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# Don't Know, Do Not Resuscitate: A Principle for the Creation of the Kingdom of Ends in the ICU

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Colby College

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# **Don't Know, Do Not Resuscitate: A Principle for the Creation of the Kingdom of Ends in the ICU**

**Griffen Isaac Allen  
Colby College  
Department of Philosophy**

**First Reader: Lydia Moland, PhD  
Associate Professor of Philosophy**

**Second Reader: Paul Berkner, DO  
Colby College Medical Director**

This thesis, *Don't Know, Do Not Resuscitate: A Principle for the Creation of the Kingdom of Ends in the ICU*, is submitted in partial fulfillment of the requirements for Honors in Philosophy  
by Griffen Allen

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First Reader: Lydia Moland, PhD  
Associate Professor of Philosophy

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Second Reader: Paul Berkner, DO  
Colby College Medical Director

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## **Chapter I**

### *An Introduction*

Everybody dies, but some deaths are better than others. Around 2.5 million of those people who die each year are Americans who die from pathologies like lung cancer, heart disease, pneumonia, accidents, and numerous other causes that have plagued humankind its entire history. Whereas from the beginning of recorded history these ancient diseases and afflictions mostly ended without significant human intervention beyond herbalism, religious ritual, and comfort care, beginning in the 1950s and 60s the advancement in medical knowledge and technology has brought a new form to death to countries like the United States. These new deaths tend to take place in wards of hospitals called Intensive Care Units (ICUs). These ICUs represent the pinnacle of modern medical treatment in which the cutting edge of medical progress is brought to bear in the war against disease and death. These new and powerful medical technologies range from mechanical ventilators, to powerful drugs, daring surgical interventions such as organ transplants, and electric defibrillation. With these technologies, it is possible to replace or at least mitigate the failure of various physiological functions, and sometimes a victory can be won against the process of disease and a recovery achieved. However, frequently disease and medicine reach a stalemate in which the patient rests in a Kafkaesque stasis between life and death, and this stalemate should not be considered a calm stasis between life and death.

Rather this stalemate is like the trench warfare found on the Western Front of the First World War in which the two sides slowly shift positions at the price of great pain and human suffering until ultimately there is either a breakthrough or the powers that be surrender after deciding the suffering is not worth the possibility of victory. What happens all too often is that a

patient will become seriously ill without an advance directive dictating how they would like to be cared for, so if they lose the capacity to make decisions for themselves then legally a loved-one such as a partner, child, or sibling gains the power to make medical decisions for them as their surrogate. Consider the hypothetical case:

An 82 year old COPD (Chronic Obstructive Pulmonary Disorder) patient is moved into the ICU from the regular inpatient wards or emergency department, because their condition requires constant medical attention. The intensivist physician tells the family that their loved one is not breathing well, and placed a tube down their throat to ventilate them manually through a mechanical ventilator. He does not want to crush their hopes and is uncertain about the patient's prognosis himself, so he offers words of encouragement to the family concerning the possibility of their loved-one's chances. However, the patient develops sepsis secondary to a hospital acquired bacterial pneumonia that requires IV antibiotic therapy and pressors to compensate the loss of blood pressure secondary to sepsis. The patient remains like this for a few days, but the patient is failing to respond to antibiotic therapy. One of the pressors ordered by the physician to help combat the sepsis, levophed (norepinephrine), is beginning to cause necrosis in the patient's appendages through its vasoconstrictive effects. As a result, one of the patient's toes becomes gangrenous, and a surgeon is brought in to amputate it. As the anesthesiologist induces the patient for surgery the patient's heart enters an arrhythmia and accordingly ceases to pump blood effectively. The anesthesiologist notices this and a 'code blue' i.e. adult cardiac arrest is called. A normal sinus rhythm is restored after three minutes of chest compressions and anti-arrhythmic medications. The surgery is cancelled, and the only thing the patient has to show for it on their return to the ICU is a few broken ribs. The ICU physicians reach the conclusion that it is unlikely that the patient will return to health and approach the family about getting a "Do Not Resuscitate" order to move to comfort care measures. However, the family does not wish to "give up" on their loved one, and out of guilt, fear, and some remnants of hope does not wish for a DNR to be issued. As a side-effect of the powerful antibiotics the patient is being treated with this the patient begins to develop renal failure, and now requires dialysis multiple times a day. A day or two later the patient codes again, and after twenty minutes of sustained effort the physicians 'call the code' and declare the patient deceased. System after system of organs were replaced, but ultimately death won out after a painful Sisyphean struggle.

This will sound like a horror story to those not familiar with medicine; however, to those familiar with end-of-life care this case represents a paradigmatic course of treatment for many

patients. The initial diagnosis that brought the patient into the hospital may vary, their disease course may vary, the complications that arise from treatment may vary, and ultimately how they die may vary. However, the sort of death that happens in the ICU will broadly resemble the course of the patient described above with the variance tending to be in the details rather than the big picture. The pattern of a patient getting ill, their condition deteriorating, and their organ systems slowly being replaced delaying death until either death overwhelms the human ability to intervene or the family decides the cost of continuing this stalemate is too great and nevertheless is repeated daily in almost any American ICU. It is an unambiguously painful way to die, and what little consciousness the patient may have through this process will likely be a blur of pain, confusion, and helplessness.

The deeper connection between all these deaths is the immense uncertainty that dominates the minds of all the agents in the ICU from the physicians to the family members of the patient to the patient themselves. The doctors are uncertain of how effective their treatments will be, their patient's prognosis, and their patient's desires. This is despite the fact they have collections of statistics that attempt to paint an empirical picture of the usual course of disease combined with their wealth of experience. The human body is simply too variable and complex to *always* be certain. The patient, if their disease course has not yet destroyed or diminished their intentionality, is likely living in a blur of uncertainty about their future, the workings of the massive institution of the hospital, and the actions of the myriad of healthcare workers swarming around them. The family members may be unsure about what their loved one wants done, what they want done to their loved one, and whether any hope remains for their loved one. Thus,

above all uncertainty reigns, and works together with massive institutional, legal, and cultural factors to create the experience of the American ICU.

What is at the core of this death is a loss of autonomy contingent on the fact that decision making in the ICU is often illusory or impossible. The patient no longer is able to decide the death they want, so it falls to the physicians and family members to make choices that at once respect patient autonomy while also attempting to do the best for the patient. In an ideal situation, the surrogate and doctors will act in a way that respects the will of the patient and treats them as an end in themselves; however, all too often this is not the case as will be shown later. Frequently physicians and family members will decide on courses of action that place their own desires above that of the patient, and accordingly they will peruse aggressive intervention against the best interest of the patient.

This situation then is deeply problematic; however, what must be done to solve this problem is also uncertain. In my thesis I want to prove first that the American ICU is a painful and uncertain place that decreases patient autonomy, and then as a solution suggest a principle I call “Don’t Know, Do Not Resuscitate” that will be couched in neo-Kantian moral thought. I believe this principle could offer a deeply useful tool to cause a change in the way Americans are cared for at the end of their lives. I argue this currently in violation of the version of the Kantian Categorical Imperative known as the Formula of Humanity. This is a Kantian principle that demands all people be treated as ends in themselves and never merely as means to an end. People can never be simply used for some means then, and instead they must always be treated as what they essentially are, a person. I hope this principle will help replace conceptions of autonomy that focus on unrestrained choice with a more meaningful definition of autonomy based around

principled self-legislation as found in the version of philosophers like Immanuel Kant, Christine Korsgaard, and Onora O'Neill. In doing so it is possible to achieve the progress needed to create and a Kingdom of Ends in the ICU.

Accordingly, to address this problem I will first make the uncertainty and pain that dominate in the American ICU manifest in my chapter entitled "How Americans Die: An Exploration of the Factors that Create the Form of Death in the ICU." This chapter will demonstrate through the use of Sharon Kaufman's *And a Time to Die* that death in America is a complex and Kafkaesque process, created by the confluence of several factors, which ultimately does no favors for the doctors, patients, nurses, or family members. Her argument highlights the immense uncertainty found in the American ICU, and points to how it makes meaningful autonomy difficult. Although her account is an anthropological one, and does not enter to the complexities and many forms of autonomy discussed in the philosophical literature, it will provide a framework for my more explicitly philosophical analysis in the following chapters.

My third chapter "The Don't Know, Don't Kill Framework: Alexander Guerrero's Moral Epistemic Contextualism" will introduce Alexander A. Guerrero's paper "Don't Know, Don't Kill: Moral Ignorance, Culpability, and Caution" and its principle "Don't Know, Don't Kill" (DKDK). Guerrero makes a strong defense of the concept of moral epistemic contextualism, and through it reaches his DKDK principle. This principle advocates for not killing an animal in the face of moral uncertainty regarding the moral status of the creature. This principle has great potential for modification for other situations, and I will build my own principle, "Don't Know, Do Not Resuscitate" (DKDNR) of moral epistemic contextualism from it. My revised principle will center on how one must act (or not act) in the case of the uncertainty found in the ICU.

A key feature of Guerrero's principle is that it is normatively neutral, which is to say that it can be adjusted to function in any number of normative theories. Therefore, to develop my own extension of Guerrero's principle it is necessary to put forward a normative theory to guide the principle. I will do this in my fourth chapter, "Kant, Korsgaard, and O'Neill: The Neo-Kantian Reformulation of Kant's Insights," through exploring the normative claims made by Immanuel Kant in his *Grounding for the Metaphysics of Morals* and how his contemporary commentators, Onora O'Neill and Christine Korsgaard, have reformulated and deepened his original insights. Kant's normative framework is incredibly useful in diagnosing the problem that produces the form of death that dominates today in the ICU, is that within the current decision making paradigm meaningful autonomy is lost.

It is important to note here why I have decided to use a Kantian framework, so that the reader understands the general intuitions behind my thought. It is clear that no one is ever going to announce on CNN that philosophers have found the objectively correct moral theory that everyone can agree upon. That would be absurd. However, in order to undertake this project I feel it is important that I firmly plant my feet in a moral theory so as to avoid vagueness and contradiction. Kant's moral theory I feel captures most accurately what it means to be a moral agent, and the normative claims he draws from this then most persuasively give an account on what matters in the life of a human. Put shortly, to be human is to live a life among other people where as an agent one must respond to the "tug" of necessitation. A key part of responding to this tug is that one must treat all other humans as being truly human rather than simply as an object. All too often other people use their fellow humans as mere tools to achieve their goals. However, people are ends, and to make oneself free it is necessary to realize this principle. A

world in which this principle is most fully realized is then a Kingdom of Ends. My use of Kant this stems from my belief that his concepts can lead us well in our ethical lives, and that his view of people as ends and never merely as means combined with his emphasis on giving oneself the moral law is uniquely applicable in a healthcare setting. Ultimately, then, I will use this Kantian normative theory to demonstrate how efforts to create a Kingdom of Ends where all patients (and people more generally) are treated completely as ends in themselves can resolve the deep problems that are present today in the ICU.

Once this first-order normative theory is elucidated, it then can be combined with Alexander Guerrero's framework to form the basis of a principle of DKDNR. This principle will primarily argue that if deep uncertainty is present over the future outcome of a course of treatment for a patient at what might be the end of their life, then extreme care should be taken by physicians and surrogates before deciding upon an aggressive course of treatment that can cause significant pain and dehumanization. Morally this is based upon the fact that often in deciding upon an aggressive course of treatment patients' families and physicians may not actually be treating the patient as an autonomous agent, accordingly violating the Categorical Imperative. Therefore, my principle of caution will be an attempt to move towards the creation of a Kingdom of Ends in the ICU through advocating for caution before action in the case of uncertainty to prevent the risk of violating the Kantian autonomy of the patient. In my later chapters I will consider objections, and I hope to show that my principle is a strong one through demonstrating its practical applications and future directions for its use.

In all, DKDNR is a principle that emphasizes the fact that our society deals with death very poorly, and this manifests itself through the means of the application of technology in the

ICU of hospitals across the United States. We do everything to prevent death while ignoring the fact that death is an essential part of being human and the fact that ultimately we cannot stop death. In fact, there are far worse things than death, and one is being kept in a painful and dehumanizing limbo for days, weeks, or months before physicians and family members finally allow you to die. This is exemplified in the novel, *The House of God*, written by Samuel Shem and published in 1978. In this account, a second year resident tells a new intern that most of what they do involves treating people who have no hope of recovery: “[their patients] are human beings who have lost what goes into being human beings. They want to die, and we will not let them.”<sup>1</sup> Through change, this tragedy can be avoided, but this change necessitates the development of a true kingdom of ends in the ICU. For this to be possible many factors must change, and I want to suggest a principle of DKDNR can be part of this change. We need to remember how to die in America, and we need to remember how we must treat our fellow humans. My principle can help achieve this realization of the Kingdom of Ends.

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<sup>1</sup> Samuel Shem, *House of God* (New York: Dell Publishing, 1978) 17.

## Chapter II

### *How Americans Die: An Exploration of the Factors that Create the Form of Death in American ICUs*

What does it look like to die in an American Intensive Care Unit (ICU), and what causes people to die in the specific way they do? This is the question that must be answered in order to characterize the problem of death in America. It will be intuitively clear from mere empirical description that death in this manner is unmistakably awful and deeply problematic; however, I will refrain from a thorough philosophical diagnosis until chapter V after I introduce a neo-Kantian framework for discussing precisely why the deaths that occur in the ICU are so distasteful from a more abstract and rigorous standpoint. Yet before that is possible it is first necessary to simply paint a picture of death in the ICU and point to the cultural, institutional, and others factors that manufacture such deaths.

In order to accomplish this I will first discuss in general terms the technological tools and activities that are essential to the practice of critical care medicine, while still avoiding an overly technical discussion of the various aspects of end of life care. Following this general sketch of what an ICU does with the tools it has at its command it will be possible to describe the decision making process of a person in an ICU. Due to many patients' inability to make their own decisions as a result of their medical condition, surrogacy, having a family member or other legal representative acting as their medical decision maker, is necessary. Accordingly, since this happens frequently, and will later be demonstrated to be often problematic in practice, I will take particular care to describe this role and its function. Once the basics of how decisions are reached in the ICU become clear then it will be possible to examine the effects of these decisions and what institutional and cultural factors create the environment these decisions are made in. In this

section I will rely heavily on Sharon R. Kaufman's *And a Time to Die*, which turns an anthropologist's eye towards how personal, institutional, and ideological factors work together to manufacture what death looks like in America in a single ethnography. Finally, I will then summarize the various intuitions that arise concerning why such deaths feel so wrong in order to discuss the underlying problem of these intuitions (an utter loss of meaningful autonomy as a result of the uncertainty of several agents) in chapter V.

