutions such as the medical profession (Blendon et al., 2014), many sought a new doctor-patient relationship. Responsibility does not always come from "authorities 'from above' in the service of

'social control'" (Rose & Lentzos, 2017, p. 30), and "strategies of responsibility have no single political allegiance" (p. 33).

Disapproval of citizens' being assigned—or accepting upon themselves—at least partial responsibility, as a product of their agency, raises its own questions. More privileged members of society generally do enjoy greater "cultural health capital" with which to enact the contemporary, post-Parsonian "empowered patient" model (Shim, 2010). Yet, if we resist application of agency and responsibility to those less privileged, can we avoid consigning them to a 1950s-style passive patient role? How best to navigate between the Scylla of responsabilization and the Charybdis of paternalism?

Social change and new technology have enabled new forms of patient activism, demonstrating agency's enormous potentials. Patient-driven enterprises include crowd-sourced citizen-science such as PatientsLikeMe (Kempner & Bailey, 2019) and Clinica-Crowd (Guzmen-Carmeli & Rier, 2021), and even "participant-driven genomic research" (PDGR) (McGowan et al., 2017). Writing about PDGR, McGowan, et al. observed:

One of the most powerful cultural shifts accompanying the rise in PDGR relates to a rise in social expectations that individuals should monitor and manage their own health. This expectation undergirds terms such as "participatory medicine," "Health 2.0," "Medicine 2.0,"....The communities that have devised and promoted these terms are committed to the idea that people are no longer "patients" but are instead "participants" and instigators of their own health management plans. More precisely, the expectation is that individuals participate proactively in health monitoring processes that enable them to preemptively identify and manage disease risks or factors and to maintain or enhance health and wellbeing....(p. 496)

Is 1950s paternalism even possible, anymore? Moreover, the fruits of such new technologies and activism offer countless new opportunities and options for patients. If citizens do not make their own health decisions, these will often be made for them. But by whom, exactly?

What is Public Health, Anyway?

Nutrition advice is fiendishly complex and ever-changing, many face poverty, racism, and appalling sociomedical services, and a focus on blaming individuals can bequeath an unearned "pass" to big business, government, and other powerful actors. Yet, this hardly renders it irrelevant whether individuals snack on doughnuts or celery, or try smoking fewer cigarettes. After all, blanket rejection of the individual's responsibility would constitute almost a form of public health nihilism, in which we might as well continue smoking, since society is unjust.

Since physicians cannot lose weight or quit smoking for us, since we still lack one-off vaccines against all chronic diseases, it seems unavoidable that individuals must participate. In his critique of privileging individualistic over social or environmental approaches, Mechanic (1993) yet called it "clearly worthwhile" "to urge

people to refrain from smoking, substance abuse, poor nutrition habits and inactivity...." (p. 97).

Indeed, there is no need to be entangled in a simplistic individual/state, either/or binary. For example, World Health Organization (WHO) declarations, such as the Ottawa Charter for Health Promotion (WHO, 1986) and the Helsinki Statement on Health in All Policies (WHO, 2013)—taken together—have laid out a balanced, comprehensive vision of health that included personal responsibility, but which also made clear that there exist system-wide, multi-layered responsibilities to create the environment *in which* individuals are able to make health-promoting decisions. Thus, documenting systemic inequalities and their consequences need not prevent us *also* from acknowledging the practical value—particularly *from the individual's perspective* (as discussed below)—of encouraging individuals to assume at least a portion of the responsibility for their own health.

For example, empirical evidence from HIV/AIDS prevention indicates that developing a sense of responsibility can help save lives (Offer et al., 2007). Adam (2017), quite articulate on the risks of the "responsibilization" discourse, still acknowledged that this discourse helped reduce HIV transmission amongst both gay men and injection drug users—while also reducing "overt stigmatisation" of those living with HIV (p. 186).

In practice, a host of projects, programs, and coalitions involving individual patients, community activists, local community-based organizations and providers, larger non-governmental organizations (NGOs), tertiary-care and community-based health facilities, and local and federal governmental institutions collaborate around various health initiatives (e.g., Indyk & Rier, 2006a, b; Rier & Indyk, 2006). Furthermore, and complementing the citizen-science research mentioned above, over the last few decades large research programs have increasingly been engaging the public in participatory and "co-production" frameworks which involve them in the planning, execution, and application of local health studies (see Harting et al., 2022; Yoeli et al., 2022).

