Kantian Constructivism and Practical Reasoning in Clinical Bioethics

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Abstract

Philosophers are often accused of constructing theoretical systems that are disconnected from real problems, detached from concrete issues, and sheltered in their *Turris eburnea.* This is a criticism that needs to be explicitly addressed, especially by moral philosophers. In this paper I set out to show how the metaethical and normative debate can reconnect with applied ethics: I will argue that moral constructivism can relate to empirical evidence in some areas, such as the biomedical field, to adapt their normative claims accordingly.

Firstly, after briefly introducing and defining the field of practical reasoning, I will show what moral constructivism is and what it can do in practice to face moral dilemmas. Secondly, I will argue that in the biomedical field it is possible to have behaviors, both on the part of patients and health professionals, that can be addressed as practically irrational, and I will also show which tools we can use to counter this irrationality[1]. However, the objective of this paper does not stop here and wants to propose not only blocking strategies for irrational demands, but also proactive proposals for cures, implementing the proposal of Kantian constructivism with Viafora's proposal centered on respecting the dignity of the patient as a person.

Finally, I will argue that the set of principles we can draw from the various cases, while serving the important function of guiding us in future situations, do not constitute a complete theory of practical reasoning or ethical theory. What philosophy can do in the field of bioethics is not to provide a definitive list of rules, since the variety and diversity of the contingent cases will always be too wide to fit into overly defined schemes. Philosophy can, however, provide a common language for approaching morally relevant problems and for enabling agents to grasp the moral significance of concrete situations with the right tools.

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1.1. Practical reasoning

Humans have always[2] engaged in theoretical and practical deliberation, voluntary activities that are performed for reasons and can be carried out reasonably or unreasonably, rationally or irrationally, wisely or unwisely[3]. There are different ways of understanding and emphasizing the differences between theoretical and practical deliberation[4]; since this is not the focus of the article, and we want to focus only on practical deliberation, we can here simply understand theoretical deliberation as reasoning about questions of explanation and prediction (facts)[5] and practical deliberation as reasoning about questions of normativity and justification (values).

Practical deliberation is reasoning to figure out what one should do (as contrasted with figuring out how the facts stand), assessing and weighing reasons for actions. We are all familiar with this activity, although we may not always realize it since we are immersed in it all the time when we infer anything practical, like deciding which clothes to buy. Sure, sometimes these decisions are biased rather than irrational or just randomly chosen, or sometimes we can still be akratic regarding our rational inference: a person might end up playing videogames for another hour, while at the same time judging that it would be better, on the whole, to go back to work on their paper for the upcoming deadline[6]. In all these situations, however, we are always practically deliberating, balancing arguments or intentions to decide which has more value or weight in that particular context. Practical reasoning is indeed usually described as goal-directed reasoning from an agent's scope, and from some action selected as a means to carry out the goal, to achieve the action[7]. This is called instrumental rationality, and instrumentalism is the doctrine according to which all practical inferences are means-end inferences; therefore, providing a practical justification in the instrumentalism framework is merely showing that a proposed end is a means to a further end.

This is a natural position at which to arrive at reflection; for what could possibly be adduced in support of a practical conclusion except its addressing a goal or desire already possessed? In fact, this form of rationality has usually been viewed as the single unproblematic[8] substantive norm of practical reason. However, not only instrumentalism has its

limits, but after a closer look, it seems to be self-contradictory, as shown by Millgram (2005). Since any chain of practical inference will terminate in a desire that one just has, primitive, we have the problem of arbitrary desires[9]. The explanation for taking the perception of some secondary quality to provide a reason for action will involve a non-instrumental pattern of practical inference, and this is why instrumentalism is an insupportable view of practical reasoning: there are desires that cannot be justified in instrumentalist terms, and justifying it requires abandoning instrumentalism.

All these limitations are even more evident in versions of ethical theories that are based on instrumentalism. In fact, since a moral theory is very roughly a theory about what one should do, and a theory of practical reasoning is a theory of how to figure out what to do, the two kinds of theories are related as a theory of product to a theory of process (Millgram 1992)[10]. An ethical theory that is based upon instrumentalism is, for example, utilitarianism, which recommends taking actions that maximize utility. There have been different ways of understanding the notion of utility, and so there have been correspondingly different varieties of utilitarianism in play. Nineteenth-century utilitarians took the mental states such as pleasure and pain to be the core of the notion of utility and disutility, but later on, the mattering-makers became propositional attitudes, namely desires and preferences. Millgram (2005) argued that both these positions forget that these mental items are there to do something: both pleasure and desire have cognitive functions that cannot be maximized above them. The point of pleasure and desire is precisely to guide choice (utility can only be then an indicator of change in our well-being, not a goal) therefore maximization of utility of all future pleasures and desires is not something desirable.

Among the ethical theories that have tried to dispense with instrumentalism, there is certainly a broad family of constructivist theories. According to the constructivist, specifically, the Kantian constructivist, practical reason is governed by constitutive principles, and what makes these constraints normative is precisely their relation to the will of the agents[11]. All practical inferences that are in accordance with our constitutive principles of practical reason are valid inferences; and is precisely thanks to these inferences that we can construct moral principles that can guide us in taking actions in the everyday life.