### **What is an ICU? Medical and Technological Factors**

In the introduction I recounted a hypothetical case of a patient in the ICU and introduced some of the interventions and relevant technologies; however, for the sake of clarity and completeness it is necessary to formally recount the history and function of the ICU. An ICU or intensive care unit is a medical ward designed for people who need “constant medical attention and support to keep their body functioning. They may be unable to breathe on their own and have multiple organ failure. Medical equipment will take the place of these functions while the person recovers.”<sup>2</sup> The ICU is designed centralize medical resources to the benefit of a deathly ill patient in order to stabilize the patient so they have a chance them to recover. The development of these units began around fifty to sixty years ago with the development of intensive care units to closely monitor patients post-operatively. Respiratory intensive care units for degenerative neuromuscular conditions followed in the 1950s, and ultimately cardiac intensive care units followed in the 1960s.<sup>3</sup> Following these initial forays into intensive care medicine, neonatal care units, burn care units, and pediatric units were established to take

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<sup>2</sup> “Intensive Care,” *NHS.uk*, last modified September 7, 2014, <http://www.nhs.uk/conditions/Intensive-care/Pages/Introduction.aspx>.

<sup>3</sup> John M. Luce and Douglas B. White, “A History of Ethics and Law in the Intensive Care Unit,” *Critical Care Clinics* 25, no. 1 (2009): 224.

advantage of the new technologies of mechanical ventilation, dialysis, defibrillation, and other novel medical interventions. These technologies combined with an ever-increasing amount of medical knowledge regarding physiology and pharmacology gave physicians a new and startling power over when death would come.

Previously an inability to breathe, filter wastes, regulate the heart's electrical activity, or any number of other basic physiological activities would mean death; today that is not necessarily the case. If a patient's respiratory drive fails then they will be intubated with an endotracheal tube, and then a mechanical pump will breathe for them at an adjustable rate, tidal volume, oxygen concentration, and a myriad of other settings. Sometimes taking over an organ system or two can allow the patient's body to recover with the help of medicine, surgery, or time, and accordingly allow them to return to a normal or mostly normal life. However, often this is not the case, and instead of winning a medical victory, a medical stalemate with disease is reached if the body's regenerative capacities cannot respond to the disease sufficiently. In this common case, organ systems will fail one by one until either the disease process overcomes the ability of the physician to intervene or the care required is decided to be futile and abandoned. Therefore, despite all efforts, after a time hovering at the fuzzy boundary between life and death patients eventually die. It is then sufficient to say that the close monitoring combined with modern ability to delay death through technology makes the ICU essentially what it is today. ICUs then are reserved for the sickest of patients, and today are incredibly popular for their ability to prolong (while not necessarily save) human life. In fact, one in five Americans will die

in an ICU, which makes it deeply important to understand what death looks like and what factors apart from the technological aspect discussed above produce such deaths.<sup>4</sup>

### **How Decisions Are Made in ICUs**

The necessary technology and knowledge is, then, readily at the hands of doctors; however, the question remains as to how it is applied and what guides this decision since this application is the most immediately visible factor that determines how someone dies in an ICU. From the standpoint of the physician, it can be generally said that they aim to make decisions out of the best interest of the patient in keeping with the current best practices established by the evidence-based practice of medical research. A central principle of modern medical ethics is that patients must make their own choices regarding their treatment rather than simply have their course of treatment dictated to them by a physician. Thus, the modern patient-physician relationship is centered on a model in which “clinicians help patients define their best interests, provide treatment alternatives through which the interests can be served, and assist the patients in deciding which alternative is best.”<sup>5</sup> In fact, a medicine given or a surgery performed without the consent of the patient to treatment is legally nothing but assault, and professionally considered a grievous breach of medical ethics and professionalism. However, in the course of medical treatment due to the patient’s condition or the treatment itself often the patient is rendered either unconscious or irrational, and accordingly cannot decide for themselves. In this case, the current practice is that legally power of attorney is transferred to the closest living and component relation so that they can direct the course of treatment for the patient. This person is termed the

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<sup>4</sup> Derek C. Angus et. al., “Use of intensive care at the end of life in the United States: an epidemiologic study.,” *Critical Care Medicine*, 32, no. 3 (2004): 638-643.

<sup>5</sup> Luce and White, “A History of Ethics and Law in the Intensive Care Unit,” 225.

surrogate, and acts on the principle of substituted judgment. This principle is derived from the idea that it supports the “patient’s autonomy by leading us to the decision that the patient would have wanted.”<sup>6</sup> There are problems with this principle achieving this as I will demonstrate later, but it is generally the dominant means of decision making for most ICU patients today since only “fewer than 5% [of ICU patients] have sufficient mental competence to make their own decisions.”<sup>7</sup> Therefore, surrogacy is an essential concept to the ICU that demands both discussion and critique. I will describe surrogacy in this chapter, while it will be addressed in a critical manner chapter V once a Kantian framework for a critique is introduced in chapter IV.

In order to determine whether the patient may decide for themselves or if a surrogate is necessary, one must determine whether or not the patient is a competent decision maker. So, what practically constitutes competency for medical decision-making? A paper published in the July 15, 2001 issue of *American Family Physician* titled “Can the Patient Decide? Evaluating Patient Capacity in Practice” suggests practical methods of doing this. It suggests that four key abilities are required to be present for the patient to be considered competent to make their own decision: “the ability to understand information about treatment; the ability to appreciate how that information applies to their situation; the ability to reason with that information; and the ability to make a choice and express it.”<sup>8</sup> Typically patients are considered competent until proven otherwise, and accordingly are allowed to make decisions about their care in keeping

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<sup>6</sup> Alexia Torke et al., “Substituted Judgment: The Limits of Autonomy in Surrogate Decision Making,” *Journal of General Internal Medicine* 23, no. 9 (2008): 1514.

<sup>7</sup> TJ Pendergast and JM Luce, “Increasing incidence of withholding and withdrawal of life support from the critically ill,” *American Journal of Respiratory Critical Care Medicine* 155, no. 1 (1997): 15-20.

<sup>8</sup> Marc Tunzi, “Can the Patient Decide? Evaluating Patient Capacity in Practice.,” *American Family Physician* 64, no. 1 (2001): 299.

with the present medico-ethical-legal paradigm. However, Tunzi suggests there are four situations in which capacity should be evaluated more closely:

The first occurs when patients have an abrupt change in mental status...the second occurs when patients refuse recommended treatment, especially when they are not willing to discuss the refusal, when the reasons for the refusal are not clear or when the refusal is based on misinformation or irrational biases. The third occurs when patients consent to particularly risky or invasive treatment too hastily and without carefully consideration of the risks and benefits. The last scenario occurs when patients have a known risk factor for impaired decision making.<sup>9</sup>

These conditions are sufficient but not necessary indications of diminished capacity, and these patients “may still be able to make their own decision.”<sup>10</sup> The article then suggests that physicians either use a directed interview technique or a formal questionnaire to evaluate capacity to make a “final assessment of whether a patient has medical decision-making capacity [that depends] whether the physician believes the patient is free of significant psychopathologic-impaired thinking and possesses sufficient abilities to make the specific in question.”<sup>11</sup> It is important to contextualize these in the culture and abilities of a patient, because patients with poor health literacy “may not completely understand all of the alternatives...however, they may still have enough understanding overall to make their own decisions.”<sup>12</sup> The physician then makes a judgment of capacity; however, in technical terms competence is a legal matter. If the physician deems the patient competent then the patient must take charge of their care as a legal agent, and if the patient is not competent “in the best-case scenario, the patient may have previously appointed an agent; in the worst-case scenario, the court may need to become

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<sup>9</sup> Tunzi, “Can the Patient Decide?,” 300.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

involved” to decide who can decide for the patient.<sup>13</sup> The surrogate then will either attempt to “make decisions based on principles of ‘substituted judgment’ (what the patient would have decided) or ‘best interest’ (what the surrogate judges to be best for the patient).”<sup>14</sup>

Therefore, as patients enter the ICU they may be initially competent to make their own decisions; however, ultimately most (95%) will have decisions made for them by surrogates. These surrogates will most often be a spouse, parent, or child who will either be individually appointed as the decision maker in an advance directive or will work together with the family to reach a decision. In the ideal form this protects the autonomy of the patient due to the close relationship between the surrogate and their incapacitated family member. Having spent a lifetime with this person, after a lifetime of discussions about what their family member would have wanted, and after careful discussion with the physicians caring for their family members, the family reaches a decision for care that is in line with the wishes of their loved one. In this way “one may argue that the families are best able to represent what the patient would have wanted, if he or she were competently able to consider the decisions at hand.”<sup>15</sup> Furthermore, even beyond the decision itself, this principle ideally respects who the patient would like to make their decision, since “studies suggest that in 90% of cases, patients want a family member to make decisions with the doctor about their care.”<sup>16</sup> This is how medical decisions are formally made in the ICU.

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<sup>13</sup> Tunzi, “Can the Patient Decide,” 306.

<sup>14</sup> Ibid.

<sup>15</sup> Robert Arnold and John Kellum, “Moral justifications for surrogate decision making in the intensive care unit: Implications and limitations,” *Critical Care Medicine* 31, no. 5 (2003): 348.

<sup>16</sup> Ibid.

### What These Deaths Look Like

When a patient enters the ICU with an illness, what is the effect of the current decision making paradigm? In other words, when a patient and their family members navigate the ICU through their decisions, what sorts of deaths are produced? Ostensibly, if surrogacy works as well as it ought to then the deaths produced by the decisions should be good deaths, because as the old Platonic principle suggests no one would willingly choose a bad death for themselves or their family members.<sup>17</sup> However, a cursory examination of the deaths that occur in the ICU seem to suggest something is failing because the deaths produced do not seem *prima facie* to be the sort of deaths that anyone would willing choose for themselves or a loved one.

As discussed above, the primary function of the ICU is to closely monitor very ill patients and centralize the technology and expertise needed to replace the failing organ systems and physiological functions of the patient. These tools represent the forefront of medical knowledge and research, but they also are not harmless. A short survey of some of the most popular tools will demonstrate this. CPR breaks ribs<sup>18</sup>, mechanical ventilation is deeply stressful and unpleasant, commonly given drugs cause skin necrosis, psychological problems such as post-traumatic stress disorders follow successful ICU courses, and the disease itself may be intensely painful..<sup>19,20,21</sup> Physicians and nurses work to alleviate these issues through pain management, comfort measures, and other interventions, but ultimately only so much can be done. In short, it

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<sup>17</sup> Typically phrased as either everyone desires the good, or alternately at least that no one desires the bad

<sup>18</sup>Kevin Wininger, "Chest Compressions: Biomechanics and Injury.," *Radiologic Technology* 78 no. 4 (2007): 269-74.

<sup>19</sup>AJ Rotondi et al., "Patients' recollections of stressful experiences while receiving prolonged mechanical ventilation in an intensive care unit.," *Critical Care Medicine* 30 no. 4 (2002): 756-52.

<sup>20</sup>Stephen Close et al., "Cutaneous Necrosis Due to Norepinephrine II: Mechanism and Prevention.," *Annals of Surgery* 147 no 1. (1958): 44-50.

<sup>21</sup>Peter Scragg et al., "Psychological Problems Following ICU Treatment.," *Anaesthesia* 54 no. 1 (2001): 9-14.

is sufficient to say the activities of the ICU involve an amount of pain. However, discomfort alone does not necessarily mean anything is wrong, for people are more than willing to suffer in order to achieve some higher end. What ultimately matters in the ICU, however, is that often these interventions are futile, and thus in many cases it seems that patients who have no hope of survival are simply being tortured before their deaths. One in five Americans will die in an ICU, and so to repeat for emphasis, 20% of all Americans will have this awful experience before they die. Is such aggressive care necessary in each case?<sup>22</sup>

The first large study to empirically examine this problem was the SUPPORT Study or “A controlled trial to improve care for seriously ill hospitalized patients the study to understand prognoses and preferences for outcomes and risks of treatments.” It was published in the 1996 edition of the *Journal of the American Medical Association*, and its original intent was to address the growing problem of excessive end-of-life care, and to “improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged process of dying.”<sup>23</sup> This was accomplished through a 2-year long prospective observational study phase followed by a randomized control trial 2-year phase with around 10,000 patients involved. This study’s results in the first phase highlighted the magnitude of the problem with the healthcare system falling short on several key points including time from DNR to death, amount of patients in moderate to severe pain, low level of communication, and when communication happened its clarity was lacking. In short, it quantified a problem that physicians were gradually becoming aware of, and demonstrated that large numbers of Americans were dying in an undesirable

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<sup>22</sup>Angus, “Use of intensive care at the end of life in the United States: an epidemiologic study.,” 638-643.

<sup>23</sup> Alfred Connors et al., “A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT).,” *Journal of the American Medical Association* 274, no. 20 (1995): 1591-1598.

manner. It made it clear that how Americans were choosing to die seemed to be directly against their own interests or that of their family members.

Such results are further emphasized when physicians are interviewed on their feelings about how the patients in their care die. A recent 2015 qualitative study of medical residents highlights this issue well. One resident reported in the course of their treatment of a patient in the ICU that “it felt horrible, like I was torturing him. He was telling us we were torturing him. I did not think we were doing the right things.”<sup>24</sup> The study found that such an attitude was far from isolated, and in fact among medical residents in their study population it was quite common. The core of their moral distress then is the fact they are providing extremely aggressive care to patients who have no hope of recovery, but for whatever reason have ended up in the ICU. The resident continued:

We are torturing this poor gentleman; that is really all we are doing. I do vaguely feel uncomfortable about the general gestalt of what we do in the ICU to people at the end of life. I feel morally sick to my stomach about it of course. Some of what we do is awful, but some of those things have also given me the skills to resuscitate [others]. I don't mean to justify the torture that we put our elderly critically ill and dying through, but it did provide me with many learning opportunities to help people who then could be saved.<sup>25</sup>

Thus, physicians feel that they are forced to perform brutal procedures that they can only justify to themselves with great effort through such rationalizations as discussed above e.g. ‘it makes me a better doctor.’ Generally speaking, physicians then simply do not desire to treat patients who have no hope of recovery in such an aggressive way, because such treatment is not harmless. Furthermore, nurses show similar or higher distress than physicians in regards to such

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<sup>24</sup> Elizabeth Dzung et al., “Moral Distress Amongst American Physician Trainees Regarding Futile Treatments at the End of Life: A Qualitative Study,” *Journal of General Internal Medicine* 24, no. (2015): 1-8.

<sup>25</sup> Ibid.

treatment.<sup>26</sup> It is clear then from the perspective of the staff (physicians and nurses) that the number of Americans who are currently dying in this way is undesirable. If physicians and nurses do not want such deaths, it remains to see whether patients themselves or family members desire such deaths.

*Prima facie* one could assume patients would not want to be tortured without good cause before their inevitable death, and this fact is supported by empirical studies of patient wishes and their stability throughout time. A study conducted with 1138 Israeli patients compared to a similar American sample of patients over the age of 70, and it found that a large majority (86%) had a stable (over 3 years) desired less life sustaining treatment. Of those who changed their preferences most had moved from desiring more treatment to desiring less treatment over the study period. This study then indicates that generally physicians can assume that as patients age their desires tend to be stable, and if they change as they age they tend towards desiring less aggressive care.<sup>27</sup> This trend does not in any way override individual decision making in any sense; however, the general prevalence of this trend among a large sample suggests this trend should be taken into account as part of the decision making process. Another study conducted among AIDS patients in Boston found similar results with about three quarters of patients' preferences for care remaining stable. Of those whose preferences changed at follow-up the odds ratio for patients wanting more done follow-up was 0.8 (statistically significant) and the amount of those wanting less treatment was 1.5 (statistically significant). This further confirms that patient desires tend to be stable, and when they change they rarely desire aggressive end of life

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<sup>26</sup>Ann Hamric et al., "Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate.," *Critical Care Medicine* 35, no. 2 (2007): 422-429.

