Review of: "Kantian Constructivism and Practical Reasoning in Clinical Bioethics"

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Methods of Applying Kant's Ethics—

A Reply to Jacopo Morelli's Reflections on Clinical Bioethics

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In his recent article, "Kantian Constructivism and Practical Reasoning in Clinical Bioethics" (*Qeios*, October 2022), Jacopo Morelli introduces and applies one of the most controversial features of Kant's ethics, his claim that one can actually *test* ethical maxims according to their consistency with the Categorical Imperative (hereafter "CI"). Morelli proposes that two such tests can be fruitfully employed to deal with difficult cases that arise in clinical bioethics. The two tests are well known and therefore require only a brief reminder here: when facing an ethical choice, Kant sometimes suggests, we should formulate a maxim that, if adopted, would guide our choices as to how to act in the given situation; we should then test the maxim, first by reflecting on whether the maxim itself is *self-contradictory in its conception*, and then by reflecting on whether the course of action prescribed by the maxim would create a *contradiction in the will*.[1] Focusing special attention on an actual case that has arisen in bioethics, Morelli attempts to show how medical practitioners can respond to ethical dilemmas, such as the ones raised by that case, by considering whether the relevant maxims being adopted by their patient can pass these two Kantian tests. He furthermore suggests setting up international ethics committees to monitor such doctor-patient interactions.

Without going into the details of the specific bioethical scenario that Morelli describes, I shall here offer some brief comments on the problems and ambiguities that inevitably arise, whenever someone takes Kant's method of maxim-testing literally. This short response will conclude by directing attention to another, much-neglected method Kant proposes to apply his ethical theory to real situations. In his *Religion within the Bounds of Bare Reason* (1793/1794), he talks not about using the CI to "test" maxims, but about setting up social institutions (called "churches" in the context of some empirical religious traditions) that are grounded on a practical application of the four categories of understanding that he

first introduces in the *Critique of Pure Reason* (1781/1787).

One problem that arises, when Morelli discusses the case of baby Luce—a baby born very prematurely, who is therefore still being kept alive by various medical interventions, and whose older parents (both in their 40s) had for years been employing various means of medical assistance in hopes of having a child—is that Morelli never tells us what the parents' *actual* maxim is. Instead, he merely hypothesizes that *if* their maxim is "help my daughter regardless of the clinical condition", then it "obviously fails the [Kantian CI testing] procedure". The suggested maxim is indeed poorly formed, regardless of who is going to apply it, or in what situation. For in order to formulate a good ethical maxim in a *Kantian* manner, it must be expressed in a form that is at least *potentially able* to be universalized. A maxim worded in more general terms, such as "protect and extend human life at all costs" would therefore be more defensible, if assessed by the CI's twofold universalizability test.

I suggest that, when Kant talks about testing maxims against the CI, he does not have in mind an exercise that human beings will conduct every time they are about to make a moral decision. While such premeditative calculation might be possible in some situations, many (if not most) of our moral choices arise suddenly, in the spur of the moment, and allow little if any time for maxim formation, to say nothing of *assessing* a given maxim to determine whether or not it is universalizable. Instead, Kant's main aim in referring to maxim-testing is to provide *philosophers* with a tool for assessing the moral legitimacy of what a moral agent's motivation *might* have been, once he or she has made a given moral choice.

In real life, people (especially those facing bioethical dilemmas) rarely go to the trouble of actually formulating maxims to assist them in acting on the choices they face, even if they have time to do so. When a person's premeditation on a possible action does include formulating a maxim, there is always room (without straying from the letter of Kant's claims about the CI) for cleverly modifying one's proposed maxim, if it turns out that one version fails one or both universalizability tests. This raises the suspicion among critics of Kant's approach (including many students of Ethics 101 classes) that his test-taking strategy is really an excuse for rationalizing one's actions. If I am clever enough to construct a maxim that manages to slip by the two tests without being hung-up by any alleged contradiction, then the application of these two tests on their own would suggest that I may proceed with my desired course of action, regardless of how under-handed it may in fact be!

Moreover, as Morelli rightly points out, Kant's twofold universalizability test "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… simply to filter valid propositions from invalid ones." Given this fact about such a maxim-testing procedure, it seems obvious that, if their doctor (or perhaps the hospital's ethics committee) were to inform Luce's parents that the maxim guiding their choice of treatment(s) had failed the Kantian test(s) of ethical legitimacy, their response need not be to change their chosen course of action; rather, they could merely formulate a revised version of their maxim that would be more likely to pass the test(s)—or, perhaps, hire a philosopher to do so on their behalf, if they are not sufficiently adept at maxim-making to do so by themselves. For example, in line with my observations in the previous two paragraphs, they might declare the following as their revised maxim: "Where there is any hope of saving the life of a person experiencing a medical emergency, one should do everything within one's power to do so."