1.2. Kantian constructivism

Kantian constructivism, as just said, is an ethical theory according to which moral principles are constructed through a specific process of rational deliberation. The construction of moral principles performs the fundamental epistemological function of selecting which facts have moral relevance: one starts with uncontroversial construction materials (like human beliefs and attitudes toward non-moral facts such as, for example, the natural psychological sense of repulsion in torturing another human being) and arrives through an appropriately specified procedure at principles that are independent of subjective attitudes (i.e., the moral principle “torture is wrong”). To adapt North’s phrasing: a key strength of such an approach is that constructivism can justify principles of justice without invoking controversial metaphysical questions about the existence and nature of moral entities, whilst at the same time explaining the moral objectivity of principles of justice in a way that is authoritative for agents (North, 2010).

The principles constructed in this way are objective in at least two senses: 1) that they are constructed by a procedure that starts from non-moral facts that can be verified by all rational agents (the material of constructions’

objectivity) and 2) that they are validated through our constitutive principle of reasons (the constitutive objectivity). The procedure of construction 1) starts precisely from the selection of facts that have moral relevance. Let us provide an example of how, starting from some objective construction materials, we can arrive at moral principles according to constructivism. Take the moral principle, "harming others is wrong." The process of arriving at this principle starts from uncontroversial natural facts: physiologically, a perception such as pain is expressed at the brain level as the result of a series of information coming from the periphery and transported via nerve endings to higher control centers, where it is processed. Thus, the subject experiences pain and the highly unpleasant sensation it entails. From this physical fact, specifically the final qualitative experience, we come to theorize the principle that it is best to avoid pain. Both components are needed to arrive at this principle: the natural fact and the human reason that reflects on it. From this simple combination comes a moral judgment, "it is better to avoid pain." These moral judgments, however, are almost never created according to such an individual and abstract procedure, but always by a subject that is placed in an intersubjective context. That is why the principle "it is better to avoid pain" is not declined solely for my own self-interests, but for all others, for all people whom I consider to be rational[12], and became “harming others is wrong”; we universalize the principle that it is better to avoid pain because we recognize, rationally, that other people come to the same conclusions, and wish to live in a society where we do not experience unnecessary pain[13].

But the validity of the procedure is not merely guaranteed by the objectivity regarding the material of construction but also by 2) the constitutive principles of reason itself. Since we are rational agents, we have principles that are ineliminable from reasoning itself, which constitute it and are its foundation[14]. The difference between these constitutive norms and the materials from which the construction starts is subtle: both are not constructed, but these meta-norms are formal (in the dual sense of not imposing empirical content and in the sense of structuring the reasoning itself), whereas the materials are contingent natural facts of the world. Only the facts of the world can be understood in an ontological sense, while the constitutive norms are to be understood in an epistemic sense.

So, what are some of these constitutive principles of practical reason? Firstly, the acceptance of our nature of being rational agents, thus free from coercion and able to act according to reasons, in a simple word: autonomous. Autonomy is an ineliminable condition of practical reasoning, because if we did not represent ourselves as free, there would be no point in deliberating on the reasons for action, and that is precisely why it is a constitutive norm. Likewise, I know that I am situated in an intersubjective world[15], that I am not the only subject, but that I am placed in co-existence with a plurality of agents other than myself. The rational animal deliberates on the basis of reasons that considers binding for all relevantly similar beings (namely all other animals endowed with reason). This requirement of universality is a constitutive principle of practical rationality precisely because, as rational but finite agents, we find ourselves acting in pluralistic contexts, characterized by the presence of agents who, like us, are not determined by their nature and therefore are forced to deliberate about what to do and the desires they wish to pursue (Bagnoli 2014).

From the simple self-reflexive observation of our being autonomous agents, placed, however, in a world with other agents, who in a certain way limit us[16], we understand that it is correct to consider as valid reasons only those considerations that can be conceived as matters of universal legislation. This demand for universalization is a meta-norm that is correct only in the sense in which it adequately expresses the intersubjectively shared conception of rational identity. An argument is correct not because it is assumed as such by the subject himself, according to personal standards

of coherence, but because it is judged as intersubjectively rational by a plurality of rational agents, hence universal. Normative principles must be constructed through reasoning procedures aimed at intersubjective justifiability, which guides us in reducing the range of morally licit actions, though not clearly determining it.

Some Kantian constructivists tried to provide a procedural validation of an action through the constitutive principles of reason, by rendering the Kantian formulation of the Categorical Imperative a procedural test for the permissibility of a proposed action (called CI-Procedure[17]). This test can be developed in four points:

1. First, Identify the maxim of the action. Maxims can be codified as having a logical form, like: In circumstances C, do A, because of P.
2. Universalize the maxim and verify the theoretical commitment. This requires imagining a “perturbed social world” in which everyone in your circumstances does what you are proposing to do. If you can’t imagine such a world because it is literally inconceivable or if the intention expressed in the maxim is bound to be frustrated in such a world, then your maxim fails the contradiction in the conception test[18].
3. Verify the practical commitment. Ask whether there are intentions that you are bound to have simply in virtue of being a human agent, but that cannot be successfully executed if your maxim is universalized. If there are, your maxim fails the contradiction in the will test.
4. Finally, if your maxim passes both the tests, you may perform the action. If it does not, acting on your maxim is prohibited.