<sup>27</sup>S Carmel and EJ Murtran, "Stability of elderly persons' expressed preferences regarding the use of life-sustaining treatments.," *Social Science and Medicine* 49, no. 3 (1999): 303-311.

care.<sup>28</sup> Both these studies then directly indicate that a frequent reassessment of patient wishes is necessary to ensure extra treatment is not done. However, they also hint at the fact that preferences for less intervention are dominant. In short, while the nature of the ICU makes it difficult to surmise exactly what patients would desire, studies of conscious and competent elderly and terminally ill patients suggest it is safe to assume most would prefer more rather than less done in the light of the painful nature of ICU care. No one wants to die after weeks in pain with no meaningful hope of recovery, and thus it is clear that such deaths are accordingly not desired by patients.

The question of family members acting as surrogate decision desire such deaths is somewhat more complex. A study by Shalowitz et al. published in the Archives of Internal Medicine found that surrogates accurately predicted patient's wishes 68% of the time, which means that one-third of the time they failed to act in accordance with the wishes of patient.<sup>29</sup> This is a huge blow for the concept of surrogacy, since it means that while having a surrogate is somewhat better than flipping a coin to decide what the patient would have wanted, they still get it wrong a significant percentage of the time. *Prima Facie* this seems like a pretty good number; however, if one considers the stakes then the numbers are less encouraging.<sup>30</sup> This means there is a 1 in 3 chance that against their will a patient before they die will be subjected to several rounds of chest compressions (and a few broken ribs from these compressions), an endotracheal tube down their throat, and a machine breathing for them, all the while delirious from sepsis that

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<sup>28</sup> JS Weissmann, "The Stability of Preferences for life-sustaining care among persons with AIDS in the Boston Health Study.," *Medical Decision Making* 19, no. 1 (1999): 16-26.

<sup>29</sup>David Shalowitz et al., "The Accuracy of Surrogate Decision Makers: A Systematic Review.," *Journal of the American Medical Association* 166, no. 16 (2006): 493-497.

<sup>30</sup> Good betting odds certainly!

pressors and antibiotics are failing to overcome. After a week or two of this perhaps then their body will either fail despite the interventions or a family member may decide after two weeks that their loved one should die peacefully. However, it would seem then that family members would not desire such an awful death for their loved one even if occasionally they mistakenly think they would prefer to have more done rather than less. This is borne out by several studies that suggest that family members report higher satisfaction when life support is withdrawn in a timely and appropriate manner, and additionally are generally strongly averse to continuing treatment when there is no clear benefit to survival.<sup>31</sup> After all, no one wants to watch their loved one be tortured before they pass.

### **Why do We Die like This? Sharon Kaufman's Diagnosis**

These deaths are obviously undesirable from all perspectives (family, medical staff, patient), so why do they still happen? There have been several attempts to answer this question, but the medical anthropologist Sharon Kaufman makes the most complete diagnosis of the problem in her book *And a Time to Die*, which I will focus on now. This medical ethnography of end-of-life care paints a complete picture of what these deaths look like and how the current cultural and institutional paradigms in American critical care and medical thought manufacture the deaths that are observed in the ICU. Thus, Kaufman demonstrates how the individual decisions of each actor contribute to answering why deaths at once deeply distasteful and freely chosen occur.

Kaufman divides her book into three sections: "The Predicament," "The Hospital System," and "The Politics and Rhetoric of the Patient's Condition." For the purpose of my

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<sup>31</sup>Cynthia Gries et al., "Family Member Satisfaction With End-of-Life Decision Making in the ICU.," *CHEST Journal* 133, no. 8 (2008): 704-712.

argument the first section is the most useful since it outlines the problem, while the last two sections make an anthropological attempt to diagnose the problem and trace its roots. Kaufman argues that “medical treatment is always invested with a sense both of possibility and foreboding because the inventions that may cause “miracles” also take place in a Kafkaesque setting where events unfold in ways one hardly understands. The result is that most of the time very sick persons do not really ‘decide’ about resuscitation efforts at all.”<sup>32</sup> In other words, a dominant feature of death in American ICUs is that of uncertainty and confusion on multiple levels. The human body is complex enough on its own as a purely physical system, but once the complexities of medical reimbursement, decision making, institutional rules, professional standards, personal relationships, and countless other factors come together what results is a situation dominated by indecisiveness. This indecisiveness thus concerns practical questions of doubling-guessing ‘how much longer will she live?’, ‘will Medicare pay for this?’, and ‘is she hurting?’ as well as normative questions like ‘would he want this?’, ‘what is the goal of this intervention?’, and ‘should I tell the family it's hopeless?’.

In short, everyone in the ICU faces some sort of uncertainty; nevertheless, action is demanded of everyone for “the organization of the institution pushes everyone towards lifesaving treatment, even when hospital staff, patients, or families do not want to prolong dying.”<sup>33</sup> Problematically, “patients and families do not know and cannot know what to want when reacting to a complicated system of rules that is strange to them. Given this system, patients only want to breathe, to escape the place, to get better, or to die.”<sup>34</sup> Therefore, for

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<sup>32</sup> Sharon Kaufman, *And a Time to Die* (Chicago: the University of Chicago Press: 205) 49.

<sup>33</sup> Kaufman, *And a Time to Die*, 29.

<sup>34</sup> Kaufman, *And a Time to Die*, 28.

patients and families the approach toward death is confusing, restricting, and ultimately teeming with uncertainty. They are thrust into a system that demands choice of people who have no training or experience in answering the incredibly complex moral and medical question put on them. To compound this problem “physicians’ prognoses are prone to error, meaning that they tend not to be correct for any given individual...Physician Joanne Lynn and her colleagues have shown that the course of most diseases and the timing of most deaths simply are too unpredictable for accurate prognoses.”<sup>35</sup> Thus, “physicians are not always sure how to act, or which treatment, if any, is best in the long run, yet usually they are compelled to make a choice and do something.”<sup>36</sup> Finally, the traditional conduit between the family and the patients and their family and their doctors, the nurses, are limited by their own uncertainty and in which they do know the fact that they “do not want to overstep their authority.”<sup>37</sup> Therefore, within the hospital there is an abundance of uncertainty that surrounds the process of dying, and the specific examples listed above are not exhaustive. In short, there is a lot of “don’t-knowing” going on in ICUs. Why should this uncertainty be such a deep problem for family members, physicians, and others with decision making power or influence in the ICU? Ultimately, this multi-level uncertainty has many effects; however, there is one that can be clearly traced: uncertainty in agents like family members leads to more aggressive care.

Family members as surrogates often are uncertain whether ending aggressive care, a choice they must make, is the morally and medically proper choice to make. Kaufman describes

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<sup>35</sup> Kaufman, *And a Time to Die*, 32.

<sup>36</sup> Kaufman, *And a Time to Die*, 37.

<sup>37</sup> Kaufman, *And a Time to Die*, 45.

one such situation in which the family's factual uncertainty and ignorance concerning medical knowledge causes harm as a result of poor communication:

Day 14: Two weeks after surgery Mrs. Jones is still in the intensive care unit, her life sustained by powerful medications, delivered intravenously, that keep her blood pressures at a viable level, and by the mechanical ventilator that breathes for her. She is not getting well enough to go home. She cannot be removed from the ventilator. All her organ systems are failing despite the stabilizing treatments, which, staff now acknowledge, are only postponing her death. But the family, as is so typical, does not know what to want. They certainly do not want Mrs. Jones to die. They do not understand her condition in the same way the doctors do, and they have not been informed yet about her impending death.<sup>38</sup>

This is one sort of medical uncertainty due to the recalcitrance of the physicians caring for their loved one to be frank about their prognosis, and accordingly while the family members can see the failing health of the patient they are not confident enough to end aggressive care. However, even with good physician-family communication uncertainty may still dominate, since “ambivalence about what to do as a patient’s condition deteriorates and ambiguity about medical goals as death approaches are common.”<sup>39</sup> Physicians can and frequently are uncertain themselves, and this uncertainty multiplies when discussion with family members occur, so often “because no one could predict with absolute certainty that [the patient’s] condition was irreversible, mechanical ventilation was continued and the patient was transferred to the ICU.”<sup>40</sup> Uncertainty on the part of physicians trickles down, and ultimately when family members must decide, the empirical uncertainty further complicates choice.

More importantly, patients may be morally unsure, even with complete information and an adequate understanding of it, so moral uncertainty is the additional problem that is often

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<sup>38</sup> Kaufman, *And A Time to Die*, 59.

<sup>39</sup> Kaufman, *And A Time to Die*, 39.

<sup>40</sup> Kaufman, *And a Time to Die*, 55.

coterminous with the empirical uncertainty. This can take several forms. For example, questions of what the patient would have wanted or whether it is right to “give up” on the patient are frequent. As previously discussed, surrogates are only moderately accurate about predicting patient desires, and one-third of the time get it wrong. However, in the ICU due to the rapid medical changes and intense nature of treatment such errors may be even higher and more costly. However, a more problematic form of moral uncertainty takes the form of uncertainty of whether “giving up” is the right choice.

This leads often to disputes in which “typically the physicians consider aggressive care to be futile and comfort care appropriate, while the patient’s family or surrogate disagree.”<sup>41</sup> These disputes arise above all because modern technology allows for the preservation of certain bodily functions as organs fail, so this “fosters a growing perception that modern medicine is capable of exerting control over life and death.”<sup>42</sup> Initially, physicians were enamored by these technologies, and used them aggressively; however, “after an initial period of overzealous use of organ replacement support, physicians have recognized their limitations.”<sup>43</sup> Unfortunately, the public perception still has not caught up with this change in physician behavior, so due to a combination of not wanting to “give up” on a loved one and the perception that such efforts to not “give up” will be beneficial to the patient, physicians and families often end up in disputes due to the moral uncertainty of family surrogates over the proper course of action. A qualitative account by Dzung et al. describes the moral conflict felt by physicians and family members in this situation:

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<sup>41</sup> Vickram Tejwani et al, “Issues Surrounding End-of-Life Decision Making,” *Patient Preference and Adherence* 7 (2013): 773.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

When people see their family members suffering and they are there suffering with them, I am more understanding of their decision...I agree with giving the patients choice, but oftentimes it's the family member. If the patient says "Torture me, I want everything done." Fine. The family member is doing it for other reasons. Like guilt, they can't let go.<sup>44</sup>

Thus, frequently surrogates demand excessive treatment out of fear of being morally blameworthy by themselves, others, or by the imagined feelings of their loved-one, and physicians must follow their wishes due to the legal structure within the ICU. Surrogates then are often under immense stress in caring for their loved one, and frequently this stress may lead to unnecessary treatment due to their family members' fear of "quitting" or "letting go."

The combination of empirical and moral uncertainty then contributes a great deal to the deaths produced by the ICU. Empirical uncertainty and moral uncertainty together push family members as surrogates and their physicians to produce the aggressive treatment that leads to such undesirable deaths. As Kaufman's book describes such uncertainty combines with other large institutional factors to create the form of death that a fifth of all Americans endure; however, in terms of the choices of moral agents' ability to directly influence the problem this uncertainty is the clear culprit. Institutional and other factors may push agents in one way or another, but ultimately it still must fall on the agent to choose even if they are constrained by structures. Accordingly, within the ICU the uncertainty and ignorance of the family and physicians of the patients can be proximally attributed for producing the deaths observed.

### **Conclusion**

The ICU was developed as a way to centralize technology and expertise to provide aggressive care for the sickest patients in order to improve their survival chances. However, for

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<sup>44</sup> Elizabeth Dzung et al., "Moral Distress Amongst American Physician Trainees Regarding Futile Treatments at the End of Life: A Qualitative Study," 1-8.

many Americans treatment in an ICU is futile, and amounts to little more than torture before what ultimately is an inevitable death. A neutral observer of the ICU would likely remark that no sane person would choose such treatment if it would ultimately prove to be futile. Physicians, family members, nurses, and the patients themselves agree that such deaths are not optimal. They still occur at an astounding rate, which leads to the question of how this can happen. This diagnosis is deeply complex due to the byzantine nature of the American healthcare system, but one factor that is clear is that the uncertainty, both moral and factual, leads to a failure to act and stop aggressive treatment. In the ICU a failure to act is not benign, since the default course is aggressive treatment. Thus, the deep uncertainty and ignorance of the ICU complicates care, and leads to the question of how one should act in these circumstances.

### **Chapter III**

#### *The Don't Know, Don't Kill Framework: Alexander Guerrero's Moral Epistemic Contextualism*

Given the situation described the previous chapter it is exigent that some action be taken, and I would like to propose that Alexander Guerrero's paper "Don't Know, Don't Kill: Moral Ignorance, Culpability, and Caution" may offer some guidance in the form of the principle he advances. This principle is called "Don't Know, Don't Kill" or DKDK. It pertains specifically to the ethics of the consumption of the meat of beings with possible moral status; however, it presents a general framework that is highly versatile. My version of this principle will be called "Don't Know, Don't Resuscitate," and will generally argue that agents with decision-making power over patients at the end of their life must exercise caution when demanding aggressive intervention for a patient because of the risk of treating a patient as a means to an end. In Guerrero's calls risk arising from ignorance a blocker, and I will show that within the course of treatment in an ICU many blockers exist that are frequently ignored. Accordingly, as I will show in chapter VI, the default should almost never be aggressive care if uncertainty exists, and so the ICU should only be used with great caution and with clear-cut cases in which hope exists for a meaningful recovery.

However, in order to understand how such a principle of DKDNR could be useful, it is first necessary to understand how Guerrero's principle of DKDK functions and how Guerrero himself uses it which will be the focus of this chapter. DKDK at its core is a refutation of the moral ignorance thesis (MIT) and the ignorance thesis more generally. The ignorance thesis simply states that if an actor is blamelessly ignorant of some fact, such as a moral fact in the MIT case, they cannot be blameworthy if some bad result occurs as a result of their ignorance.

Guerrero tests this claim by imagining cases of an ancient slave-owner and of someone who eats meat in order to show that even though these people did not know a certain moral fact, like that slavery is wrong, the actor can still be blameworthy. He bases this on the thought “that when making certain sorts of decisions, or preparing to take certain sorts of actions (or to refrain from taking certain actions), what is required of us from an epistemic point of view may be sensitive to what is at stake from a moral point of view.”<sup>45</sup> In other words, the moral gravity of an action directly informs our epistemic obligations of what is required of a moral agent as regards morally grave actions.