Another way to think of this involves public health's success in reducing smoking. US Census Bureau data show that, by 2015, per capita US cigarette consumption had dropped by nearly three-quarters since 1970 (Statista, 2022). These declines are partly attributable to diverse national and state policies such as advertising bans, health education, smoke-free spaces, and taxation, and the various forces and actors that brought those about. Yet these declines *also* represent millions of individuals' decisions to curtail their own smoking. And this demonstrates perhaps the best reason to take personal responsibility seriously: it represents a powerful—even a necessary (if not *sufficient*)—tool for improving health.

Given the above, our question of why so many medical sociologists nevertheless seem uncomfortable with individuals' accepting responsibility for their own health seems particularly apt. To an extent, such attitudes probably reflect wider sociological discourse. Horowitz et al.'s (2018) study, published in *The American Sociologist*, is instructive. Defining themselves personally as "progressives" (and the lead author as "marxist humanist" [p. 461]), they conducted empirical research on a national sample of full-time sociology faculty to assess "sociology's (purportedly) ideological blind spots" (p. 460). In particular, they examined whether sociologists' political orientations correlated with their approaches to certain controversial topics. Their sample

included, among others, sociologists defining themselves as radical (21%), liberal (62%), libertarian (2%), and conservative (2%). Most relevant to our present discussion are their observations on their respondent-sociologists' strong reactions to the concept of agency. In the context of the culture of poverty question:

effectively denying the agency of the black urban poor is widespread....[I]n a field traditionally attentive to the interplay of structure and agency, it is unusual to witness such categorical dismissals of autonomous behavior....It appears that asking these forbidden questions expels the questioner from the group's moral community (pp. 483-484).

They also noticed a similar pattern in their sample's reactions to sociobiology:

As with the culture of poverty, it appears forbidden to concede that a vulnerable group may make "choices" that even partially account for their social location. Such "choices" must be imposed strictly by domination from without. To suggest otherwise apparently "outs" oneself as a defender of social hierarchy (p. 487).

Benefits of Responsibility: From the Individual's Perspective

The above discussion constitutes the backdrop for our focus on the perspective of the individual.

Given the relative paucity of such explicit statements in the literature, it is noteworthy that Crawford (2006)—arguably *the* classic critic of the responsibility discourse (Crawford, 1979)—remarked that,

...sociologists, myself included, often lose sight of the fact that health is imagined and taken up as a practice in the life-worlds of individuals who have uniquely personal reasons about why health has become important to them. Nothing in the present critique should be interpreted as negating the value of health for those who embrace it and attempt to live more healthful lives (p. 404).

From the individual's perspective, there can indeed be solid reasons for accepting responsibility.

First, there is the sheer dignity that individuals can experience by exercising moral agency. Consider left-wing organizer Saul Alinsky's (1972) eloquent indictment (in the related context of civic engagement) of those who:

yearn for the dark security of dependency where they can be spared the burden of decisions. Reluctant to grow up, or incapable of doing so, they want to remain children and be cared for by others. Those who can, should be encouraged to grow; for the others, the fault lies not in the system but in themselves (p. xxv).

Second: assuming personal responsibility offers additional benefits. Canoy and Ofreneo (2017) observed, regarding people living with HIV [PLHIV], that "[a]n individual perspective on agency among PLHIV has emphasized the rich inner

capacity of individuals to overcome obstacles related to their illness....PLHIV exercise agency as an adaptive coping mechanism....” (p. 577). Combine this with Offer et al.’s and Adam’s above-noted observations that individuals taking responsibility can improve their health and reduce risk to others. Crossley (1997) suggested that the influence of the empowering HIV “survivorship” ideology partly relates to the sense of control it confers, and the reassuring distance it seems to create from the physical deterioration of those outside the charmed survivors’ circle. Mental health clients resented staff or institutional exhortations to take responsibility for their own progress. However, some did manage to assume a degree of responsibility, outside this institutional framework, via their own civic engagement initiatives—and found this satisfying (Brown, 2021). Individuals’ decisions to accept responsibility for consequences of their health practices can thus facilitate improved health, a greater sense of control over their fate, and the dignity of applying their own moral agency.