This procedural scheme set out in this way has several limitations[19], but when applied to practical deliberation processes it can still serve a fruitful function. CI-Procedure is not a test of rationality, but it is a tool that can help us detect practical irrationality in some cases. In the next chapter, I will try precisely to use it in an area of applied ethics, such as clinical ethics.

2. Practical reasoning in clinical bioethics

2.1. Empirical bioethics and practical reasoning

Although bioethics was always intended from its inception as an interdisciplinary science, it must be said, as Jonsen notes, that in the first two decades of its history it was dominated mainly by philosophers and theologians to whom the morally relevant questions were put (see Jonsen, 1998, pp. 34-89). It was around the 1990s that sociologists, psychologists, anthropologists, ethnographers, and epidemiologists began to use the methodologies proper to their respective sciences to investigate the phenomena and issues on which the bioethical debate focused.

In the literature (Borry et al, 2005; Molewijk & Widdershoven, 2012; Andorno, 2012) three main factors are identified for this “empirical turn”: (1) dissatisfaction with a bioethics that is too theoretical, all centered on principles and values, perceived as abstract and paying little attention to the concreteness of si1cations; (2) the development of clinical ethics, i.e., that reflection that arises also and above all at the patient's bedside or in hospital wards, i.e., in direct contact with the lives of sick people and caregivers; (3) the growing influence on bioethics as well of the paradigm no1yed as "evidence-

based medicine," according to which the systematic use in clinical practice of the best available scientific data would enable health care providers to offer much better care to patients than would otherwise be based on non-systematic observations, personal experiences, and the intuitions of individuals.

The three factors just mentioned (that is, dissatisfaction with early theoretical bioethics, the development of clinical ethics, and evidence-based medicine) are the most main reasons for the general change toward the contribution of empirical sciences to the discussion of bioethical issues[20]. But as has been appropriately pointed out by Campagna, "the originality conveyed by the 'empirical turn' should be seen in the theoretical effort to articulate the relationship between the empirical and normative sphere in a new way" (Campagna, 2013, p. 24)[21]. As Furlan (2013) noted, the fundamental risk one runs when introducing empirical data into bioethical or ethical reflection in general is that of believing that one can draw a normative conclusion directly from them, thus making a logical error. The immediate shift from empirical to normative is one of the many invalid inferences to be guarded against when arguing in bioethics (see Sulmasy & Sugarman, 2010, pp. 8-10). Thus, one cannot limit oneself to an accumulation of empirical data uncritically in order to mechanically obtain a normative judgment (Furlan, 2013, p.21), but one must accept a fruitful two-way relationship between the two planes.

As has been noted (Borry et al., 2004b, pp. 43-50; Sulmasy & Sugarman, 2010, pp. 11-16), empirical studies can be important for normative reflection in many different ways and without falling into trivial errors of inference. For example, descriptive studies of what a certain group believes to be morally right or wrong with respect to an issue can highlight facts that are not known and therefore not considered by normative reflection[22]. This article, however, aims to carry out a purely philosophical analysis, specifically using the tools of practical reasoning and Kantian CI-procedure, and thus cannot aspire to provide an interdisciplinary work validated by empirical and statistical studies that would require more time. However, the empirical part is the basis for the analysis: starting from real clinical cases, situations of akrasia and practical irrationality will be tested. The aim of the article is not limited to this, to provide a vademecum on when a health care provider, a patient or his or her relative is thinking incorrectly, but wants to broaden the perspective: in addition to blocking requests and proposals that do not pass CI-procedure, it is necessary to show how it is possible to resolve moral issues that are raised in the ward and how to mend the care relationship with patients and their relatives.

The central idea of this article is to reconnect the perspective of Kantian constructivism to the third approach in the empirical/normative debate distinguished by Furlan (see footnote n.22) and in general with Viafora's proposal (1993, 2019) to give specific importance in philosophical argumentation to the concept of dignity of the person. This means, first and foremost, not to consider people only as recipients of philosophical reflection, mere executors of a normative code that is constructed and then provided, but to involve them as much as possible as subjects of a common critical reflection. To provide an ethical vocabulary is not to merely memorize authoritative principles, but to have a common language that enables one to deal with situations in which moral dilemmas are present. In this way, bioethics abandons the convenient pretense of lowering truths from above and returns to its philosophical origins as a discipline that must educate and form the person before the agent.