The basis for such a claim is the epistemological theory of contextualism, which holds “that the standards for knowledge shift depending on the practical context.”<sup>46</sup> Traditionally, contextualism is used as a response to radical skepticism and the question of the truth of its claims; however, Guerrero modifies it into a form of moral epistemic contextualism that is distinct from traditional contextualism:

It is contextualism not about when it is true to say that some individual S knows or is justified in believing something or not, or whether that individual can justifiably assert p, but rather when it is morally appropriate for S to act as if S possesses justified true belief or certainty with regard to some issue. What is at issue is whether that individual can (morally) permissibly act as if they are justified in believing p, given what they have done to evaluate and consider their belief in p.<sup>47</sup>

In other words, rather than being a question of truth-value, such contextualism focuses on the ethics of belief. Then it becomes the case that “what is required of us from an epistemic

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<sup>45</sup> Alexander A. Guerrero, “Don’t Know, Don’t Kill: Moral Ignorance, Culpability, and Caution,” *Philos Stud* 136, no. 1 (2007): 68.

<sup>46</sup> *Ibid.*

<sup>47</sup> Guerrero, “Don’t Know, Don’t Kill,” 69.

point of view increases as what is at stake from a moral point of view increases: our epistemic obligations grow as the relevant context becomes more morally serious.”<sup>48</sup> Thus, whether a belief is actionable depends on the moral context of a belief, and on whether some epistemic blocker exists that should demand further inquiry until its resolution. For example, belief concerning the acceptability of borrowing a friend’s shirt is made actionable far more easily than a belief held by a police officer on whether some person is a lethal threat or not.

It is important here to expand on what blockers are exactly, and to draw out some examples of how they function since showing what blockers exist within the ICU will prove essential to my DKDNR principle. In short a blocker is formally defined as “any state of affairs which, if it obtained, would make it morally impermissible to perform some action A, a ‘blocker’ with respect to A.”<sup>49</sup> What Guerrero’s moral epistemic contextualism tells us is that in cases in which blockers might exist and these blockers are serious the amount of caution needed regarding whether an action can be undertaken increases significantly. In the shirt case the blocker is that the friend might not want to have their shirt borrowed and doing so would be accordingly inappropriate, and if one is uncertain on a friend’s policy about borrowing shirts then a principle of DKDB (Don’t Know, Don’t Barrow) might be appropriate. However, as previously suggested the amount of caution warranted is much less than the police officer deciding to act in spite of the blocker of killing an innocent person. Accordingly, in chapter V and VI I will work to demonstrate the principal blocker that exists within the ICU, and then accordingly argue that within a moral epistemic contextualist framework the stakes are raised enough to demand more caution than is currently exercised.

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<sup>48</sup> Guerrero, “Don’t Know, Don’t Kill,” 70.

<sup>49</sup> Guerrero, “Don’t Know, Don’t Kill,” 73.

With this bedrock established, Guerrero is able to develop his DKDK principle, which claims that if a person does not “know whether a living organism has significant moral status or not, it is morally blameworthy for her to kill that organism or to have it killed, unless she believes that there is something of substantial moral significance compelling her to do so.”<sup>50</sup> This means that if DKDK is true the actor can still be morally blameworthy. This is true even in cases in which no harm is done, this is the case because regardless of the result the fact remains the agent acted in spite of a state of ignorance. This principle places a high bar on moral agents to think critically about both empirical and moral facts; however, it does allow for expectations in cases of moral exigency. For example, DKDK could be violated by a parent of a child if an animal whose moral status is unknown is aggressively attacking their child. The moral importance of saving that innocent child’s life then can outweigh the risk taken by acting on what would typically be a non-actionable belief. In short, then, Guerrero’s DKDK principle raises the bar for ethical action due to increasing the epistemic demands upon the agent.

As previously mentioned, my account will rely on neo-Kantian reformulations of Kant’s moral theory as put forward in the *Grounding for the Metaphysics of Morals*. However, in order to avoid making this decision entirely arbitrary some preliminary justification must be made. To fail to do this renders any principle of DKDNR derived from Guerrero’s framework inherently arbitrary. Ultimately this paper cannot completely defend Kantian ethics as a normative theory in itself from all attack, and while I believe such an account of ethics is highly compelling, this is a limitation of my paper. Therefore, I will next present what I believe is a persuasive account of human moral life; however, as with any moral theory it is open to criticism and accordingly my

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<sup>50</sup> Ibid.

principle will then be open to similar criticism. Ultimately, I think a Kantian account of morality powerfully captures several of our most deeply ingrained moral intuitions and adds the benefit of human reason to them, and I think this will be well demonstrated in its application through my principle. In short, I will use Kant's account, because I believe it is compelling and there is a long and fruitful tradition of the use of Kantian ethics in medical ethics.

## Chapter IV

### *Kant, Korsgaard, and O'Neill: The Neo-Kantian Reformulation of Kant's Insights*

As discussed previously, Guerrero's moral epistemological framework requires a first-order normative theory to function, and accordingly I will now put forward what I feel is a compelling moral theory. This theory is the deontological moral theory of Immanuel Kant that has since been reformulated in useful ways by Christine Korsgaard. Her project aims to synthesize Kantian and Aristotelian insights with some Platonic insights to account for the traditional criticisms of Kant. The result is an incredibly useful framework for approaching moral issues. I will first recount Kant's moral theory, and emphasize in particular his discussions of autonomy, heteronomy, the Formula of Humanity, and the concept of the Kingdom of Ends. I then intend to show how Korsgaard's interpretation and reformulation of Kant can reinvigorate what is an often criticized project. Her reformulation of Kant's insights combined with Kant's original work will prove incredibly useful in showing how the diminished autonomy that occurs within the ICU harms patients, doctors, and family members, and ultimately how it prevents the formulation of a Kingdom of Ends. In order to demonstrate how meaningful autonomy is lost I will rely on several of Korsgaard's works along with Kant's original works. Specifically, I will use Korsgaard's book *Self-Constitution* and several essays from her collection *Creating the Kingdom of Ends* along with Kant's *Grounding for a Metaphysics of Morals*.

Furthermore, in medical ethics today autonomy is a buzz-word that is frequently heard and is emphasized as paramount; however, as I have suggested previously this emphasis is rather shallow. I believe this is the case because the dominant definition of autonomy used in medico-legal culture today has its origins not in a Kantian form of principled autonomy but instead J. S. Mill's writings in *On Liberty*. To demonstrate this claim I will introduce the arguments of Onora

O'Neill puts forward in her *Autonomy and Trust in Bioethics*. The vision endorsed by Kant and O'Neill is a radically different vision of what it means to be an autonomous agent compared to that advanced by Mill, and I will demonstrate in chapter V how the Millian version of autonomy is deeply problematic and contributory to the problem of end-of-life care. However, in this chapter I will simply demonstrate what the operative differences are between them to prevent any confusion from arising. Once this groundwork is complete I will then be able to move to an explicit Kantian diagnosis in chapter V to show what Kantian blockers exist within the ICU in chapter VI.

### **Kant's Normative Claims**

The core of Kant's moral philosophy is the idea so deftly stated in *the Grounding* that "there is no possibility of thinking of anything at all in the world, or even out of it, which can be regarded as good without qualification, except a good will."<sup>51</sup> This is to say that it is not the results of an action that matter in terms of the moral worth of that action, but rather the intention with which that action was undertaken. Kant then argues that the actions that have the most moral worth are those that are done out of deference to duty, because they are undertaken purely because they are the right thing to do. The question then becomes: what determines the nature of this duty? It is important to Kant that "an action done from duty must altogether exclude the influence of inclination...hence there is nothing left which can determine the will except objectively the law and subjectively pure respect for this practical law."<sup>52</sup> This means that action cannot be guided on the basis of mere sentiment, and instead it is necessary to isolate a rigorous

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<sup>51</sup>Immanuel Kant, *Grounding For the Metaphysics Of Morals ; With, On A Supposed Right To Lie Because Of Philanthropic Concerns*. trans. James Ellington (Indianapolis: Hackett, 1993) 1.

<sup>52</sup>Kant, *Grounding for the Metaphysics of Morals*, 13.

formula for deciding which action to undertake. Through a series of philosophical moves Kant reaches four principles that reflect what he believes are the essential features of acting from duty. These, Kant claims, are the four formulations of the Categorical Imperative: the Formula of the Universal Law, the Formula of Humanity, the Formula of Autonomy, and the Formula of the Kingdom of Ends. These are all held to be equivalent statements that will result in the same actions if followed.

The Formula of the Universal Law expresses the idea that to act from duty it is necessary to “act as if the maxim of your actions were to become through your will a universal law of nature.”<sup>53</sup> Practically this means that in order to adopt a maxim it must not result in a contradiction if willed universally, so one cannot will particularistically and instead must will their maxim universally. The second and more useful formulation in this work is the Formula of Humanity. This contains the probably most widely influential part of Kant’s moral philosophy, which is that one must “act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means.”<sup>54</sup> It is this formulation that I will discuss the most throughout this thesis, since it most directly contains Kant’s conception of how we ought to treat our fellow humans. Finally, the Formula of the Kingdom of Ends and the Formula of Autonomy together represent a synthesis of the first two formulations of the Categorical Imperative. These formulations express in the most complete form Kant’s moral vision of the world, which is one of rational beings living principled lives as self-legislators giving themselves the moral law and respecting the principles of others at the same time. Kant calls this vision his Kingdom of Ends, and he argues, “A rational being

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<sup>53</sup>Kant, *Grounding for the Metaphysics of Morals*, 30.

<sup>54</sup>Kant, *Grounding for the Metaphysics of Morals*, 36.

belongs to the kingdom of ends as a member when he legislates in it universal laws while also being himself subject to these laws.”<sup>55</sup> Together these four formulations represent the core of Kant’s first-order normative theory that he builds from his metaethical theory. The ultimate goal of these as Kant sees it is to render oneself an autonomous agent against the forces of inclination that would leave the determination of the will to forces outside oneself.

It is important here to emphasize the difference between autonomy and heteronomy. Something is heteronomous when it is being controlled by something other than itself. People then can be heteronomous when they allow inclination to rule their actions, which functionally then, as Korsgaard will later argue, makes their actions really not *their* actions at all since they cannot properly be said to have done them. These Formulations then, as will be again later expanded with Korsgaard, aim to ensure that rather than acting heteronomously from inclination that the moral agent acts autonomously by giving themselves the moral law. The Formula of the Universal Law, Autonomy, Kingdom of Ends, and Humanity together all ensure that one respects one’s own autonomy and the autonomy of others. Actions that are then not in accord with these Formulations of the Categorical Imperative are heteronomous. It will be important then throughout my critique of the ICU to follow in chapter V to remember this distinction.

### **O’Neill’s Distinction Between Principled and Individualistic Autonomy**

Due to the frequent discussion of autonomy in bioethics, and the frequently ambiguous nature of what people mean by it, I would like to emphasize the distinction O’Neill makes between the Kantian form of autonomy and what she calls John S. Mill’s conception of individual autonomy. In *Autonomy and Trust in Bioethics* O’Neill makes this distinction clear as

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<sup>55</sup>Kant, *Grounding for the Metaphysics of Morals*, 40.

part of her discussion about the need for the medical and scientific community to regain the trust of the public after years of misguided paternalism. She argues that today autonomy is traditionally seen as “a matter of independence, or at least a capacity for independent decisions and action,”<sup>56</sup> which makes it relational, selective, and graduated. This means that autonomy takes the form of being defined in terms of being “autonomous from something,” which is to say it is relational. Furthermore, it is selective in its circumstances of application, for a person who may be considered autonomous in one circumstance may not be considered autonomous in another. Finally, it is graduated in that “some individuals may have greater and others lesser degrees of independence.”<sup>57</sup> This form of autonomy then is very far from a Kantian conception of autonomy in that these attitudes (relationality, selectivity, and graduativity) are diametrically opposed to the idea of a Categorical Imperative and instead promote the dominance of hypothetical imperatives. This Millian account of autonomy is never actually described as autonomy by Mill; however, its features are found throughout his corpus particularly in *On Liberty*. His project is distinctive in that it attempts to incorporate “an account of individual autonomy into a naturalistic account of action.”<sup>58</sup> This vision of autonomy is viewed by Mill as “the only way to secure the development and flourishing of ‘persons of individuality and character’”<sup>59</sup> in the light of his view of human action. This flourishing is possible then not merely as a function of acting on random desires, but rather this flourishing “requires persons to ‘own’ or identify with certain desires, to cultivate certain feelings and impulses rather than

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<sup>56</sup>Onora O’Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press 2002) 23.

<sup>57</sup> Ibid.

<sup>58</sup> O’Neill, *Autonomy and Trust in Bioethics*, 29.

<sup>59</sup> O’Neill, *Autonomy and Trust in Bioethics*, 31.

others, thereby becoming well-developed human beings.”<sup>60</sup> This then is the basis of Mill’s claim for human liberty, since he believes such a flourishing is only possible in the presence of protections for individual liberty from the interferences of others or the State.

This form of autonomy then is laissez-faire, as it were, since it depicts actions as autonomous when they are the product of “desires that the agent has controlled, or moderated, or endorsed, using other desires and beliefs.”<sup>61</sup> Individual autonomy then exists in distinct contrast to Kantian autonomy, which “is manifested in a life in which duties are met, in which there is respect for others and their rights, rather than in a life liberated from all bonds.”<sup>62</sup> This is in direct contrast to a Millian conception of autonomy in that being an autonomous being is not about being free from oppression or being able to express oneself. To be autonomous for Kant is to be a being who gives themselves the moral law as a legislating citizen of the Kingdom of Ends. It is this self-legislation that truly gives life meaning not some liberty to pick. This distinction and its implication will be examined later in greater detail in chapter V; however, for now this is sufficient to make it clear that the Kantian autonomy discussed here is not what today is typically thought of as autonomy. In most settings, to be autonomous takes on a laissez-faire meaning centered on the agent being able to act on whichever whim she chooses. This conception proves distinctly useless and accordingly harmful in complex situations like end-of-life care, and thus I will later demonstrate how it is actually part of the problem. It remains first, however, to understand how such self-legislation is possible for Kant, since such a task seems quite demanding from a metaethical standpoint.

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<sup>60</sup>Ibid.

<sup>61</sup> O’Neill, *Autonomy and Trust in Bioethics*, 33.

<sup>62</sup> O’Neill, *Autonomy and Trust in Bioethics*, 83.

### **Korsgaard's Metaethical and Normative Theories**

Kant reaches these conclusions through a series of metaethical moves that ground how humans should act from a particular account of the phenomenon of necessitation combined with an account of human nature in *the Grounding for the Metaphysics of Morals*, and while this is clear in his work, Korsgaard's interpretation of this metaethics provides what I believe is a clearer and more vibrant statement of Kant's metaethical insights than are available in Kant's own writings. Kant's moral project has often been criticized as being cold and inhuman in that "necessitation is conceived as repression,"<sup>63</sup> and that to be a Kantian demands that one constantly deny human feelings and inclinations in favor of cold, hard, Kantian practical reason. Christine Korsgaard in her work *Self-Constitution* seeks to refute this claim, and in doing so she is able to demonstrate with great clarity the normative force behind Kant's moral theory. Through this reformulation a new holism is brought to the work of Kant that is well suited to talking about the emotional, human, and complex situation that is end of life care. Most importantly, it provides a vibrant definition of what it means to be autonomous in a way that provides a stark contrast to the dominant form of Millian autonomy, and accordingly her discussion of respect, reciprocity, and responsibility is far more fitted for the joint venture of end-of-life care than the radically individualist Millian account of autonomy.