Morelli states several times that Luce's parents have urged the doctors to continue working to extend their daughter's life, even though they (the doctors) see virtually no hope that Luce will ever be able to live a normal, healthy life, because they are hoping for a miracle. For anyone who believes that miracles never happen, this confession might be taken as sufficient reason to remove the struggling infant from her life support. After all, if a miracle is needed to make Luce's life viable, then the doctors (or ethics committee) might argue that, if God intended to intervene in this case, surely the miracle would have already happened by now. In a context where resources are limited (and especially where demand for care exceeds the available resources), putting so much effort into saving the life of one baby who is very ill might have a negative impact on the hospital's ability to save the lives of other struggling infants.

A key question raised implicitly by Morelli's reflections on Kantian bioethics, but never addressed explicitly, is: what is the *purpose* of testing one's maxims? Does it have more to do with helping a person decide what to do, or with helping a person be *properly motivated* when attempting to implement whatever moral choices he or she has made? If the former rather than the latter is the true purpose of CI maxim-testing, and if Luce's parents really did state the maxim Morelli attributes to them, as an unambiguous declaration that this is the basis for their decision to urge the doctors to keep trying to save their baby, then the proper response to Morelli's conclusion (assuming for now that it is correct), that their maxim fails both of Kant's two CI-tests, is not necessarily that they should change their preferred course of action, but rather that *if* they wish to continue pursuing that course of action, then they need to come up with a better *reason* for doing so, a maxim that more legitimately explains how their choices are based on an essentially moral motivation.

In any case, as an alternative to the usual contradiction-test for the CI, Morelli follows C. Viafora's proposal of implementing a rather different, two-step *dignity* test, whereby the second step consists of *contextualizing* the proposed maxim, to ensure that the action(s) under consideration will *really* show maximal respect for the humanity of the person(s) involved. Such contextualization is, indeed, a crucial step in any proper interpretation of Kantian ethics. Without it, any method of maxim-testing is bound to be cold, formalistic, and thus to risk being ultimately contrary to its intended purpose. In hopes of enhancing our ability to contextualize cases that give rise to bioethical dilemmas, Morelli suggests the need to set up "a top-bottom change in structure and organizations, for example providing an international network of ethics committees among various hospitals".

While Morelli's suggestion is worth considering and is already being implemented in some places, I believe such committees could cause more harm than good, if they are set up in the way Morelli describes them. A more authentically Kantian way to set up such a network of ethics committees would be to require them all to be *bottom-up*, rather than "top-bottom". Helpful guidance here can be gleaned from Kant's recommendations regarding the proper organization of churches, in *Religion*. In §IV of Division One of the Third Piece, Kant argues that a "visible church" must seek to emulate the form of the one true (rational/moral) "invisible church" by implementing applied versions of the human understanding's four key categorial principles, as follows:

universality: the church's *quantity* must be one;

integrity (*Lauterkeit*): its *quality* must be morally pure;

freedom: the *relation*, both between church members and between the church and the government, must aim at minimal regulation; and

unchangeability: the *modality* of these four principles must be regarded as the only necessary ones, such that all other principles of organization are always open to revision.[2]

In line with this fourfold (categorial) test for the authenticity of a visible (humanly organized) church, I shall conclude by proposing four principles of Kantian health care that hospitals and other health care providers should adopt, to ensure that patients under their care *really are* treated with the dignity that Morelli (quite rightly) insists is crucial. Modelled on the aforementioned principles of church organization, these four principles are as follows:

1. *Quantity*: Decisions about a person's health are to be made by*one* person, the patient. The role of doctors and other health care providers is to empower patients by informing and educating them as to the options available, not to insist that their patients follow their advice. Likewise, the role of ethics committees is not to pontificate from on high, but to ensure that safeguards are in place to protect the *universal* right of each patient (or, in the case of incompetence, his/her designate) to decide.

2. *Quality*: The patient's choice of health care protocol is to be determined not by the goal of minimizing pain and/or maximizing pleasure, but by the goal of maintaining *holistic health*, through an integration of the person's physical, mental, and spiritual needs. Health care providers should therefore devote funding to sufficient counselling services to guarantee that patients who have chosen unhealthy lifestyles can be guided and supported to change their unhealthy habits and choices.

3. *Relation*: The patient's choice of a healthy lifestyle must be seen as part of a*community* effort, such that the friends and family of the person seeking medical care are allowed (and actively encouraged) to be part of the process rather than isolated from it. But maximum *freedom* must be allowed, both in the relation between the patient (or decision-maker for the patient) and the doctor(s) and in the relation between the doctor(s) and members of the ethics committee.

4. *Modality*: The *possibility* of attaining a state of full health must be the end in view that constantly guides everyone involved in the process, whether they be patients, friends/family members, medical health providers, or (especially) health care ethics committees. All guidelines imposed by an ethics committee shall be subject to revision according to the ever-changing nature of medical science and social expectations, *except* the fundamental status of these four principles.

In endnote 9, Morelli makes the following astute observation: "Before searching for the means to return the patient to health, the physician must first decide what health, in these circumstances, would be[.]" While the foregoing four principles do not, in and of themselves, answer the question, "What would it take for patient A to be declared 'healthy'?"—that question can be answered only by the ever-changing cutting-edge empirical knowledge assumed by the science of the day, answers that will always remain imperfect—they *can* serve as helpful formal guidelines that could be used by an ethics committee to determine when a particular physician is *not* treating a given patient in an ethically responsible way. As such, employing this fourfold set of categorial guidelines as "tests" could supplement and flesh out the more formalistic universalizability tests that Kantian ethicists typically focus on.