2.2. A Kantian analysis of a clinical case

Let us immediately try to use the tools of practical reasoning to analyze some controversial cases submitted to ethics committees. In this paper, I will focus on analyzing the case of Luce, drawn from the experience of an ethics committee for clinical practice in the Veneto region. Luce is a three-month-old newborn, born prematurely at 27 weeks + 2 days, following an urgent cesarean section. Previously, at 23 weeks + 2 days, she had been diagnosed with low growth and poor amniotic fluid. The parents had been promptly informed, along with the prognosis of unfavorable outcomes related to the situation. The pregnancy was the result of medically assisted procreation (PMA). The child is the only daughter of the couple (43-year-old mother, 41-year-old father). At birth, the baby weighed 620 grams (3rd percentile). She was viable, but hypotonic, hyporeactive, and cyanotic (good cardiac activity though). Given her overall critical condition and depression respiratory, Luce was immediately intubated and during her first three months of life, she almost always needed more or less invasive respiratory support (to this day, the child is ventilated in SIMV mode, with elevated parameters). Today she weighs 1.4 kg and is fed breast milk enhanced by gavage (nasogastric tube) with no problems with intestinal transit and absorption. The neurological situation, although still not fully evaluable, is very serious. In addition, among other things, both hearing and vision are partially impaired. From the point of view of endocrinology, congenital hypothyroidism has been found, for which therapy with levothyroxine. Despite genetic and infectious investigations, so far it has not been possible to establish the diagnosis etiology. For this reason, it is not easy to define with certainty the prognosis, which, however, appears extremely poor.

Against this backdrop, the treatment team has begun to question what plan of care is most respectful for Luce: indeed, in view of the persistent respiratory difficulties, the impellent question will soon be whether to perform the tracheostomy and other interventions necessary to counteract the various problems or whether to opt for a palliative approach. The latter appears to the caregivers to be the recommendable choice; the parents, however, are of a different opinion: partly because of their enormous existential investment in the pregnancy (achieved after several attempts at PMA, in Italy and abroad), they demand that everything technically possible be done for Luce. According to reports from the treating team, the parents are aware of the serious condition of their little one and the relative prognosis since they are informed daily of the situation. Nonetheless, they are hopeful for a miracle and are asking to move forward. The medical and nursing team is therefore experiencing a very uneasy situation: on the one hand, they have the fear that they may slip into therapeutic obstinacy in order to meet demands that appear to be based on unrealistic expectations; on the other hand, they not know how to deal with the demands of Luce's parents to go ahead at any cost and their accusations of giving up fighting for their child.

How to solve this situation? It is necessary to clarify the arguments (logical-argumentative side) but understand the attitudes (personal-emotional side). Understanding the situation of Luce's parents, and how much they wanted this child when it seemed impossible to succeed, makes it more understandable that they desperately want to cling to an albeit remote miracle, but it does not, however, make their attitude justifiable[23]. In a case like this, the CI-procedure tool can give us instant help by blocking any irrational requests from parents and can also be useful in helping the medical team to discard proposals for action as irrational. Attempting to universal a maxim such as "help my daughter regardless of the clinical condition" obviously fails the procedure and is contrary to any principle of justice: if doctors applied this maxim to every parent who asked for it, there would not be enough resources then to help patients who can really be saved. It fails both the contradiction in conception and the contradiction in the will test.

By letting the parents' arguments shine through and weighing them one by one, the only argument brought in support for continuing treatment is that of hoping for a miracle, which is something we cannot consider when rationally deliberating on a practical situation[24], so this is undoubtedly a case of therapeutic overkill on an infant: the parents want at all costs to save their child even in the face of the evidence that this is not possible, not understanding that these vain attempts will only prolong her pain. They fail to understand, therefore, that they are not wanting her good (which unfortunately is no longer possible as they understand it, i.e., a healthy future life) but her harm, namely a prolongation of pain and unpleasant sensations.

The work of the ethics committee cannot however simply stop at this clarification, leaving the doctors and nurses alone in having to decide how and in what way to communicate the decision to discontinue treatment to Luce's parents. It is not the goal of this paper to provide a specific vademecum on how to behave, since every specific situation must be addressed with specific tools and tones[25]; however, what I want to try to do in the last paragraph is to integrate the tools of practical rationality with a broader and more specific proposal that also concerns the method of care, the proposal of Viafora.

2.3. Rationality and ethics of care

The CI-procedure can be used mainly for the*pars destruens*, to block requests (patients and relatives) and proposals (medical team) that fail the two tests and are therefore not universalizable, but also for the *pars costruens*, since the maxims that pass the test instead can be considered at least consistent. However, it does not help us choose between different possible courses of action when they are both valid, because that is not its function: what the CI-procedure does is, as mentioned, simply to filter valid propositions from invalid ones. Once that is done, there are other tools of practical reasoning that help us choose what to do and how to solve certain moral dilemmas that arise.

The intention of this paper is also to provide a methodology for proactive choice in clinical practice by implementing the proposal of Kantian constructivism with Viafora's proposal centered on respecting the dignity of the patient as a person. In this approach, before verifying the presence of any ethical dilemmas, it is first necessary to check the quality of the care relationship: the goal of this operation is to ascertain how adequate the information is and how aware the patient's consent is, since what is at stake is precisely the patient's possibility of being personally responsible for the choices that affect his or her health and life (thus his dignity) as well as the possibility itself of initiating a relationship of trust, which is the first condition for coping with any ethical decisions[26]. In the same perspective, an effective interaction is also to be promoted within the health care team and in the team's relationship with the family members.