As mentioned above, she begins her study of Kant with a defense of the phenomenon of necessitation. Necessitation at its essence is simply the idea that "human beings are condemned to choice and action," so that "action is necessary" as part of "our plight: the simple inexorable fact of the human condition."<sup>64</sup> This necessitation means we must choose, which opens us up to

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<sup>63</sup>Christine Korsgaard, *Self-Constitution* (Oxford: Oxford University Press 2009) 3.

<sup>64</sup> Korsgaard, *Self-Constitution*, 2-3.

the risk of making bad choices. Typically the philosophical discussions about necessitation divide themselves between the “good dog” and “tortured sinner” model in which either a person just becomes trained to be virtuous or is constantly suppressing their natural instincts. Therefore, people either talk about the stereotyped version of Kant that paints people who take it seriously as constantly in a state of self-denial in the face of necessitation, or the stereotyped virtue ethical view of the ideal person who by mere character lives in such a way that they never feel this tug. The problem with these accounts, Korsgaard argues, is “they do not give an adequate explanation of how we are necessitated.”<sup>65</sup> Thus, both theories fail to understand why we are necessitated, what this means, and how we should respond to this properly without either becoming a “good dog” or “tortured sinner.” As an alternative to this stereotyped and dichotomous view of necessitation, Korsgaard declares that “the principles by which we achieve the psychic unity that makes agency possible” are normative standards, and “the work of achieving psychic unity, the work that we experience as necessitation, is...self-constitution.”<sup>66</sup> This is the case because since we cannot escape the pull of acting, action then becomes the process of creating ‘the self’ since our ‘selves’ are determined by the choices we make and how we make them. This means then that to feel the tug of duty is really to feel the tug of desiring to be something more than a mere heap of inclinations and molecules. It is not to feel the tinge of guilt as described by the “guilty sinner” model or the lazy accidental goodness described by the “good dog” model. As Korsgaard will argue, to be a person at all is to give yourself the moral law in response to the necessitation that comes as part of being human.

Like Kant, Korsgaard argues that an account of action must be central to any moral

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<sup>65</sup>Korsgaard, *Self-Constitution*, 4.

<sup>66</sup>Korsgaard, *Self-Constitution*, 7.

theory. To Kant and Korsgaard, the aim is always included in the description of the action. Action is the object of choice, and so the action “properly speaking is morally good or bad.”<sup>67</sup> So, since the aim is included in the action “an action is an essentially intelligible object that embodies a reason, the way a sentence is an essentially intelligible object that embodies a thought.”<sup>68</sup> Therefore, like a thought requires a thinker, it is necessary that an action is performed by an agent, so “for a movement to be my action, for it to be expressive of myself in the way that an action must be, it must result from my entire nature working as an integrated whole.”<sup>69</sup> In short, the actions one undertakes make oneself a self, which is to say “your identity is in a quite literal way constituted by your choices and actions.”<sup>70</sup> This seems like a burden in that one must act to make a self; however, in a very deep way it is a fact of the human condition. The claim that “action is self-constitution” implies that “what makes actions good or bad is how well they constitute you.”<sup>71</sup> This means that some actions are either more or less of action than others. This is the difference between someone purposefully raising their hand and a marionette’s hand being pulled up by a string. One is an action, one is not. This fact is why “the principles of practical reason bind us because, having to act, we must constitute ourselves as unified agents,” and as will later be argued the principle of practical reason that binds us best and makes our actions our own is the Categorical Imperative. Thus, to experience necessitation is to experience the work of pulling oneself together, and so “a good person, it follows, is one who is good at this work. A good person is someone who is good at being a person.”<sup>72</sup>

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<sup>67</sup>Korsgaard, *Self-Constitution*, 12.

<sup>68</sup>Korsgaard, *Self-Constitution*, 14.

<sup>69</sup>Korsgaard, *Self-Constitution*, 19.

<sup>70</sup>Ibid.

<sup>71</sup>Korsgaard, *Self-Constitution*, 25.

<sup>72</sup>Korsgaard, *Self-Constitution*, 26.

Humans are unique in that rather than just responding to things they are able to act on reasons instead of just responding to incentives. Non-human animals can act as well, and accordingly be autonomous and efficacious; however, only humans are subject to imperatives in that only humans are able to “choose our own maxims, the content of our principles.”<sup>73</sup> This is to say “[humans] are conscious of the potential grounds of our actions, the principles on which our actions are based, as potential grounds.”<sup>74</sup> In short, humans entertain proposals rather than merely acting from instinct, and accordingly they enter into the normative realm of reason. This leads to the fact that deliberation and work is necessary to pull the parts of ‘you’ together. This deliberation then is a deeply human activity, and may not arrive at the Categorical Imperative just as a builder may build a house poorly; however, at the core “the kind of practical deliberation that issues in bad action is not a different activity from the kind of practical deliberation that issues in good action. It is the same activity badly done.”<sup>75</sup>

Korsgaard argues, using the classes of the city of Plato’s Republic, then that the best sort of deliberation leads to unification through imperatives between the ‘rulers’, the ‘auxiliaries’, and the ‘masses’ in a constitutional model of the soul. This is in contrast to what is commonly described of as the combat model in which each part of the soul is in conflict, and one must choose between following one part of the soul over another. The constitutional model, by contrast, places the agent as the sort of constitution of a city which exists above the city and not with one single section. Roughly this Platonic model of the ideal city corresponds to the ideals of reason, courage, and moderation, and when the city or person works well justice prevails. In

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<sup>73</sup>Korsgaard, *Self-Constitution*, 108.

<sup>74</sup>Korsgaard, *Self-Constitution*, 115.

<sup>75</sup>Korsgaard, *Self-Constitution*, 132.

short, “appetite makes a proposal, reason decides whether to act on it or not, and spirit carries the decision of reason out,”<sup>76</sup> and in a well ruled city a constitutional model rather than combat model prevails. Thus, justice in the city is when all the classes are able to come to a shared and deliberative decision. Korsgaard finds that this justice then is best achieved through a Categorical Imperative reached through deliberation “because they bring the constitutional unity that makes action possible to the soul.”<sup>77</sup>

She then moves to analyze defective action, which just as in *The Republic* is when the wrong law comes to govern the city. This produces “autonomous action and yet it is defective as autonomous action,” which is to say more broadly that defective action exists on a scale from mostly efficacious and autonomous to purely inefficacious and heteronomous. This can be seen in the soul of the ‘timocratic person’ who has good intentions, yet “is a person in whom spirit, the sense of honor, has usurped the role of reason.”<sup>78</sup> Korsgaard argues, like Plato, that often this works out well; however, ultimately it is not ideal. In contrast, the democratic person is almost entirely unruly “for the person is government only in a minimal or formal sense...he may be almost completely incapable of effective action.”<sup>79</sup> Finally, at worst the tyrannical soul may develop in which actual evil can be seen. This then is the soul in which a person can range from being entirely self-constituted or entirely unruly, and this depends on their ability to give themselves the moral law. This will be discussed in more detail in chapter V.

Accordingly, Korsgaard is able to draw a picture of self-constitution from action and her account of necessitation. Several key normative conclusions emerge for both integrity and

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<sup>76</sup>Korsgaard, *Self-Constitution*, 142.

<sup>77</sup>Korsgaard, *Self-Constitution*, 158.

<sup>78</sup> Korsgaard, *Self-Constitution*, 165.

<sup>79</sup> Korsgaard, *Self-Constitution*, 169.

personal interaction. One particularly important one is that one cannot actively choose not to be a unified agent, because “you can’t, in the moment of deliberative action, choose to be something less than a single unified agent.”<sup>80</sup> Thus, everyone strives to be someone, but some are more successful than others at achieving this. This then leads to the question of how we should interact with people who are less than entirely unified, which Korsgaard uses Parfit’s example of the Russian nobleman to illustrate.<sup>81</sup> This example paints a picture of a young Russian nobleman who is currently an idealistic socialist who wants to give his wealth away in his old age; however, knowing his idealism will fade as he ages and acquires more wealth he leaves it to his wife to execute his conflicting wills. This makes interaction with this nobleman in terms of his wishes impossible since he is not himself unified in his wishes. Ideally, Korsgaard argues that interaction ideally results in the unification of the wills of two people, which is the core of the idea of treating someone as an end in themselves. However, with disunified people this becomes impossible, and the unification of the wills is impossible. Practically this means “when we interact with each other what we do is deliberate together, to arrive at a shared decision.”<sup>82</sup> This leads to the fact that you also must treat others as ends in themselves if this is to be possible because “I must treat your reasons...as reasons that is considerations that have normative force for me as well as you.”<sup>83</sup> Both parties are people trying to perform shared action through shared reasons that are public; Korsgaard then turns inward to find that “that every person interacts with others as he interacts with himself, and in this the good person is no different...It is this that made Plato and Kant so confident that the inwardly just person will also be outwardly just; or to put it

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<sup>80</sup> Korsgaard, *Self-Constitution*, 180.

<sup>81</sup> Korsgaard, *Self-Constitution*, 185.

<sup>82</sup> Korsgaard, *Self-Constitution*, 192.

<sup>83</sup> *Ibid.*

Kant's way, that legislating for oneself, and legislating for the Kingdom of Ends, are one and the same thing."<sup>84</sup> Humans are constantly interacting with themselves and others, "so the laws have to be laws for every rational being, laws whose normative force can be shared."<sup>85</sup>

This concept is further elaborated in Korsgaard's essay "Creating the Kingdom of Ends: Reciprocity and Responsibility in Personal Relations," which forms the basis for Korsgaard's claims regarding responsibility and reciprocity in *Self-Constitution*. Within this work Korsgaard makes several key normative claims that will prove invaluable in later chapters to demonstrate what demands are placed on people in interpersonal relationships generally and how these translate to specific obligations between doctors, patients, surrogates, and other agents within the ICU. The ideal human interaction, Kant and Korsgaard argue, is manifested in reciprocal responsibility in which both parties "are prepared to exchange lawless individual activity for reciprocity in some or all forms."<sup>86</sup> This is the essence of what it means to take others' reasons as normative. One must give up one's ability to act in whatever way one desires to gain a deeper lawful freedom. This means to abandon the state of nature, enter into personal relations, "and so relinquishing force and guile, you are ready to share, to trust, and generally speaking to risk your happiness or success on the hope that [your fellow human] will turn out to be human."<sup>87</sup> 'Turning out to be a human' simply means that "to hold someone responsible is to regard her as a person--that is to say, as a free and equal person, capable of acting both rationally and morally"<sup>88</sup> and so because rational and moral behavior is not guaranteed, it is necessary to act out of the

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<sup>84</sup>Korsgaard, *Self-Constitution*, 206.

<sup>85</sup>Korsgaard, *Self-Constitution*, 214.

<sup>86</sup> Christine Korsgaard, "Creating the Kingdom of Ends: Reciprocity and Responsibility in Personal Relations" in *Creating the Kingdom of Ends*, ed. Christine Korsgaard (Cambridge: Cambridge University Press 1996) 189.

<sup>87</sup> Korsgaard, *Creating the Kingdom of Ends*, 190.

<sup>88</sup>Korsgaard, *Creating the Kingdom of Ends*, 189.

hope of reciprocity as a necessary condition for meaningful human interaction. Without reciprocity there cannot be any hope of mutual undertakings, and without mutual undertakings there remain very few things of value left in the human life. Thus, this essentially is what it means to treat others as ends in themselves.

When people enter into personal relationships like friendship, marriage, fatherhood, sisterhood, etc. they sacrifice part of their own lawless freedom to gain lawful freedom in return, and thus “people who enter into relationships must be prepared to share their ends and reasons; to hold them jointly; and to act together.”<sup>89</sup> This requires that certain personal inclinations be sacrificed, but in turn requires that the agent hold other agents responsible. This is the case because one only enters into relationships of reciprocity “with someone you expect to deal with reasons in a rational way. In this sense, reciprocity requires that you hold the other responsible.”<sup>90</sup> Responsibility entails that one is prepared to hold reactive attitudes like “blame [or] resentment”<sup>91</sup> to the behaviors of those one enters into relations with. This idea is key, because often in the ICU it is necessary to make judgments and hold surrogates and doctors responsible to their patients to ensure a Kingdom of Ends is brought about. Thus, ultimately what it means to be a moral agent is that “when we enter into relations of reciprocity, and hold one another responsible, we enter together into the standpoint of practical reason, and create a Kingdom of Ends on earth.”<sup>92</sup> My later argument will be about how these relationships of reciprocity and responsibility have broken down in the ICU, and how Guerrero’s framework can help change this.

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<sup>89</sup> Korsgaard, *Creating the Kingdom of Ends*, 196.

<sup>90</sup> Korsgaard, *Creating the Kingdom of Ends*, 196.

<sup>91</sup> Ibid.

<sup>92</sup> Korsgaard, *Creating the Kingdom of Ends*, 212.

### **The Double Level Distinction**

A problem remains, however, which is that often in more complex situations that occur in human life Kant's moral framework seems to at best offer no clear guidance or at worst offer conflicting imperatives. Kant himself seems to have a harsh take on the flexibility of his moral theory in these situations as demonstrated in his discussion of the right to lie. These situations generally are a weak point of Kant's moral theory in that they make his theory seem impractical for actual applied use. These questions can be as complex and pressing as being forced to lie to a murderer at one's door about whether his intended victim is inside, or as simple as whether little white lies like 'I like that sweater on you' are acceptable. Under the Formula of the Universal Law Kant believes these examples would eventually result in a contradiction if universalized since if everyone lied as a maxim there would be no benefit to lying. Under the Formula of Humanity it is treating the other person as a means to avoiding an uncomfortable interaction, and accordingly not treating them as an autonomous agent thereby preventing the realization of a Kingdom of Ends.

Korsgaard resolves this difficulty through the introduction of John Rawls' distinction between ideal and nonideal theory. Ideal theory is developed under certain assumptions like "strict compliance [for] it is assumed that everyone will act justly [and]...that historical, economic, and natural conditions are such that realization of the ideal feasible."<sup>93</sup> Nonideal theory refers to the fact that there are certain ongoing states of affairs "which may always prevent the full realization of the ideal state of affairs: the problems of dealing with the seriously

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<sup>93</sup> Christine Korsgaard, "The Right to Lie: Kant on Dealing with Evil" in *Creating the Kingdom of Ends*, ed. Christine Korsgaard (Cambridge: Cambridge University Press 1996) 147,

ill...belong in this category.”<sup>94</sup> Generally speaking, this category excludes all situations in which “people, nature, and history will behave themselves so that the ideal can be realized”;<sup>95</sup> thus frequently this non-ideal state is the case because people, nature, and history rarely behave themselves. The ideal component of a double level moral theory’s imperatives can be used “then to determine--in light of that ideal--what is to be done in actual circumstances when [these imperatives] do not [offer guidance].”<sup>96</sup> Many of the situations in the ICU that I must address are then of this sort in that frequently a full realization of the agent as a rational being is impossible, so the ideal of interpersonal interaction becomes strained. Therefore, it will be useful to examine the characteristics of a double-level approach to justice, and examine how a Kantian approach when adapted so such a system becomes even more dynamic.