Third, pragmatically: social programs, and the votes and funds sustaining them, come and go. Fundamental social change might be the ultimate means of preventing and managing diseases such as AIDS or diabetes. Yet those already ill, or at risk, may conclude they cannot afford to wait for a fairer society. They may consider it more realistic to focus on decisions *within their personal control*, such as dieting, avoiding high-risk sexual encounters, and exercising. Which social actors or institutions, in the world *in which individuals live now*, has experience taught them to trust to assume responsibility for them, and protect them? The state? Physicians? Sociologists²? It should not surprise us that many, “even” among the poor, persist in accepting some responsibility for their own fate. Such calculations may also help explain the attitude of Mosack’s respondent, quoted above.

Some Possible Explanations

Having discussed “what?”, we briefly ponder “why?” It is simpler to demonstrate dominant currents in how medical sociology understands individual responsibility than to account for them, which project demands its own dedicated studies. Still, we propose some possible reasons for these patterns; hopefully, this brief, preliminary attempt will stimulate subsequent empirical investigations.

First: the discrepancy between individuals’ and sociologists’ approaches to personal responsibility partly reflects a certain broad social science stance towards public health. Frank (1997, p. 104) described a “politics of critique”, associated with a “hermeneutics of suspicion” in which “anything smelling of prescription is dangerous”. This closely tracks with Mizrahi’s (2016, [forthcoming](#)) wider critique of the “liberal grammar of critical sociology”, and its deep-rooted “suspicious” mode of inquiry.

Second: sociologists, particularly, recognize the broader socio-economic, structural forces shaping illness. This reflects wider concerns amongst sociologists, mindful of their relative privilege and “committed to the disadvantaged”

² Ironically, it has been sociologists who have done so much to document, and question, the power of the professions, experts more generally, and similar actors over individuals’ lives.

(Treas, 2010, p. 13), to defend the vulnerable from moral censure arising from dominant individualistic social, political, and corporate ideologies that obscure structural forces (Greenbaum, 2015; Treas, 2010; Wilson, 2009; Wright, 1993). (Indeed, American sociology has a deep-rooted “ameliorative”/reformist tradition [Smelser, 1994]).

Such forces, rather than individual-level factors or moral judgments, are of course sociologists’ stock-in-trade. Mills’ “sociological imagination,” for example, discerns the structural-historical context of personal woes, and their relationship to social problems (Mills, 1959, pp. 1–13). Sociologists thus recognize that not only individual behaviors, but also factors such as social structure, environment, and genetics, cause illness (and that, amongst scientists, the precise weight of behavior on disease causation remains unclear). Yet this insight may, paradoxically, hinder our ability to perceive these issues as do our subjects, whom we might consider victims of social structure, suffering from false-consciousness (Mizrachi, *forthcoming*, p. 8).

A third possible factor is fear of undermining our credibility by uttering views considered politically incorrect (see, for example, Horowitz et al., 2018, p. 484). Thus, when those living with illness either accept personal responsibility for their own actions, or hold others responsible for those others’ own illness, we might tend to explain (away) such behavior in terms of, say, internalized stigma and discrimination. As suggested above, however, if the analysis stops there, we risk unwittingly patronizing our subjects by negating their moral agency, i.e., the ability to formulate and apply their own moral standards (which may differ from our own). Today’s sociological discourse, conversely, often tends to construct individuals *only* as passive objects of socio-cultural and economic forces, helpless to reduce their risks, and unable to assume or attribute personal responsibility for decisions. Yet, even if sociologists are professionally focused on distal, structural (or “root”) causes, and feel obliged to remain morally neutral in their work, “civilians” with a personal, life-and-death stake in these issues might not feel such constraints.

Fourth: disciplinary homogeneity suggests another dimension. Decades of American empirical research indicates professors are much likelier, than are the wider population, to hold liberal views and vote Democrat. Gross & Simmons (2014) found that 62% of academics defined themselves as at least some shade of liberal, while only 20% defined themselves as at least some shade of conservative. At the tails, 9% identified as “extremely liberal”, while only 1% as “very conservative” (pp. 24–25). Looking specifically at social science faculty, those identifying as liberals (58%) outnumbered those identifying as conservatives (5%) 11.6:1 (p. 26). Most recently, the *Harvard Crimson* surveyed professors from Harvard’s Faculty of Arts & Sciences and School of Engineering and Applied Sciences. Of respondents, 45% identified as “liberal”, and another 37% as “very liberal”. Only 1% identified as conservative, and none as “very conservative”—leaving liberals outnumbering conservatives by a ratio of 82:1 (Xu, 2022). Note that in the above-mentioned Horowitz et al. (2018) sample, sociologists defining themselves as “liberal” or “radical” outnumbered those defining themselves as “conservative” 41.5:1.