Only at this point can we move on to identify the specific ethical problems that the case presents. The most immediate way of identifying them is to review all those junctures that in the development of the case give rise to doubts and uncertainties, which are often at the origin of conflicts between medical indications and the patient's wishes, conflicts within the health care team itself, as well as between the health care team and family members. Usually, the ethical issues that a clinical case raises are many. They need to be identified one by one, so that misunderstandings and confusion are avoided. A first approach, therefore, will be more analytical and should state the terms of each individual problem. A second, more comprehensive approach is aimed at placing ethical problems in their specific clinical context.

This placement, on the one hand, provides the first parameter for identifying the most important ethical problem and, on the other hand, allows one to address this problem with the most appropriate tools.

It is now necessary to identify possible choices, that is, to use moral imagination. Moral imagination is indeed needed to identify all the choices that can be envisaged to solve the ethical problems that the case raises. Normally in clinical practice, moral imagination finds its first source in the particular ethical sensitivities gained through experience by the health professionals most directly involved in a given clinical setting. In more dilemmatic situations that challenge strictly professional-ethical and legal guidance, it is a reference to practical reasoning that allows the moral gaze the most openness and creativity. A more argumentative approach allows one to move beyond the simplistic positions of those who repeat that "it has always been done this way" or that "the law does not allow it", with the sole aim often of avoiding the effort of trying, truly, to reasoning.

Finally, one must justify ethical judgment, an act that occurs for Viafora in two, constitutive steps: reference to principles and reference to the clinical context. The Function of the first moment is to justify the judgment on the basis of the ethical principles called to promote the constitutive dimensions of the human most directly involved in the health field. Viafora implements a reinterpretation of Beacuhamp's and Childress' principles, reconceptualizing them within his system; during the ethical analysis, reference must be made to the principle of beneficence (understood as the unity of the person), the principle of autonomy (responsibility in the first person), and the principle of justice as solidarity (the sharing of the human that is common to us). These principles, rather than being in tension with each other like those of Beacuhamp and Childress, are different explications of a single principle based on respect for the dignity of the patient as a person. According to the ethical nature of the choice, its validity is wholly dependent on the strength of the arguments on which it is based, in essence on the ability of these arguments to respond to any counterarguments.

The function of the second moment is to compare the choice that is most respectful in principle with the circumstances of the clinical setting, to see whether, in addition to being respectful in principle, it actually is. If in the first moment the comparison with principles determines what in principle respect for the dignity of the patient as a person demands, in the second moment the comparison with circumstances determines what respect actually demands, in the sense of making it responsive to the particular situation in which this patient is situated. The argumentative strategy that with the integration of these two moments is proposed consists not so much in the balancing of mid-level principles each of the same compelling force, but in the interpretation of what the fundamental ethical principle of respect for the patient as a person demands in a given clinical context.

The two steps in the justification of ethical judgment thus concern, respectively, the recognition of each patient as a person with a commitment to respect his or her dignity, and the justification of what this recognition demands in each clinical setting. If the recognition of the patient as a person is based on a predisposition to identify ourselves with the humanity that is in the other (in the sense that Kant himself intended, especially in the metaphysics of morals), the justification of the actual ethical judgment comes through argumentation. We move then, according to Viafora, from the question "which choice is the most respectful of the dignity of the person?" to "which choice is actually the most respectful?" The first question requires confronting the constitutive dimensions of the person most directly involved in the context of clinical practice. It is in relation to these anthropological dimensions that the most respectful choice in principle is determined. The second requires comparing the in-principle most respectful choice with the particular circumstances of

the clinical case to see if, in addition to being respectful in principle, it is also actually respectful, that is, respectful of this patient in this particular clinical context

To better understand the effectiveness of this approach we can briefly put it to the test of a common clinical situation: the communication of a prognosis to a patient with advanced cancer. CI-procedure cannot help us here[27]: one must proactively decide how to behave toward the patient to whom the news is to be communicated. In principle, even in cases such as these, the prognosis should be communicated, since respect for the patient's personal dignity demands that he know all the data necessary to be able to make decisions about his life himself and not to find himself exposed to the domination of others who know in front of him that he does not know (it is precisely his self-esteem as a person, his sense of dignity precisely, that goes with it). Where, however, good reasons are given for thinking that communicating the truth results in a burden from which this person is likely to be crushed, communicating the prognosis may not actually be the most respectful choice. How to resolve the conflict? Beginning with the fundamental ethical principle that the patient's personal dignity should be respected, on the assumption that even the terminal phase is a time to be lived and fully included in the space of human dignity, the argumentation, supplementing reference to principles with reference to the circumstances of the case, has the function of justifying what in this context demands respect.

Once the conflict has been resolved at the level of principle, justifying, on the basis of respect for the patient's personal dignity, the prevalence of the principle of autonomy and the choice to communicate the prognosis, the question arises as to whether this, which is the most respectful choice in principle, is also actually the most respectful. And here we come to the second moment of the practical deliberation. The arguments that are confronted at this level are no longer arguments at the level of principle, but at the empirical level, they relate to the particular circumstances of the case. Is there data to suggest that the patient is unable to cope with the impact of the truth? What resources could be activated to help him cope? How should communication be set up so that we can tune in to this person's needs and accompany him or her in such a way that the awareness process does not occur in isolation? If it has been felt that there are elements that do not allow the prognosis to be communicated directly to the patient, for the patient's own health, one will then have to find times and ways to accompany this person in his or her process of awareness and to ensure, at the same time, that this process does not take place in isolation.