The point of such a double level theory is to avoid the problems illuminated by Bernard Williams’s in his *Critique of Utilitarianism* in which the single-level theory of the consequentialist “may lead to violations of what we would ordinarily think of as integrity.”<sup>97</sup> One can imagine such a single-level theory in complex situations demanding an action of someone that is deeply antithetical to her character, and “no matter how mean or how savage the act required to secure the best outcome is, the utilitarian thinks that you will be irrational to regret that you did it, for you will have done what is in the straightforward sense the right thing.”<sup>98</sup> For example, Williams cites an example of a worker at a nuclear weapons factory who must choose between working at the factory despite her misgivings or alternatively using that

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<sup>94</sup> Ibid.

<sup>95</sup> Korsgaard, *Creating the Kingdom of Ends*, 148.

<sup>96</sup> Ibid.

<sup>97</sup> Korsgaard, *Creating the Kingdom of Ends*, 150.

<sup>98</sup> Ibid.

money to support her family knowing that she can be easily replaced at the factory. The utility gained by working at factory may mean that a utilitarian would claim the moral thing to do is to abandon one's integrity instead of quitting and causing a net decrease on overall utility. Williams find this problematic as it ignores the values of our moral commitments and feelings. The advantage of a double level theory then is that it provides us with moral guidance, yet does not automatically demand actions that are seen as morally distressing when the ideal theory is strained by the nonideal conditions of the world. In a single-level theory the common sense approach is to abandon "our ordinary rules and standards of conduct when the consequences of following them would be 'very bad.'"<sup>99</sup> This is problematic in that how "bad" something is to justify this abandonment is vague, and it may "lead down a familiar consequentialist's slippery slope: if very bad consequences justify a departure from ordinary norms, why do not slightly bad consequences justify such a departure"?"<sup>100</sup> Instead, in a double-level theory a clear demarcation between ideal and nonideal is made at the point in which adhering to the ideal would seemingly interfere with the general conception of justice. This is to say some judgment is necessary in deciding to forgo following the ideal, so "it is not as inexact as a wholly intuitive qualitative measure."<sup>101</sup> Furthermore, this double level theory allows agents to keep their integrity, and then attribute their regret not at violating their own deeply held beliefs but rather having to act in nonideal circumstances. In short, a double level theory addresses the inevitable problems that a single-level approach will face, and does so in a manner that protects the integrity of the agent without requiring an abandonment of the normative theory.

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<sup>99</sup> Ibid.

<sup>100</sup> Ibid.

<sup>101</sup> Korsgaard, *Creating the Kingdom of Ends*, 151.

The problem faced by single-level theories is exemplified in a traditional interpretation of Kant in which it seems the Formula of Humanity demands that we must tell the truth even when it will apparently cause great harm. Broadly speaking then, “it can be argued that the Formula of the Universal Law and the Formula of Humanity are expressions of the same idea--that humanity is the source of value, and of the justifying force of reason.”<sup>102</sup> However, as evidenced by the problem of lying the Formula of Humanity is more demanding, and sometimes forces us into untenable courses of action “when we are dealing with the misconduct of others and the recalcitrance of nature.”<sup>103</sup> Thus, in cases in which the complexities of life render the Formula of Humanity not perfectly applicable it is possible to view it as a goal to achieve rather than a direct guiding ideal. It then is not abandoned, but rather it becomes a tool to help triage our moral commitments while the Formula of the Universal Law can still remain functional as it is less demanding. All rational beings can hope to reason in the way demanded by the Formula of the Universal Law; however, the Formula of Humanity is designed for application in a world where the Kingdom of Ends is realized. In other words, it is an ideal, and often this ideal can be achieved. However, in the course of human life it is inevitable that the malfeasance or inability of others to create this Kingdom means that often the Formula of Humanity serves then as a suggested rather than demanded route. Kantian ethics is much more flexible and powerful when couched in these terms:

The Formula of Humanity and its corollary, the vision of a Kingdom of Ends, provide an ideal to live up to in daily life as well as a long-term political and moral goal for humanity. But it is not feasible always to live up to this ideal, and where the attempt to live up to it would make you a tool of evil, you should not do so. In evil circumstances, but only then, the Kingdom of Ends can become a

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<sup>102</sup> Ibid.

<sup>103</sup> Ibid.

goal to seek rather than an ideal to live up to, and this will provide us with some guidance. The Kantian priorities--of justice over the pursuit of obligatory ends, and respect over benevolence--still help us to see what matters most.<sup>104</sup>

Korsgaard's mention of evil here is worth elaborating on. The circumstances that happen in the ICU are not evil. Everyone in the ICU, barring rare exceptions, wants the best for the patient. However, despite this fact, on a daily basis patients are tortured to death. This I believe, while not evil in the traditional sense, represents a situation *prima facie* where the Kingdom of Ends is not realized, and therefore means that frequently in the ICU a double level distinction is necessary. The Kingdom of Ends in the ICU is not realized because of a desire to harm, but rather because of a complex number of factors that work together to produce something that is truly awful. Accordingly, such a double level distinction will prove key to talking about what goes on in the ICU, and what can be done in situations in which it seems like there is little hope of realizing Kant's dream.

### **Conclusion**

In summary, morality to Korsgaard and Kant is what is required to make yourself a particular person, and personal interaction is necessary to achieve this. To be a person is to give oneself the moral law, and an essential part of this is to respect the moral law of others. This means we must enter into relationships of reciprocity with them in order to navigate our moral world where each party takes the other party's reasons as normative. Each then must hold the other responsible for their actions, and this entitles agents to hold reactive attitudes towards others who are acting badly. Finally, because of the complexities of the ICU often it may seem that Kant's theory cannot offer an answer. However, once Korsgaard's application of John

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<sup>104</sup> Korsgaard, *Creating a Kingdom of Ends*, 153.

Rawls' concepts of ideal and nonideal theory are introduced, it becomes clear that while Kant may not always be able to give an ideal answer, his principles can offer guidance regarding how to move towards creating a Kingdom of Ends in the ICU. A Kantian analysis of the ICU then can be both pragmatic, possible, and insightful.

## Chapter V

### *The Dominance of Heteronomy in the ICU: A Kantian Critique of the Actions of Physicians and Surrogates*

With the Kantian framework elucidated in chapter IV it is now possible to apply it to the situation described in chapter II in order to produce a precise philosophical critique of the modern American ICU. This critique will be grounded in Immanuel Kant, Christine Korsgaard, and Onora O'Neill's description of what it means to be an autonomous agent, why such autonomy is worth striving for, and accordingly what specific actions construe agents as autonomous. I will demonstrate that within the American ICU patient autonomy is decreased, and due to the reciprocal nature of autonomy this loss of patient autonomy renders family members and physicians heteronomous as well. Accordingly, in order to demonstrate this I will examine how the dominant medico-legal decision-making process combined with a problematic individualistic Millian view of autonomy that fails to capture its deeper Kantian meanings and makes this loss of autonomy unavoidable.

To begin this diagnosis it is first necessary to illustrate the central problem within the ICU applying O'Neill's distinction between individualistic autonomy and principled autonomy as discussed in chapter IV. This problem is simply that the truly meaningful Kantian definition of autonomy is nowhere to be found, and instead the cheap alternative that is Millian autonomy is culturally, legally, and institutionally enshrined as the dominant form. Once this distinction is clear I will demonstrate several specific violations of the Categorical Imperative that arise from it in terms of the Formula of Humanity. These violations specifically occur when physicians and family members allow their good intentions of 'saving' the patient to overrule the patient's likely desires. Despite ideally wanting what is best for the patient these parties allow personal interests

that conflict with the patient's best interest to cloud their judgment, and if they act on these judgements then they are treating the patient not as an end in themselves. This can be seen in the previous chapter in the discussion of the Formula of Humanity, and what it means for Korsgaard to act with shared reasons. The details of what it means to treat someone as an end in themselves will be further examined in this chapter as well in light of what it means to treat someone merely as a means in the example of end of life care. Additionally, there is the interesting case in which patients who fail to get an advance directive are not fully treating themselves as ends due to the violation of the imperfect duty of self-love. Once these violations of the Categorical Imperative are clear I will use Korsgaard's framework to demonstrate how not only in choosing to pursue aggressive interventions do physicians and family members harm the patient, but in acting this way they fail to completely constitute themselves as autonomous agents. Finally, the goals for a solution can be located in Korsgaard's discussion of reciprocity, respect, and responsibility that I hope in conjunction with my principle (DKDNR) will pave the way for the creation of the Kingdom of Ends in the ICU.

### **The Central Problem**

As introduced in chapter IV, a significant source of the problems from a more abstract standpoint in end-of-life care described in chapter II can be traced to what Onora O'Neill describes in *Autonomy and Trust in Bioethics* as the dominance of J. S. Mill's conception of individualistic autonomy which has overshadowed the deeper form of Kantian autonomy. In many ways, it is the "bargain bin" version of autonomy that was "purchased" by society after a series of broad breaches in public trust by the medical profession throughout the 20th century. In the 1994 edition of the seminal textbook in applied bioethics, Tom Beauchamp and James

Childress acknowledged that while “the physician’s primary obligation is to act for the patient’s medical benefit, not to promote autonomous decision-making. However, autonomy rights have become so influential that it is today difficult to find clear affirmation of traditional models of medical beneficence.”<sup>105</sup> This broke the dominance of paternalism in the medical profession; however, in an attempt to solve the problem it defaulted to the more culturally dominant paradigm of Mill’s conception of liberty rather than the more demanding and ultimately more valuable form of Kantian autonomy.

Practically speaking, O’Neill argues, that this can be seen in the triumph of informed consent within medical practice, which *prima facie* is a good thing. However, the operationalization of informed consent has rendered it rather as the only necessary condition for medical action. Furthermore, it is important to remember that informed consent does not necessarily have to come from the patient themselves, so in cases in which surrogacy is necessary it is the surrogate who must give their informed consent. The justification for this practice of informed consent is typically centered around “the Millian arguments for the importance of individuality and character,” which then gets operationalized through ensuring informed consent allows “for individuals to choose autonomously, however that is to be constructed.”<sup>106</sup> It is important to note here that this practice of informed consent in no way guarantees any of those grand Millian ideas are actually realized, but instead all that is guaranteed “often amounts simply to a right to choose or refuse treatment on offer, and the corresponding obligations of practitioners not to proceed without patient’s consent.”<sup>107</sup>

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<sup>105</sup> Onora O’Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002) 35.

<sup>106</sup> O’Neill, *Autonomy and Trust in Bioethics*, 37.

<sup>107</sup> *Ibid.*

Therefore, patient autonomy cannot be meaningfully said to be protected simply by informed consent since there is no assurance that reflective, principled choice will prevail, and accordingly the “much-discussed triumph of autonomy is mostly a triumph of informed consent requirements.”<sup>108</sup> The question then becomes to what extent can informed consent achieve any sort of meaningful autonomy at all if it is the primary means by which autonomy is supposed to be protected?

As suggested in chapter II by Kaufman, within medicine this practice of informed consent within the ICU cannot truly be operationalized successfully, and accordingly its valorization inevitably leads to problematic situations. Uncertainty prevails within a system that demands choice, and the system attempts to overcome this problem through informed consent. However, the uncertainty and stress of the situation means that “when we are ill or injured we often find it hard to achieve any demanding version of individual autonomy.”<sup>109</sup> Once one enters the system “typically a diagnosis is followed with an indication of prognosis and suggestions for treatment to be undertaken. Patients are typically asked to choose from a smallish menu—often a menu of one item—that others have composed and described in simplified terms.”<sup>110</sup> Therefore, the fatal combination of uncertainty combined with the illusion of choice as described by O’Neill and Kaufman means that individualized autonomy just becomes “an inflated term for informed consent requirements.”<sup>111</sup> As suggested by the Kaufman and O’Neill’s analyses of end-

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<sup>108</sup> O’Neill, *Autonomy and Trust in Bioethics*, 38.

<sup>109</sup> Ibid.

<sup>110</sup> Ibid.

<sup>111</sup> O’Neill, *Autonomy and Trust in Bioethics*, 73.

of-life care “the supposed triumph of individual autonomy over other principles in bioethics is, I conclude, an unsustainable illusion.”<sup>112</sup>

On a small scale, as discussed in chapter IV defining autonomy in the individualistic way is troubling, yet ultimately when limited to a single person defining their ethical obligations it may only prove to harm that person and render them heteronomous. Unfortunately, this is not the case, and the medico-legal practice of the day has valorized individualistic autonomy, and principled autonomy is almost always absent from the discussion. This means that within the end-of-life decision making process the focus is entirely removed from what it means to be truly autonomous, and all the discussion of autonomy and bioethics ultimately proves to be fruitless in the absence of this principled autonomy. In fact, it proves to be actively harmful since it lulls agents into a false sense of moral calm since they can claim “autonomy” is being protected by the legal structures that valorize individualistic autonomy. It allows agents to abdicate their moral responsibility, and the harm to the patient from this is clear. The question then becomes what must be done to overcome this culturally and legally valorized conception of what it means to be an autonomous agent in the domain of bioethics? This will be approached in the next chapter through a cautionary principle of DKDNR that will stand against the problematic cultural and legal factors that produce the form of death in America as it is seen today.

### **Some Clear Failures Explained in Kantian Terms**

In order to make it clear how the modern ICU is failing under this regime of individualistic autonomy, it is necessary to discuss several ways specific groups of people are failing to treat the patient as an end in themselves for various reasons despite following what the

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<sup>112</sup> Ibid.

system deems as the appropriate procedure. This listing will not be exhaustive, since it would be impossible to list every single way humans fail to treat other people as ends in themselves. Instead I will aim to demonstrate in combination with my description proffered in chapter II some central failures that occur in the ICU. Furthermore, the analysis of these specific cases will be easily applicable to other novel or less common cases, so my limited analysis will present a framework for further analysis of other issues that may arise. Specifically here I will examine three ways in which individual actors, specifically family members, physicians, and patients themselves can treat the patient or themselves as a means to an end rather than an end in themselves. I will also look at how a Kantian might approach some of the larger systemic issues that also contribute to the problems of the modern ICU, and demonstrate to what extent Kant's moral theory can be applied to address larger systemic issues.