Such disparities help explain sociology’s disciplinary embrace of a particular, liberal worldview—and the consequences thereof. As Mizrachi (*forthcoming*, p. 3) observed: “Once liberalism became sociology’s own theoretical stance....

this normative commitment bound sociology's self-awareness to the limits of the liberal imagination, hampering its ability to offer a fuller reading of non-liberal subjects...."

Continuing, Mizrahi (p. 7) remarked that, "sociology's alliance with just one moral and political vision has culminated in contorting sociologists' views of the many groups that do not share that same vision and constraining its ability to elicit generalizable insights...." Thus, liberal academics influenced by ideologies and values such as secular humanism and feminism may have difficulties understanding populations motivated by different values, and differing views of free will and individual responsibility.

Indeed, Horowitz et al. (2018) concluded, from their data, that, "sociologists differ systematically in their responses based on their commitment to the field's moral mission, preferred research paradigm, gender, and—most notably—political orientation" (p. 469). They suggested that, "sociologists' research agendas and attendant theories are likely bound up with their shared moral sensibilities and reinforced by like-minded colleagues in 'tribal' ways" (p. 474).

Turning to religiosity, Gross & Simmons (2009) found professors 3.2 times likelier than Americans overall to be atheists or agnostics (p. 113). These gaps were greater for: all social scientists (5.5:1); sociologists (5:1); and for professors in elite, doctorate-granting institutions, compared with those at other institutions (5.1:1). Writing in *The American Sociologist*, Wills et al. (2019) noted the mismatch between sociology faculty and their students, which latter group were likelier to hold conservative religious beliefs, and who reported feelings of marginalization and alienation in the classroom.

Our own case of the apparent disconnect between medical sociologists and those they study, regarding personal responsibility, may partly reflect a "research" version of this secular/religious mismatch. Compared with academic sociological researchers, the general public is more likely to hold traditional religious beliefs. The traditional religious world-view often takes individual responsibility quite seriously. For example, the Jewish Talmud (Tractate *Berachot* 5a) enjoins those stricken with suffering to search their deeds. Israeli social scientists have found that ultra-Orthodox Jewish women confronting prenatal diagnosis believed they received the tests and challenges they needed and deserved (Ivry et al., 2011). Teman et al.'s (2016) research on ultra-Orthodox women's reproductive experiences demonstrated that they regarded themselves as divinely obligated—*responsible*—at least to make appropriate efforts to secure healthy outcomes.

Bioethics has already begun confronting the reality that patients and families from, say, Latin-American or Asian backgrounds are often motivated by norms and values differing from those at the heart of US medical ethics (Rising, 2017). Perhaps we could benefit from equivalent reflections on our own work. Indeed, Martin (2016) noted that sociologists may find their subjects' behavior puzzling, in part, because they fail to appreciate their differing ideological or value priorities (p. 123).

Discussion

Many individuals accept at least some responsibility for their own health-related behaviors, and may expect others to do likewise. This highlights the differing moral and ideological landscapes of (and sometimes, disconnect between) sociologists and those we study.

Despite its value, the dominant sociological critique of the responsibility discourse has certain limitations. For example, it: overlooks the relevance of responsibility to those *not* poor; ignores what individuals can, in fact, contribute to their own health; risks restoring a paternalistic framing of individuals as passive and dependent; and can obscure salient aspects of individuals' experiences. Rather than automatically rejecting or explaining away individuals' acceptance of responsibility, sociologists would do well to consider this more carefully, lest we deny our subjects' moral agency and miss critical insights into individuals' experiences. This may require treading a fine line, but surely we are up to the challenge.

To that end—though proper discussion of solutions lies beyond the scope of this paper—future scholars might explore some of the following approaches.

Audiences

Perhaps our discourse can vary with our intended audience. If neoliberalist discourse has grown to be almost hegemonic among the health and governmental establishment, the *critique* of that discourse seems near-hegemonic in the sociological literature. How many medical sociologists are apt uncritically to accept the responsibility discourse? To whom, then, are authors writing when, immediately after presenting data on their respondents accept personal responsibility, they proceed to restate their critique? Maybe their true audience lies outside the research community, with policymakers and others more directly positioned to effect change.