The difference with an approach like that of Beachuamp and Childress is that the various principles are not anarchic and difficult to order among themselves according to the situation, because this focus on the dignity of the person allows the other principles to be oriented. Principles of justice and beneficence certainly count in this argumentative strategy, but at the center, there is the patient as a person. The encounter with the patient in his or her personal uniqueness and wholeness is the primary condition that arouses and nurtures the moral gaze: it represents the ultimate reference for the justification of judgment in the particular situation in which the patient finds himself.

Conclusions

What this paper was intended to show is how the simple CI-procedure is not enough to provide healthcare providers with an omni-comprehensive procedure for dealing with the various moral dilemmas that will arise on the ward. It is,

however, one of the many useful tools that are part of the ethical literacy provided by the framework of Kantian constructivism, which is not mutually exclusive with other systems and indeed can be implemented and integrated with various other approaches such as the conception of dignity and the method of moral reasoning in bioethics provided by Viafora, as I have tried to show. All these tools do not, however, allow us to arrive at an ultimate system applicable to every case, but they do provide the right tools to enable healthcare professionals to analyze in the most appropriate and suitable way the individual cases that they will face every day.

Despite this virtuous indeterminacy, which is open to the specifics of each case presented to it, it would be useful to have more precise guidelines on the administrative side of the hospital. What would be needed would actually be a top-bottom change in structure and organizations, for example providing an international network of ethics committees among the various hospitals, not only for moral doubts and dilemmas, but also and especially for best practices. Ethics committees should not remain aloof in the *turris eburnea*, waiting for controversial cases to arise, but working to directly train healthcare professionals to recognize good arguments from bad arguments, justified reasons from (albeit understandable) unjustified ones, as well as in communicating correctly and in the most appropriate ways possible.

Footnotes

[1] I will do this by analyzing a specific relevant clinical case.

[2] Since they reached the stage of sapiens approximately. This idea, however, is not introduced by evolutionary thinker, but goes back to Plato (*Protagoras* and *Republic*, book 4) and Aristotle (*De anima*). There is a lot of interesting literature regarding when and how animals can be considered to deliberating too, but this is not the topic of the paper. See for example Driessen (2014).

[3] In this definition, there is an assumption that link deliberation with rationality, and that is indeed the definition of deliberation in the everyday language, an activity regarding the weighing or examining of reasons for or against a given choice in order to arrive at a judgment or conclusion. The philosophical definition is not too far from that, however, there have been some theories or proposals that have tried to distinguish, not only semantically but also conceptually, deliberation and rationality; see, for example Arpaly 2000 and 2006 in which rationality without deliberation is discussed.

[4] Sometimes, theoretical reasoning is considered to be related to normativity too rather than to factual question, and specifically with the question of what one ought to believe. It attempts to answer this normative question by assessing and weighing reasons for belief, the considerations that speak for and against the particular conclusions one might draw about the way the world is (Wallace, 2020). Another way of confronting the two kind of rationality is by saying that the former produces changes in our mental states, whereas the latter gives rise to bodily movements. But it would be misleading to boldly contrast them in these terms: practical reasoning gives rise not to bodily movements per se, but to intentional actions, and these are intelligible as such only to the extent they reflect our mental states. It would thus be more accurate to characterize the issue of both theoretical and practical reason as attitudes; the difference is that theoretical reasoning leads to modifications of our beliefs, whereas practical reasoning leads to modifications of our intentions (Harman 1986, Bratman 1987).

[5] Looking backward to events that have already taken place, theoretical reasoning asks why they have occurred; looking forward, it attempts to determine what is going to happen in the future. Practical reason, by contrast, takes a distinctively normative question as its starting point. It typically asks, of a set of alternatives for action none of which has yet been performed, what one ought to do, or what it would be best to do. It is thus concerned not with matters of fact and their explanation, but with matters of value, of what it would be desirable to do.

[6] In this case maybe we can still say that the agent acted irrationally, namely that he acted against what he itself judged to be rational in that situation. The debate regarding akrasia or the weakness of will and rationality is too vast to be addressed in this paper but see for example (Stroud & Svirsky 2019). Here we will focus specifically on practical irrationality and see in the next chapter a case regarding the clinical field. If we assume that this strong kind of practical irrationality is possible, however, then we must grant that practical reason is not automatically practical in its issue. A more accurate way to represent the consequences of practical reason would be to say that rational deliberation about action generates appropriate intentions insofar as an agent is rational (Korsgaard 1996a).

[7] This line of thought can be traced back to the philosophy of David Hume, who famously asserted that ‘Reason is, and ought only to be the slave of the passions’ (Hume 1978, 415).

