The relevance of Kant's philosophy for contemporary medical ethics

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Abstract

In this article I briefly consider the limitations of principlism, before considering how elements of Kant's philosophy can support medical ethics. I highlight the difference between the medical profession and other jobs, and consider how Kant's political philosophy potentially offers support to universal healthcare. I then consider how science and technology studies are essential for a more robust approach toward biomedical ethics.

Keywords Ethics; Kant; principlism; science and technology studies; universal healthcare

Key points

- Traditional ethical accounts are not suitable for resolving issues in contemporary medical ethics
- Principlism offers little guidance for managing moral disagreements and is in danger of becoming a mere checklist, rather than an ethical framework
- Aspects of Kant's philosophy, such as his account of duty, highlight the exceptionally high level of commitment required from the medical profession
- Research from science and technology studies (STS) helps to expose underlying inequalities and injustices in medical ethics

Can the 18th-century German Idealist philosopher Immanuel Kant offer anything valuable to contemporary discussions relating to biomedical ethics? Most people who have come across Kant's philosophy in passing are probably familiar with his account of the categorical imperative. Put simply, he argues that, in order to be moral, we ought to formulate and live by maxims that are universalizable. This means that there cannot be any exceptions where the maxim could be broken by anyone, at any time, and still be considered morally right. These maxims must never treat others as means to an end (which Kant terms a hypothetical imperative), but rather as ends in themselves. Moreover, Kant argues that we have a *duty* to follow maxims formulated as categorical imperatives, otherwise we fail to manifest our freedom to the best of our abilities. Le Morvan and Stock (2005) argue that the ideal of never treating others as means to an end is incompatible with medical ethics as new medical procedures often involve high learning curves and require using living patients to learn new techniques, sometimes putting patients at additional risk and harm (see Further reading).

One of few examples that Kant offered for a categorical imperative was that of never lying. A caricatured example is to imagine that an axe murderer comes to your door with the intention of killing your family and asks for their location. According to the example, those guided by Kantian ethics are required by duty to tell the truth to the axe murderer. I suspect this example is deployed to show the absurdity of ascribing to Kant's moral philosophy and the outrageous demands it places on reason over our other motivations in life such as love for our family.

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Clearly, there is a widespread belief that traditional ethical accounts are not appropriate for medical ethics. Philosophers disagree about the most seemingly straightforward aspects of ethical theories. The concepts used in Kant's philosophy, such as freedom and duty, are not commonplace in medical settings. In response to the inadequacy of previous theories when considering medical ethics, Tom Beauchamp and James Childress first published *Principles of Biomedical Ethics* in 1979.

Beauchamp and Childress's account, generally referred to as principlism, has become dominant within medical ethics. They propose that within medical contexts ethical decisions should be guided by four foundational principles: respect for autonomy, non-maleficence, beneficence and justice. These principles are non-hierarchical, meaning that no principle can take priority over any other. Principlism attempts to bring together two leading theories in traditional ethics: utilitarianism and deontological (or Kantian) ethics.

One criticism of principlism is that it inevitably leads to conflicts. These can either be conflicts arising between the four principles, leading to questions about how to prioritize them, or conflicts between the attempt to combine utilitarian and deontological theories. According to K. Danner Clouser and Bernard Gert, 'Each principle seemed to have a life and logic of its own, as well as a number of internal conflicts' (p. 231). Clouser and Gert also charge principlism with simultaneously recognizing the importance of moral theories above principles without providing any framework for resolving inevitable conflicts between different moral theories when considering moral actions. An adequate moral theory needs to 'explain both our moral agreement and disagreement, and show which disagreements can be settled and which cannot, and why' (p. 233). Principlism offers no method for managing moral disagreements, and thus is not fit for purpose.

In the previous edited collection, I defended principlism by arguing that although there might be differences between actions undertaken by the guidance of the four principles, this did not entail that the principles themselves were not universal (see Further reading). I underestimated the danger with principlism as it does not offer any way to reconcile the internal differences

that arise, and this means that it cannot offer any substantial direction for resolving disputes. Clouser and Gert state:

> At best, "principles" operate primarily as checklists naming issues worth remembering when considering a biomedical moral issue. At worst "principles" obscure and confuse moral reasoning by their failure to be guidelines and by their eclectic and unsystematic use of moral theory. (p. 220)[1]

Clearly, Childress and Beauchamp did not intend principlism to amount to a mere checklist, but it has come to serve that function because of the way it is taught to medical students. According to Autumn Fiester, 'it is not the theory of principlism that is taught to student clinicians but, rather, a very abridged substitute, which is more akin to a checklist than an exposition of a nuanced moral framework' (p. 684).[2] Although principlism emerged from the need for an ethical system specific to medical practitioners, in practice it does not provide sufficient engagement with the supporting ethical theories that underpin the core principles of the theory. These shortcomings of principlism justify engaging with alternative ethical accounts to offer new perspectives to contemporary medical ethics.

