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

Aleksy Tarasenko-Struc

Potential competing interests: No potential competing interests to declare.

Thank you for the interesting essay. Here are some high-altitude comments that I hope you'll find helpful as you revise the paper and try to find it a home in a suitable venue.

It would be better, first of all, to dive into the main intended contribution of the paper—showing that Kantian constructivism yields a serviceable moral vocabulary and method for clinical decision-making—instead of devoting several pages to set-up. To get going with the project, the reader only needs a brief, canonical definition of Kantian constructivism and a sketch of how the view can meaningfully inform moral reasoning. The other bits of set-up (e.g., the explanation of the distinction between practical and theoretical reasoning, the overview of how ethics came to be empirically informed in its incarnation as bioethics, etc.) are unnecessary and slow the momentum of the paper. Similarly, the initial case study should be moved up to p. 2 or p. 3, instead of p. 6, and more work needs to be done to flesh out the positive proposal. (More generally, the paper needs to be case-driven to a much greater degree than it is, at the expense of methodological reflections, particularly to ready it for publication in a clinical ethics venue.)

In particular, a greater effort should be made to strengthen your argument for the conclusion in the case of Luce as well as for your claim that the CI procedure generates the correct verdict in this case—leaving aside the question of whether the procedure is applied properly, about which some might have doubts. One major worry that I had about your handling of the case is that what's wrong with continuing to provide care in the face of a dismal prognosis is not—or not obviously—that the maxim of providing all manner of life-sustaining treatment to the child fails the universalizability test (because society lacks the resources to allow everyone with this wish to pursue such treatment). Rather, the main wrong-making feature—or obligation-undermining feature—seems to more directly concern the child herself and the effect that continuing care has on her: life-sustaining treatment harms the child, not to mention the fact that it is incompatible with the physician's role as a healer. Universalizability is, at best, a secondary consideration in this case.

Finally, your discussion of respect for human dignity (in the context of the choice of whether to inform a terminally ill patient of her prognosis) could be both more focused and more persuasive. We need a real case, for one, but aside from that, it's unclear how importing the concept of respect for persons helps here, and it may even threaten the case that

you're trying to make. After all, failing to disclose a prognosis, particularly when deciding on a plan of care, seems to amount to a violation of the standard of informed consent, which constitutes a paradigmatic failure to respect the patient as an end-in-itself. Additionally, and beyond that, I was a little surprised not to see more attention given to the classically Kantian notion of instrumentalization or treating people merely as means—a topic with an already substantial literature. It seems to me that deploying this notion might enable us to critically evaluate different practical options in clinical ethics much more plausibly than the CI procedure or abstract talk of respect for human dignity. Considering how some procedures are tantamount to treating patients merely as means would improve the paper.