If an ethics committee is set up to implement a set of guidelines for the medical practitioners working in a certain region or in a specific hospital, a top-down management style is precisely the *problem* faced by many who receive unsatisfactory health care today: they are victims of a system that presumes to know more about what is good for the humanity of the patient than is known by the persons themselves, who are supposed to be helped by that system. Morelli's recipe for a Kantian revolution in the health care industry risks doing more harm than good unless it insists on a *reversal* of this top-bottom trend. In endnotes 24 and 25, he indicates quite explicitly that he really does have in mind that ethics committees should be ultimately responsible for exercising *control* over medical practitioners and, so too, over the patients themselves. In my view, this is utterly unKantian, as it conflicts with the third formulation of the CI, autonomy in a realm of ends. Endnotes 26 and 27 leave no doubt that in Morelli's analysis it is medical practitioners, not the patients themselves, who have the duty to exercise appropriate "practical reasoning" before deciding how to treat their patients. While I would not want to deny that medical practitioners (and so also, the members of ethics committees) do need to engage in practical reasoning, my argument is that a genuinely Kantian approach to health and wellness requires each individual person to be responsible, first and foremost, for their own medical choices.

The primary role of health care professionals, like that of pastors in a church, is to be educators, while their secondary role is to implement the choices made by their patients and to do so in the best interests of their patients. The role of ethics committees should be to act only as safeguards: to oversee medical professionals, ensuring that they do not overstep their own proper bounds by engaging in top-down treatment protocols. In this way, such a committee would protect patients from just the sort of medical practice that Morelli assumes all good doctors will employ—namely, doctors who believe that practical reasoning about their patients' health is primarily *their* task *rather than* the patient's.

This revision of Morelli's proposal leads to my main point in this short response: as Morelli himself recognizes, universalizability is not the entirety of the CI, according to Kant, but is only its *form*. The *matter* of the CI is respect for the *humanity* in every person; and the *synthesis* of these two versions of the CI is *autonomy* for each person, considered as co-inhabitants of a *kingdom of ends*. Morelli never considers in any detail how the second and third aspects of the Kantian moral law might impact the moral decision-making for patients who are enmeshed in the kind of bioethical dilemma he considers. As noted above, his consideration of dignity (which is tied to the second formulation of the CI, the *humanity* in each person) appears to relate only to the practical reasoning of medical practitioners (and/or ethics committees), not that of the patients themselves. By contrast, if we see the CI whole, so to speak, I believe we can gain some insight as to how to choose between different maxims in situations where more than one (conflicting) maxim does manage to pass both versions of the (universalizability) CI.

The second formulation of the CI (respect for humanity) is closely related to the special form of practical reasoning that Morelli recommends as the best supplement to the twofold universalizability CI-test: assessing the extent to which different options for moral choice preserve the *dignity* of the person(s) involved. What Morelli does not explain with sufficient clarity, which I have briefly attempted to flesh out, is that Kant ties dignity directly to what he sometimes calls the "humanity in a person". In *Religion within the Bounds of Bare Reason*, before formulating the aforementioned four guidelines for an authentic church, Kant introduces three levels of the "predisposition to good" in human nature: following

animality, the other two are humanity and personality. I have argued elsewhere[3] that Kant's concept of dignity is grounded in this second predisposition, but only insofar as it is possessed by beings (such as us humans) who *also* possess personality. That is, the "humanity in a person" is precisely our status as beings who are situated between the extremes of animality (as expressed by our inclinations) and divinity (as expressed by the moral law): to be human is to be forced to choose between these two; and the *possibility* of choosing the moral law is what gives us our dignity. Spelling out these details of Kant's theory of dignity helps to support Morelli's claim, that choosing the path that leads to greater dignity is a meaningful way of supplementing the standard (and, on its own, rather sterile) two-fold universalizability test. My suggestion is that a good way to do that would be to model health-care organizations on the fourfold categorial standard that Kant proposes for religious organizations.

References

Kant, Immanuel (2009). *Religion within the Bounds of Bare Reason*, trans. Werner Pluhar. Indianapolis: Hackett.

Morelli, Jacopo (2022). "Kantian Constructivism and Practical Reasoning". *Qeios* (October). https://doi.org/10.32388/3HFS7Y; accessed November 16, 2022.

Palmquist, Stephen R. (2016). *Comprehensive Commentary on Kant's Religion within the Bounds of Bare Reason* Chichester, U.K.: John Wiley & Sons.

[1] Unfortunately, Morelli never discusses how we are to proceed if a particular maxim passes one version of the universalizability test but not the other.

[2] For a more detailed account of these four principles and their application to Kant's theory of the church, see Palmquist 2016, §VII.3.i. Kant introduces these four principles at 6:100-102 (Academy Edition numbering).

[3] See my unpublished paper, "Kant on the Dignity of Authentic Religion".