When addressing this wider audience, such as via public testimony, media interviews, or even blog or Twitter posts, perhaps sociologists must—given current political and economic conditions—continue to shout their critique from the rooftops, to counter the dominant neoliberal discourse. But, when we speak to *each other*, through our academic journals, greater nuance might be possible, to address the sorts of baby-in-the-bathwater concerns raised herein.

Balanced, Patient-centered Thinking

This leads, in turn, to another possibility.

Above, we questioned the apparent all-or-nothing dilemma created by the current critique of neoliberalist responsibility discourses, which would seem to offer individuals few options to protect their health save waiting for society to reform itself. Fortunately, alternatives to this false dichotomy have begun to emerge. In a parallel to equivalent, above-referenced developments in public health practice, researchers such as Minkler (1999), Devisch (2012), Tuohimaa (2014), and Neutelings et al.

(2017) have recommended a "co-responsibility" approach, encompassing both structure *and* agency. One example is an empirical study of injecting drug users focusing on differences between those who did and did not avoid contracting HIV and hepatitis C (Meylakhs et al., 2015). Levy & Storeng (2007) explored how South African HIV+ women embraced a "living positively" discourse, which the authors identified as "a dynamic strategy co-created and transmitted in the public realm by activist organizations, support groups, and public health agencies with the leadership and involvement of their HIV positive constituencies" (p. 56). While duly describing structural and other obstacles these women faced, and hence the challenges of their assuming responsibility, the authors *also* noted how this discourse yielded them emotional and practical support.

Another approach is a Bourdieusian focus on health practices, rather than behaviors (Baum & Fisher, 2014; Blue et al., 2016; Cohn, 2014; Nettleton & Green, 2014). This, too, can attend both to structural and individual factors. It also affords finesse in framing: avoiding placing all responsibility on the individual—while encouraging, for example, *individuals* to engage in healthy *group* activities such as sport (Bunn et al., 2016; Wiltshire et al., 2018).

Hervik and Thurston's (2016) discussion of citizens of the Norwegian welfare state reminds us that structure, agency, and responsibility can be considered also in *non-neoliberalist* contexts. This demonstrates the possibility of holding government responsible for certain aspects of health, while also recognizing that citizen' agency and autonomy generate their own responsibilities for health promotion.

Future research should examine whether, by helping redress polarizing imbalances from contemporary binary approaches, such alternative models might better capture the situation many individuals face. That in turn, could render our work both more "individual-centered" and more useful for policy debates.

Diversity

American sociology has long worked to make the discipline more representative of wider society. These efforts have centered largely on characteristics such as race, ethnicity, and gender. Given some of the imbalances cited above, and how these may correlate with a particular approach that constrains the breadth of sociologists' views on topics such as agency, future scholars might investigate extending this project to include ideology. In fact, Martin (2016, p. 127) has already made such a suggestion in the pages of this journal. Recruiting researchers closer to the worldviews of wider sections of American society might facilitate more nuanced treatment of the responsibility discourse, especially from the individual's perspective.

Conclusion

Social scientists have done a fine job of critiquing the responsibility discourse. Yet we have not done as well at turning our critical gaze inward, reflexively, to consider certain limitations of that critique. By questioning sociologists' resistance to individuals'

acceptance of responsibility for their health, rather than problematizing the latter's acceptance of responsibility, this paper draws attention to, and begins to address, this imbalance. It suggests why individual acceptance of responsibility can sometimes be realistic and sensible, particularly from our respondents' perspective.

To the existing debates over responsabilization discourses, the present paper also contributes: a summary of certain advantages and disadvantages of responsabilization discourses; a preliminary consideration of why sociologists and other social scientists may resist imputations of responsibility to the individual; a look at why those we study often take a very different view; and some suggestions for future research on how to address these issues.

For, however we explain differences between sociologists and those they study regarding personal responsibility, it seems clear that responsibility deserves some additional attention by our discipline. Earlier medical sociologists drew attention to physicians' failure truly to listen to their patients (e.g., Mishler, [1984]1997). Yet we risk an analogous pitfall. By failing to pay due attention to individuals' role in preventing or managing disease, we can fail to understand, to respect, our respondents' acceptance of responsibility for their personal practices. To paraphrase that earlier message to physicians—as well as Mizrachi's (forthcoming, p. 9) broader, more recent one—*perhaps our respondents have something to teach us*.

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