I will first examine the least egregious problem, which is patients who fail to make their wishes clear in an advance directive if their health is at all poor or failing, and in doing so violate an imperfect duty of self-love. This example is distinct from the others in that it happens outside of the ICU, and is somewhat less obvious than the others; however within the *Grounding for a Metaphysics of Morals* there are several examples Kant gives to explain his formulations of the Categorical Imperative that are relevant to how the failure to get an advance directive is problematic. In this instance the violation is that of a failure to act rather than an active harm that is being done. Failing to get an advance directive then ought to be considered a violation of an imperfect duty inasmuch as it involves failing to undertake efforts to ensure one is treated as an end in themselves.<sup>113</sup> In some sense then it is similar to Kant's discussion of suicide and the

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<sup>113</sup> It is conceivable that this could be interpreted as a perfect duty in that a failure to get an AD can be construed as a willful disregard of whether one's person is mutilated or damaged, which is a deeply interesting philosophical

Formula of Autonomy. He argues that “I cannot dispose of man in my own person by mutilating, damaging, or killing him,”<sup>114</sup> thus it is clear within a Kantian framework that one has a duty to oneself as a moral agent just as much as another person.<sup>115</sup> I will later reject Kant’s analysis of the character of suicide and “giving up” as necessarily immoral (chapter VIII: Objections and Refutations); however, his point on the status of oneself as a moral agent that demands equal consideration stands. Therefore, as Korsgaard argues, “unless you regard others and your future self as moral agents, there will be no content to your duties at all, for all duties (according to Kant) are owed either to other persons or to the enduring self.”<sup>116</sup>

Accordingly, patients can fail to treat themselves as ends in themselves through their failure to get an advance directive when it is reasonably clear that they might be hospitalized, which places them in violation of the Categorical Imperative. To fail to get an advance directive in this case represents a careless indifference to one’s future self that makes it difficult for the patient and those caring for and treating them to treat them as an end in themselves.

Accordingly, like the previous discussion of Parfit’s example of the Russian nobleman “you cannot act in concert with one who does not act in concert with himself,”<sup>117</sup> and so it is equally hard to act in concert with someone who has not made their wishes explicit to themselves and their family. A failure to get an advance directive then is simply a failure to respect oneself as an end in oneself, so like for the Russian nobleman if a patient fails to get an advance directive

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question that I intend to treat elsewhere. Here though I will refer to it as an imperfect duty since space is limited for the adequate treatment of this question.

<sup>114</sup> Immanuel Kant, “Grounding for the Metaphysics of Morals” trans. James W. Ellington (Indianapolis, Hackett, 1993) 36.

<sup>115</sup> Again, whether this is better viewed as a violation of a perfect or imperfect duty is an open question.

<sup>116</sup> Christine Korsgaard, “Creating a Kingdom of Ends: Reciprocity and Responsibility in Personal Relations” in *Creating the Kingdom of Ends* ed. Christine Korsgaard (Cambridge: Cambridge University Press, 1996) 208.

<sup>117</sup> Korsgaard, “Creating a Kingdom of End,”) 208.

when it is clear he should get one “his problem is not disrespect for his future self, but disrespect for himself here and now.”<sup>118</sup> This failure to live up to the Kantian imperatives is one that often occurs in the elderly, and on this basis patients should be encouraged to have advance directives so they can better construct their will throughout their life even if they cannot actively decide this will for themselves. However, this failure to act is a mere violation of an imperfect duty rather than the violation of a perfect duty, so while the proliferation of advance directives would solve or prevent many problematic situations it cannot be the end of the analysis since there are far more significant active violations that have far greater moral weight in that they violate perfect duties. It would ensure that a principled form of autonomy could be achieved through explicit self-legislation, which would overcome many of the limitation that the current Millian paradigm in bioethics causes. These are those actions that follow from decisions and positions taken by those with the decision making capacity in the ICU: the family members and physicians.

As suggested in chapter II, in the event the patient cannot decide for themselves a surrogate is given charge of the patient’s medical decision making, and this surrogate decision making is the most dominant form of decision making in the ICU.<sup>119</sup> Usually this surrogate is a family member, and if the patient has no identifiable family then the American Medical Association suggests that “when there is no family, domestic partner, or close friend, persons who have some relevant knowledge of the patient should participate in the decision-making process. In all other instances, a physician may wish to consult an ethics committee to aid in identifying a surrogate decision-maker or to facilitate sound decision-making.”<sup>120</sup> However, most

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<sup>118</sup> Korsgaard, *Self-Constitution*, 204.

<sup>119</sup> Derek C. Angus et. al., “Use of intensive care at the end of life in the United States: an epidemiologic study,” *Critical Care Medicine*, 32, no. 3 (2004): 638-643.

<sup>120</sup>(Ama-assn.org 2016)

of the time a family can be found as even in cases of distant family relationships often the sudden illness of a parent, sibling, or other relative will bring relatives back into contact and into a position of control after long periods of separation.<sup>121</sup> Therefore, in terms of decisions made in the ICU that stand in conflict with the Categorical Imperative responsibility can be most directly placed at the feet of the surrogates who most often are family members. It is important to note here that family members do not act alone, and that the guidance and attitude of physicians has an immense direct influence over the choices of surrogates. Hence I do not want to imply they are solely responsible at all, but merely they are the most direct cause of any action taken in the ICU in legal terms. I will analyze their moral responsibility and areas of possible problem first then I will move to analyze the responsibility of physicians which has a distinct character.

The most common way in which family members may treat the patient as a means rather than an end and accordingly violate the Formula of Humanity is that they may prioritize their own desire to ‘not let go,’ or to ‘give it 100%’ over what is actually morally and practically best for the patient. For example, a son or daughter may not feel ready to let their mother go despite their mother having no chance at a meaningful recovery, and they may opt to continue treatment for this reason.<sup>122</sup> There is a strong risk that this decision to continue care would conflict with the patient's wishes, and accordingly make the patient a means to the end of the child to avoid

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<sup>121</sup> Lofty L. Basta, *Life and Death on Your Own Terms* (Amherst: Prometheus Books: 2001) 276.

<sup>122</sup> Some may question how letting someone die is respecting the noumenal person in which the noumenal person is the real, transcendental self that unifies all sensible experience. In less theory-laden terms, the noumenal self is that self which exists behind the mere collection of sense-data. In other words, it is not merely the empirically gained idea of being a self that one gets from a constant conjunction of experience. Rather it is the condition for the possibility of having that experience in the first place, and thus can be thought of as the true source of unity and self-hood in a person. It is the seat of reason and accordingly then is the moral center of the human. After all, letting someone die is *prima facie* a strange way to respect them; however, as I will demonstrate in chapter VII (objections and responses) often the Kantian imperatives demand that we allow the phenomenal body and mind to die in order to render the necessary respect for the person.

their fear of loss. This conclusion is suggested both by evidence on changes in patient preferences (see chapter II) and by imagining what a typical person would want done in such a situation. As suggested in chapter II this problem arises from the fact that within the public sphere the perception is that modern medicine can extend life far beyond death with ventilators, CPR, and other tools remains. For example, one study in evaluating methods to improve CPR showed a baseline rate of return of spontaneous circulation (ROSC) of 51.3% and a survival to discharge rate of 9.2%<sup>123</sup> when performed in a hospital setting.<sup>124</sup> Despite this fact, in every medical TV drama, action movie, and pop culture reference, CPR is shown to be a relatively benign intervention that always works. Perceptions like this then lead family members and the general public to have a skewed perception of the ability of physicians and hospitals to save their loved one. A 1996 study published in the *New England Journal of Medicine* found that on television CPR had a ROSC rate of 75% and a survival to discharge rate of 67%.<sup>125</sup> Accordingly, CPR and aggressive interventions like it are believed to be far more successful by the general population than they actually are. With this perception the risk increases drastically that a family member might request interventions not for the sake of the patient's wellbeing with the belief that the interventions they are requesting are more benign and successful than they actually are.<sup>126</sup> In short, it is easier to think of oneself and justify this thinking when one views the consequences of an action as less drastic and painful than they really are. It is important to note

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<sup>123</sup> Wi? Weng et al, "Improving the rate of return of spontaneous circulation for out-of-hospital cardiac arrests with a formal, structured emergency resuscitation team." *Resuscitation* 60, no. 2 (2004) 137-42.

<sup>124</sup> It is far lower outside of hospital settings.

<sup>125</sup> Susan Diem et al. "Cardiopulmonary Resuscitation on Television — Miracles and Misinformation," *New England Journal of Medicine* 334 (1996) 1578-1582.

<sup>126</sup> There is a question here as to the role ignorance plays within the evaluation of the actions of an agent. This will be addressed once the role ignorance is given a formal analysis in my next chapter.

that this is not an evil or mean-spirited case of the family members crassly using their sick loved one.<sup>127</sup> Rather this is the common case in which the right thing to do is hard, which is often to allow one's loved one to die.

These actions and those like them by surrogates, despite their good intentions, still fail to live up to the demands of the Formula of Humanity. If one is afraid to give up on the family member at the end of their life and chooses to prolong treatment, despite the love that motivates that decision it still represents a failure to respect the patient as an end in themselves. The surrogate is making a decision here to protect themselves rather than to protect the dignity of the patient, and this then makes the patient a means to this end. Surrogates risk extending the patient's life as means to the end of not being forced to "give up" or lose a loved-one. To treat the patient as an end in themselves requires sometimes that hard decisions be made, and if the surrogate does not make these decisions then they stand in violation of the Formula of Humanity. Therefore, an intervention requested that has dubious benefit for the patient's ability to function as an thriving autonomous being and instead only prolongs their life in a limbo between death and a life of suffering should be closely scrutinized. In some cases it will prove that the ambiguity of the medical reality will mean that a surrogate could pursue such an intervention genuinely out of the patient's best interest;<sup>128</sup> however, frequently the risk arises in high-stress and emotionally charged situations like end of life care that sometimes surrogates will make the easier choice of continuing interventions where they are not medically or ethically appropriate. This problem then is one of the two primary ways in which the patient is not treated as an end in themselves in the ICU by the active moral agents.

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<sup>127</sup> It is conceivable this could happen though.

<sup>128</sup> In this situation my principle will suggest caution in the face of this uncertainty.

Despite the fact that they lack direct decision making power, physicians can treat patients as means rather than ends too through their advice to the family members and the attitudes they may adopt towards treatment. This violation is more subtle; however, the role of physician as the expert who offers treatment options to families cannot be ignored. The family member gets to decide which treatment offered by the doctor is appropriate, but the physician must decide which options to present to the family and how to frame these options. Therefore, a physician's personal beliefs and inclinations may have a drastic influence over the course of the treatment of the patient. For example, Kaufman describes how in the film *Near Death* physicians "rarely mention death per se. They never tell patients that no matter which treatments they choose, their medical condition will lead to death, or that death is imminent."<sup>129</sup> This is done with the best intentions as "the physicians in the film believe in hope, and they say repeatedly that there is always hope."<sup>130</sup> However, once again having the kindest intentions is not equivalent with respecting the autonomous person especially in a case of an epistemic imbalance between the family and the physician.<sup>131</sup> Thus, in either giving overly optimistic prognoses or not mentioning the reality of death this renders choice "a distortion or misrepresentation because the choices available are actually guided and limited by the options physicians and others present."<sup>132</sup> This means the choice of the family members is constrained by the options presented and influenced by the way they are presented, so this makes it difficult for them to treat the patient as an end in themselves. Simply put, forcing illusory choices that may not respect the patient as an end in

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<sup>129</sup> Sharon Kaufman, *And a Time to Die* (Chicago: University of Chicago Press, 2006) 46.

<sup>130</sup> Kaufman, *And a Time to Die*, 47.

<sup>131</sup> Miranda Fricker's *Epistemic Injustice* may offer more tools for discussing this issue further; however, for the sake of brevity I will not do this here.

<sup>132</sup> Kaufman, *And a Time to Die*, 49.

themselves upon someone out of either a misplaced sense of goodwill, fear of quitting, or some other inclination also violates the Formula of Humanity.

A final and perhaps more intractable problem is the larger and more systemic factors that influence the treatment as Kaufman discusses in *And a Time to Die*. This raises several questions key questions, and many of these cannot be treated here since they would require significant tangents to treat satisfactorily. Both the choices of family members and physicians are constrained by any number of factors, which exist at governmental, institutional, social, and cultural levels. The healthcare system itself can then railroad patients to certain choices of treatment when physician's available choices "exist within a system of institutional directives."<sup>133</sup> This can ostensibly be seen as a case in which a large and indifferent system callously treats patients as mere cogs in its machine. Kant's ethical philosophical machinery is often rightly criticized as poorly equipped for dealing with such large scale issues outside of the interpersonal action he focuses primarily on. Accordingly, this matter cannot be fully dealt with here, and further ethical theories better equipped for dealing with large systems might be better suited to address this issue.<sup>134</sup> Additionally, in *And a Time to Die* Kaufman deals with the empirical facts of these issues to a larger extent than discussed here. However, in the end despite what influences the system may have I ultimately believe it falls to individual to act.

### **What This Means in Korsgaard's Terms**

These situations and others not listed here can be clearly shown to be violations of the Categorical Imperative in that family members and physicians treat patients as means rather than

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<sup>133</sup> Kaufman, *And a Time to Die*, 48.

<sup>134</sup> G F W Hegel's *Philosophy of Right* has been suggested by my thesis advisor as being a fruitful source for dealing with such issues for instance.

ends rather than make difficult choices; however, frequently Kant has been accused of failing to demonstrate the importance of following the Categorical Imperative other than simply that it is what one ought to do. As suggested in chapter IV, Korsgaard's work in *Self-Constitution* overcomes this problem, and accordingly it can demonstrate the normative force these imperatives hold on us and the consequences for failing to adhere to them. Therefore, I would like to argue, through Korsgaard, that the core of the ethical wrongness of the current ICU stems at once from both the obvious disregard for the patient as an end in themselves and the fact that by failing to treat the patient as an end in themselves physicians and family members are failing in the process of self-constitution to some extent. This means, as suggested previously, that the role of the Categorical Imperative is not to be some arbitrary and harsh rule imposed from outside, but instead "when you deliberate in accordance with these principles, you pull yourself together and place yourself, so to speak, behind your movement, rendering it an action that can be ascribed to you as a whole."<sup>135</sup>

Therefore, practically speaking when agents within the ICU fail to do this process through failing to adhere to the Formula of Humanity they are failing not only the patient through treating them as a means but themselves as well by failing to legislate universally. They are failing to deliberate in such a way that renders them autonomous, which makes their actions less unified and accordingly less authentically their own. To act in disunity is to possibly not act at all. The 'you' behind the action disappears in cases of serious disunity. This is a serious problem in that it would be patently absurd to imagine if offered a choice between being something or nothing that anyone would choose to be nothing. To refuse to undergo this process

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<sup>135</sup> Korsgaard, *Self-Constitution*, 179.

of self-constitution then is to reject one's status as a human being capable of being more than a mere heap, and to then condemn oneself to a life of defective action. Within the ICU the case might not be as extreme as I will show, but generally speaking this practically means instead of deliberating and picking a choice that is authentically one's own choice that frequently action in the ICU is dictated by inclinations. Action that follows the whims of inclination is no more of an action than some subconscious animal instinct that exists on the other side of the spectrum from self-constitution. Ultimately, it will prove that within the ICU family members and physicians' actions are somewhat defective, while far from being as bad as not being actions at all.