[8] But within the discussion several issues emerged on which no common answer was found. For example, if this conception of instrumental rationality represents a binding norm of practical reason, then we are open to rational criticism to the extent we fail to exhibit this kind of instrumental consistency, regardless of whether we want to comply with the principle or not. This is usually followed with the assumption that there is no room for rational criticism of peoples’ ends, but only for Weberian Zweckrationalität: the rational determination of means to the realization of ends that are taken to be given, as a matter of human psychological fact (Wallace 2020), but not everyone is inclined to endorse this. In an influential paper titled "Deliberation is of Ends" Aurel Kolnai (1962 [2001]) floated precisely the idea that, very often, our goals are not definite enough to serve as the starting point for means-end reasoning. See the note below to see how this applies especially to clinical case.

[9] Some instrumentalist thinkers, as mentioned in the previous note, have no problem in admitting that since there are no straightforward criteria for reasoning successfully on arbitrary desires, practical deliberation about final ends is not a true form of reasoning. But how is one supposed to clarify one’s largest and most important ends, if not by reasoning about them in some way? Practical reasoning must consist not only in figuring out how to get what you want, but in figuring out what exactly it is you want in the first place, what is the right thing to want and to do in that place, and this is a matter of further specifying your ends. This is even more evident in applied fields, such as bioethics and especially clinical ethics. Before searching for the means to return the patient to health, the physician must first decide what health, in these circumstances, would be

[10] According to Millgram, the right way to do moral philosophy is precisely to start with the theory of practical reasoning behind the ethical theory. We should, before “appelling to any substantive moral theory, determine which theory of practical reasoning is correct” (Millgram 2005).

[11] The principles of practical reason are therefore constitutive principles of rational agency, binding on us insofar as we necessarily commit ourselves to complying with them in willing anything at all. The realm of the normative, on this approach, is not pictured as a body of truths or facts that are prior to and independent of the will; rather, it is taken to be

‘constructed’ by agents through their own volitional activity.

[12] Against these kinds of arguments could be raised the singular case of self-injurers. Should they simply be considered irrational because they take pleasure in experiencing unpleasant feelings? Actually, this deviance of theirs, whether biological or cultural in nature, should be judged irrational simply because it does not extend to other people. That is to say, the self-injurer is unable to provide arguments for feeling pain to be a standard and desirable situation for everyone. As we will see later, not only the will to create a world of people in pain would not overcome the CI-procedure, but self-injurers fails more profoundly in one of the main characteristics of rationality, which is the publicity of reasons. This is the same technique that Gibbard (1990) implements with regard to anorexics.

[13] In this sense, moral principles seem to be reduced to laws, according to certain positivist theories of law (Kelsen, 1952), but there are cases where they simply fall within the choice of the individual while being rationally universalizable, such as the principle "it is wrong to eat three jars of Nutella in a row," which is easily arguable for all rational agents, but likewise would be superfluous if it became law. The peculiar distinction between moral principles and political laws is an interesting topic but cannot be dealt with here. For further discussion, see, for example, Sidgwick (1907) or Ross (1939).

[14] However, this does not imply that rational but also imperfect human beings (O'Neill 1975) are always able to adopt the constitutive norms adequately and fully (Korsgaard 2009). Again, we will focus on this aspect on the next chapter.

[15] Which is not to be understood in a metaphysical sense, but, for example, as communication (Habermas, 1984).

[16] Even simply because we have obligations to them, as they have obligations to us (Richardson 2016).

[17] Despite the name canonically adopted, the CI-procedure is not technically a procedure or algorithm. Procedures can be executed mechanically and are guaranteed to terminate, and neither of these properties can be always found in the CI-procedure. Rawls acknowledged this point and tried to distance itself from the idea that the central problem of political theory could be rendered as well-defined exercise in game theory

[18] This is not merely a test of logical consistency, but of rational consistency too since it wants to exclude self-frustrating plan of action. A is a description of the type of action, C specifies the occasion that are to trigger actions of type A, and P specifies the point of the action. If P gives content to a frustrated plan of action, then the plan is self-frustrating. Both tests are, after all, a way of checking whether what you are proposing is something that you can coherently intend (Millgram, 2005).

[19] Even this is self-refuting, according to Millgram, since the maxim to adopt the CI-procedure itself gives rise to a contradiction in the will. In fact, you need a maxim to motivate anyone to act accordingly to the CI-procedure, something like the following: “When I am making up my mind what to do, I will act only on maxims that pass the CI-procedure, so as to make morally or rationally permissible decisions”; but since, according to Millgram, successful agency requires exception (since when we decide on how to act we do not have all the relevant information on sight) and if successful agency cannot be successfully executed if this maxim is universalized, the CI-maxim fails the contradiction in the will test and therefore the test of the CI-procedure blocks the CI-maxim. There have been numerous replies to this. In general Kantians have tried to dodge these difficulties by claiming that constructivism is provisionally universal, which admits exception, but still aspire to absolute universality throughout revising norms. Herman (1993) has adopted a different approach and has come to see the CI-procedure as expressing respect for persons rather than thinking about it as a consistency test. Making that move opens up the possibility of restricting the applicability of the CI-procedure, because an

intention or policy will no longer have to be considered practically inconsistent if it fails to pass the CI-procedure. Millgram thinks that this move makes Kantian moral theory “much less deep and much less interesting” (Millgram, 2005, p.130).