Principlism has offered little defence against the rise of the corporate consumerist models of medical care that have resulted in the dehumanization of the medical profession and the deterioration of the physician–patient relationship (Donaldson, 2017). Although the challenges of contemporary medicine are significantly different from the issues that motivated Kant's ethics, his unwavering commitment to universal common humanity and duty towards humanity offers a defence against the 'depersonalizing influences of modern medicine' (Donaldson, 2017, p. 843).[3] Robyna Kahn (2005) states that a Kantian approach to healthcare would require us to treat individuals equally insofar as they are finite rational beings without any consideration of their financial stability, reputation, or character (see Further reading).

It is possible to use a Kantian perspective to highlight the high moral demands specific to those working in the medical profession. Garrath Williams and Ruth Chadwick draw on Kant to explain the distinction between professions and jobs. In *Groundwork*, Kant imagines a situation where a shopkeeper keeps their prices competitive in order to retain customers; the shop is not acting out of a sense of duty and is thus merely carrying out a job. In contrast, Williams and Chadwick (2012) argue that working in medicine is a profession because it demands a commitment and motivation to act for the integrity of the role (see Further reading).

In his political philosophy, Kant hints at the societal responsibility for public healthcare and education. He argues that we must presuppose a unified will of the people to develop a society that will perpetually maintain itself. In such a society, it is the responsibility of the state to 'maintain those members of society who are unable to maintain themselves'. Kant suggests that the state ought to achieve this by taxing wealthy individuals to provide basic support for those in need. The wealthy are obliged to fulfil this role for the state, 'since they owe their existence to an act of submitting to its protection and care, which they need in order to live' (Kant, 1996, p.468).[4]

Clearly, aspects of Kant's philosophy can offer some support to contemporary healthcare, from the level of individual responsibilities of healthcare professionals, to how ethics is taught to healthcare professionals, to how the healthcare institution is potentially dehumanizing. But Kant's philosophy offers little beyond an alternative outside perspective from the corporate consumerist model of healthcare. This is helpful to an extent, but we also need a contemporary *critique* of the medical profession. Critique should not be regarded as showing to be false, but rather as uncovering the presuppositions that underpin the medical profession from within.

In this sense, work in science and technology studies (STS) is a crucial element for engaging with medical ethics. Julia Knopes argues that STS can benefit medical students as it challenges the progress narrative by revealing that there are multiple epistemological perspectives at play in medicine, which have at times marginalized the perspectives of women and postcolonial communities (Knopes, 2019).[5] STS helps to uncover the ways that values have shaped, and continue to shape, all areas of society.

Some might object as an STS perspective draws attention to deeper complexities when deliberating medical ethics. Many medical professionals want medical ethics to provide them with a single correct answer for issues that arise, and in many cases adopting an STS approach moves this type of answer beyond our grasp. However, ethics rarely allows us to establish such clarity; in ethics we outline what someone ought to do, which relies on a different kind of reasoning from reasoning about factual matters, which are generally empirically verifiable. As Clouser and Gert noted, what we need is a system that helps to mediate moral disagreements, STS perspectives draw attention to how these disagreements often require us to consider the role of different underlying narratives and epistemologies. ◆

KEY REFERENCES

1 Clouser KD, Gert B. A critique of principlism. *J Med Philos* 1990; **15:** 219–36.

2 Fiester A. Viewpoint: why the clinical ethics we teach fails patients. *Acad Med* 2007; **82:** 684–9.

3 Donaldson CM. Using Kantian ethics in medical ethics education. *Med Sci Educ* 2017; **27:** 841–5.

4 Kant I. The metaphysics of morals. In: Gregor MJ, ed. Practical philosophy. Cambridge: Cambridge University Press, 1996; 353–604.

5 Knopes J. Science, technology, and human health: the value of STS in medical and health humanities pedagogy. *J Med Humanit* 2019; **40:** 461–71.

FURTHER READING

Jones A. Principlism in medicine – a philosopher's view. *Medicine* 2020; **48:** 63–9.

Kahn RI. Clinician's duty to care; a Kantian analysis. 2005, https://www.longwoods.com/content/17389 (accessed 31 December 2023).

Le Morvan P, Stock B. Medical learning curves and the Kantian ideal. *J Med Ethics* 2005; **31:** 513–8.

Williams G, Chadwick R. Responsibilities for healthcare – Kantian reflections. *Camb Q Healthc Ethics* 2012; **21:** 155–65.