[20] The empirical turn that characterizes the bioethics landscape of the new millennium has also had an impact on the activities of clinical practice ethics committees. In fact, where they are present and active, committees have taken the lead in investigations that fall squarely within the scope of empirical bioethics. Such experiences have been harbingers of lessons and directions, while highlighting some theoretical knots that are still problematic. For more, see Furlan (2018).

[21] Furlan (2013) distinguishes between three approaches to the empirical/normative relationship regarding bioethics: the first position is the classical sharp distinction between facts and values, according to which normative conclusions (ought-statements) cannot be drawn from merely descriptive propositions (mere empirical data), with empirical research being reduced to an ancillary function in regard to the ethical-normative reflection, with all the obvious negative consequences and impoverishment of data exchange. Proponents of the second approach believe that the distinction between facts and values no longer holds and that we should even go beyond the distinction between descriptive and prescriptive sciences (Widdershoven et al, 2009, p. 100); however, in the practical application, this second proposal is reduced in the clinical setting to an algorithm that leads to defining different treatments as "obligatory," "unreasonable," or "optional" solely on the basis of the expected outcomes of the treatment in question in terms of survival and disability-free years, a result that has been criticized and judged insufficient. The third approach is the one that best succeeds, according to Furlan, in accounting for the interconnectedness of facts and values found in everyday health care practice and other situations of bioethical interest. Proponents of the third orientation do not choose the path of declaring the distinction between empirical and normative elements dissolved: they believe that it is the specific task of philosophical reflection to distinguish these two realms. Thus, while it is true that empirical research can be important, if not crucial, for developing and improving concepts and theories proper to philosophical bioe1ics, it is equally true that a solid and thorough knowledge of the latter is necessary in order not to be naïve and uncritical about the results of empirical research. On closer inspection, then, planning and implementing good empirical ethics projects requires more philosophical rigor, not less. Myser (2009, p. 89) and other proponents embrace the methodological attitude of systematically, albeit critically, using the results of empirical research in normative reflection, recognizing their heuristic value and ability to aid in decision-making (cf. Borry et al., 2004a). In this way, the flattening of ethical reflection to the individual situation or to the unquestionable moral valuation of those who are experiencing it is rejected. At the same time, an ethical reflection that accepts to be confronted with the complexities of life and the novelty of problems is proposed and practiced with conviction, identifying and interpreting the relevant ethical principles for evaluating a certain practice especially through dialogue with the people involved (Adorno, 2012, p. 463).

[22] The recent emergence of evidence-based medicine (EBM) presents medical ethics with the challenge of analyzing what is the current best medical evidence in ethical decision-making. Borry, Schotsmans, and Dierickx (2006b) concludes in a famous paper that the use of the best available, most recently published research findings, is a primary moral obligation. However, this does not automatically mean that the use of these research findings will lead to better ethical decision-making. Research data can be distorted by methodological failings in the design and reporting of experiments, or by technical and commercial bias. Moreover, the introduction of norms, values, principles and ethical theories can lead to other choices than those proposed by empirical research findings. Ethical decision-making must be informed and

legitimated by the best available medical research, nevertheless, is still primarily a choice based on values and norms.

[23] It is the classic philosophical distinction between motivation (what is chosen as the reason for an act from an agent) and justification (what reason can justify an agent's action). See Alvarez (2016) for a reconstruction of the debate.

[24] Clearly one is assuming that the picture provided is correct and irreversible. If by a miracle is meant an error on the part of the medical team, who missed something, an albeit remote hope, the parents' request seems anything but irrational. However, this is a contingent issue, not a normative one. An ethics committee should offer its ethical evaluation only when the clinical situation is provided and taken as correct and true, just as the CI-procedure can only provide results if the maxims that are entered at the beginning of the procedure are true. It is up to the medical team then to verify in advance the technical accuracy of the data provided to the committee.

[25] See the conclusions at the end of this paper for some insights about a few guidelines that could be applied more generally in hospitals, top-bottom.

[26] Clearly, the starting point for an ethical analysis of a clinical case also includes the previous collection of as accurate and complete data regarding diagnosis, prognosis and treatments as possible. Always holding firm to the reference to the patient as a complex person in his or her uniqueness, the data must therefore be collected within a sufficiently broad model of analysis, so as to identify all aspects of the clinical situation: those that are strictly medical, but also those that are more personal, in order to thus propose a coherent course of treatment. An approach that focused only on disease parameters, losing sight of the patient in his or her personal uniqueness and wholeness, would inevitably be doomed to moral blindness (Viafora 2006). Only by starting from this solid database can truly effective practical reasoning be activated, even if it is not always possible to have all the information available.

[27] At least until there are no proposed courses of action to be evaluated as rational or irrational. Of course the doctor can try to formulate several possible courses of action, and see which would pass the CI-procedure test. But, should more options pass this test, then the most correct one should be chosen, which is precisely the one that most respects the dignity of the person. However, this does not diminish the usefulness of the CI-procedure in the first phase of filtering all possible proposals.

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