It is then clear that to be someone it is necessary that one undergo the process of self-constitution as described in chapter IV, and to avoid actions that impair this process. As previously suggested, when one deviates from this path it is not a binary switch between completely the lawful freedom gained in the process of self-legislation and total lawlessness, but rather exists in stages of decay that can be paralleled to the bad constitutions of several *polis* that (timocracy, oligarchy, democracy, and tyranny) Plato considers deviations from the completely just city in the *Republic*. Within my discussion, timocracy is most relevant since I focus on cases in which everyone acts with an apparently good will. Oligarchy, democracy, and tyranny as forms certainly exist within the ICU; however, they represent different, less common, and clearer deviations from duty than timocracy.

In short, each form of constitution represents an increasing failure to render oneself the author of one's actions. The worst constitution, tyranny, represents a pure force of evil in a soul that is entirely ruled not by reason in the service of justice but instead reason in the service of some dominating obsession. The democratic soul is one ruled by pure inclination and whim. The

oligarchic soul deals well with controlling those necessary impulses, but ultimately can only satisfy himself and has only a thin veneer of virtue. Finally, the penultimate constitution before the aristocratic soul, the timocratic soul, represents “a person in whom spirit, the sense of honor, has usurped the role of reason.”<sup>136</sup> Practically this means the person does well when things are clear and easy, but in areas in which non-ideal theory takes hold they fail short. This is the case because these situations rather than an unbending sense of honor “the situation actually calls for is concession, compromise, a bending of the rules, or even--as for instance in the case of civil disobedience--actions that are in some formal sense wrong.”<sup>137</sup> Timocracy then represents the focused and determined physician, the loving family member, and other such characters within the ICU who typically mean well; however, ultimately their actions fail to live up to their duty as physicians and family members for “in this kind of case, while fighting for the freedom of the city, he destroys the city.”<sup>138</sup> Accordingly, their determination to press onward with aggressive interventions rarely represents a desire to see the patient suffer, but instead it represents the fact that in places like the ICU where non-ideal theory dominates sometimes a failure to compromise means that one’s honor will end up “cutting off the nose to spite the face.” In other words, it will, out of pursuit of the good, fail to see sometimes the best course is not always to keep pressing onward despite problems that may arise. This situation at its core arises from the fact that all parties are not acting on shared reasons, but instead acting on well-intentioned reasons of their own and the active parties are often failing to hold each other responsible to each other and the patient.

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<sup>136</sup> Korsgaard, *Self-Constitution*, 165.

<sup>137</sup> Ibid.

<sup>138</sup> Ibid.

Therefore, the error of the timocratic person is their failure to understand what it means to exist in a relationship of reciprocity, since “people who enter into relationship of reciprocity must be prepared to share their ends and reasons; to hold them jointly; and to act together.”<sup>139</sup> The timocratic person then exists within relations of reciprocity; however, they do not fully understand what it means ‘to act together.’ They either act with all the best intentions of helping their loved one, but this does not necessarily mean both parties are acting together. All too often these best intentions represent the culmination of not rational joint action, but instead represent a well-intentioned fear to give up, to lose a loved-one, or fear to be the one who “pulls the plug.” It should not be concluded here that I dismiss the great emotional turmoil end-of-life care situations present to the family members of patients, but in order to truly have a relationship of reciprocity it is necessary to hold that person and accordingly oneself responsible. After all, as Korsgaard argues, “reciprocity is the sharing of reasons, and you will enter into it only with someone you expect to deal with reasons in a rational way. In this sense, reciprocity requires you hold the other responsible.”<sup>140</sup> In the case of end-of-life care this may prove to be not fully possible since the patient cannot actively hold their loved one responsible for acting out what can be assumed to be their wishes. However, while the responsibility cannot be directly achieved in the phenomenal world, in the noumenal world it is fully possible to still reach a relationship of responsibility and reciprocity despite the physical limitations of the phenomenal body. It is necessary here to explain what “noumenal” and “phenomenal” mean, and how the distinction they embody has practical effects for Kant’s moral theory. Kant argues we process experience through several

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<sup>139</sup> Christine Korsgaard, “Creating the Kingdom of Ends: Reciprocity and Responsibility in Personal Relations,” in *Creating the Kingdom of Ends*, ed. Christine Korsgaard (Cambridge: Cambridge University Press, 1996) 196.

<sup>140</sup> *Ibid.*

Categories of the Understanding and the intuitions of time and space, which means what we ‘experience’ is functionally processed and thus does not represent the objects of our experience as they are apart from experience as things in themselves. The world as we experience it is the phenomenal realm, while that realm of things in themselves is the noumenal realm. Nothing can be said about the character of the noumenal, and instead only certain practical postulates may be assumed. Kant goes on to argue the intelligible and moral self is in the noumenal realm, and that while we experience the phenomenal realm as casually determined that free will might be possible in the noumenal realm.

Accordingly then what it means to evaluate an action takes different meanings depending on whether the person is considered as belonging to the phenomenal or noumenal realm. Therefore, Korsgaard argues through Kant that there are two standpoints one can take when evaluating another’s action, which is an essential part of holding someone responsible. These standpoints are that on one hand oneself and other people are members of the phenomenal causally determined world, while the other is that one is a member of the world outside of time, the noumenal world. This is practically important because in the act of holding someone else or oneself responsible it is easy to give justifications on how “giving up” would be wrong and something that would be extremely emotionally difficult. Within the phenomenal world “human beings are subject to certain incentives-impulses which present themselves to us as candidates, so to speak, to be reasons for action.”<sup>141</sup> One such candidate for action is the good-natured impulse to attempt to keep a family member alive, but in end-of-life situations this impulse proves to lose its importance and in fact can become harmful leading to the situation described above.

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<sup>141</sup> Korsgaard, “Creating the Kingdom of Ends,” 202.

However, this impulse still makes it hard to hold oneself responsible to one's loved one or patient.

Thus, these standpoints seem to conflict, and Kant argues these disputes between the noumenal and the phenomenal world have an impossible ontological gap between them. However, this cannot be the end of the discussion of responsibility since "there are contexts in which we have to mix considerations derived from the two standpoints, and make a moral assessment of someone's action, on the basis of a theoretical explanation of what she did. This occurs when we are making judgments about responsibility."<sup>142</sup> In short, the problem is that it seems we either totally ascribe someone's actions to the phenomenal world or to the noumenal world, and in the case of holding people responsible it seems practically hard to do this without mixing the two. Ultimately, Korsgaard concludes that it is fair to allow some phenomenal considerations to enter into the process of holding people responsible, for "respect for someone's humanity is not always best expressed by holding him responsible for each and every action."<sup>143</sup> Respect then for Kant is essential but not ironclad, and sometimes part of respecting someone is realizing that "even the best of us can just slip."<sup>144</sup> For families of patients this means in terms of holding themselves responsible that sometimes their fear of loss can cause their decision making power over the loved-one to be biased. It also means that for patients they must hold physicians responsible to fully explain all issues, and to not attempt to "cherry coat" the truth. For physicians it means telling hard truths to family members, and telling them from an unbiased medical perspective what ought to be done to best help and respect the patient. And finally for

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<sup>142</sup> Korsgaard, "Creating the Kingdom of Ends" 205

<sup>143</sup> Korsgaard, "Creating the Kingdom of Ends" 211.

<sup>144</sup> Ibid.

the patient themselves, holding themselves responsible means ensuring that they clearly communicate their wishes. Ultimately, all these things must happen if the ICU is to become part of the Kingdom of Ends, and currently these things are not happening and thus truly reciprocal relationships within the ICU cannot form. Accordingly, I will develop a principle (DKDNR) that will attempt to promote this kind of respect through a principle of caution.

In short, a principled form of Kantian autonomy is the solution for the problematic situations that arise as a result of the dominance of an ineffective form of individualistic autonomy that is practically operationalized through informed consent. It is required that patients, physicians, and family members work together to gain shared reasons in the way that is required to establish a meaningful form of autonomy. To have principled autonomy is to undergo the process of self-legislation and self-constitution, and to not merely be able to pick between some options when presented to you. The latter is currently the reality of end-of-life care, and because of it real human suffering is occurring every day. What is necessary is to act in such a way “whose principle could be adopted by all others,”<sup>145</sup> and in doing this self-legislation achieves its goal which is to render the agent the author of their action. In short, it is to undertake efforts to create a meaningful Kingdom of Ends rather than accepting the loose associations of individuals that exist today. Individualistic Millian autonomy is simply the minimum condition that a human can act without constraint. It offers no guarantees of anything other than a veneer of choice, which in the ICU quickly reveals itself as illusory and harmful. When choices are hard, Millian autonomy fails most clearly since merely making it seem like choice is possible and

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<sup>145</sup> O’Neill, *Autonomy and Trust in Bioethics*, 85.

hoping for a good outcome is incredibly naive. What is needed instead is reciprocity, respect, and responsibility.

### **Conclusion**

When Kant, Korsgaard, and O'Neill are applied to end-of-life care in America today it becomes clear that there is a great and continuing failure of the system and its agents to create a Kingdom of Ends. Instead it is clear among all agents who exist within the ICU that heteronomy dominates leaving family members and physicians heteronomous while patients suffer the cost. Within the classic Kantian analysis it is clear that patients often are treated by family members as means rather than ends when family members fail to realize that sometimes the right course of action is to allow the patient to die. Physicians do the same in the way that they present options to the patient and their family, and by failing to be explicit or failing to accept defeat railroad patients to greater intervention. Interestingly patients themselves may fail to treat themselves as ends in themselves through their lack of end of life planning. However, to use Korsgaard's terms, the end result is the same which is that despite all good intentions patients suffer in the ICU and the process of self-constitution fails. This can ultimately be attributed to what O'Neill calls the dominance of individual autonomy that gained popularity in the 80s and 90s in response to medical paternalism.

To create the Kingdom of Ends much change is needed. People who are in deeply meaningful relationships of reciprocity like the patient-physician, physician-family, or patient-family relationships must hold each other responsible so that principled autonomy can come about. The question is how can such a massive cultural change be effected especially in such an uncertain environment? My answer is a principle of caution in the face of uncertainty that will

prove useful in preventing some of the more egregious failures of self-constitution found in the frequent violations in the Formula of Humanity that occur in the ICU. Through this principle it will be possible to “put the brakes” on the processes that occur daily in the ICU, and until large cultural change can occur it will be able to mitigate some of the damage done until the Kingdom of Ends can truly arise.

## **Chapter VI**

### *Don't Know, Don't Resuscitate: Combining Guerrero's Moral Epistemic Contextualism with Kantian Ethics*

With the moral epistemological framework made available in chapter III and the Kantian normative framework and assessment developed in chapters IV and V it is now possible to combine them in an act of synthesis to create a principle of Don't Know, Do Not Resuscitate (DKDNR). In order to do this I will first restate the key components of Guerrero's framework in brief with emphasis on the concept of blockers, what particular acts are morally risky, and the essential components of Guerrero's own principle DKDK. Once this short summary is given I will introduce some desideratum for my principle, which I hope will clarify why it is formulated the specific way it is in order to meet the challenges described in chapter V. Following this the blockers hinted at in chapter V will be explicitly demonstrated, and the uncertainty surrounding this will be emphasized laying the groundwork for increasing the stakes in a moral epistemic contextualist framework and leading to a principle of DKDNR. Finally, the principle itself will be introduced, demonstrated to meet the aforementioned desideratum, given an explicit breakdown into its various components, and then practically analyzed in terms of its effects and function. Objections and refutations to my framework and its application will be considered in the next chapter.

#### **The Framework Reviewed and Desiderata**

Guerrero's framework essentially examines under what conditions we may justifiably act in the face of uncertainty, and he concludes that certain morally risky possibilities, known as blockers, raise the contextual standards for morally justifiable action. Therefore, if one is uncertain whether a blocker may be present or not then if this blocker is morally significant then

the standards for what an action requires to be morally justifiable rises significantly. Only if extremely morally pressing obligations outweigh the blocker is it possible then to act in uncertainty over its existence. In short, what a moral epistemic contextualism says is that if “a state of affairs that is a blocker for actions that the person is contemplating performing, then one is morally required to do more from an epistemic point of view with regard to investigating whether p is true, whether the relevant state of affairs obtains.”<sup>146</sup> Guerrero applies this framework in a principle he calls ‘Don’t Know, Don’t Kill,’ which claims: “if someone knows that she doesn’t know whether a living organism has significant moral status or not, it is morally blameworthy for her to kill that organism or to have it killed, unless she believes that there is something of substantial moral significance compelling her to do so.”<sup>147</sup> This principle, and any similar principle, has four parts: the epistemic state component, the fact F component, the action component, and the justification component. In the DKDK case these are broken down in the following manner:

**Epistemic state component:** one knows that one doesn’t know whether F  
**Fact F component:** that some particular living organism has moral status  
**Action component:** to kill an organism or have it killed  
**Justification component:** one believes that there is something of substantial moral significance compelling one to perform the action<sup>148</sup>

Therefore, any similar principle will be formed along similar lines, and how these components are designed will then affect how the principle functions in action. Therefore, it is important to be clear in each section to avoid confusion and conflicting conclusions, and it additionally needs to be clear that this framework is being applied within a neo-Kantian

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<sup>146</sup> Alexander Guerrero, “Don’t Know, Don’t Kill: Moral Ignorance, Culpability, and Caution” *Philosophical Studies* 135 (2007) 74.

<sup>147</sup> Guerrero, “Don’t Know, Don’t Kill,” 78.

<sup>148</sup> Guerrero, “Don’t Know, Don’t Kill,” 79

framework. Applied with a different normative theory as previously suggested in chapter III, such as a Scanlonian account, one may find radically different conclusions:

We can see this if we consider cases in which the moral status of human beings might be uncertain. Consider, for example, a case in which there is a question raised of whether people in comas or other vegetative states have moral status. In such a case, it seems quite reasonable to think that a principle like DKDK serves to protect our interests (rather minimally), given that we might end up in such a state, and might exit such a state.<sup>149</sup>

This is a radically different conclusion than my principle and, as I discussed previously, I will again address this comment of Guerrero's in the next chapter; however, for now it is just essential to remember the context in which a principle of DKDNR functions.

Thus, with those ideas in mind I will examine what the desideratum of my principle should be in order to most adequately deal with the problem of the modern ICU and the frequent violations of the Formula of Humanity that occur within it. A primary desideratum (1) must be that such a principle does not itself treat the patient as a means instead of an end in themselves, so the principle must be isolated from larger concerns like reducing ICU end-of-life spending for example. It must be entirely patient oriented and phrased in such a way that it cannot function as an excuse for families, physicians, or hospitals to withdraw care too soon for unscrupulous reasons. In short, it must not force the pendulum to swing too far in the other direction, which would be to allow patients who may have lived to die for fear of violating DKDNR. After all, the maxim of 'do no harm' should not be forgotten.

With that stipulation in mind then it is possible to discuss the positive desiderata. The primary positive desideratum (2) is the inverse of the primary negative desideratum, and it is rather simply that the principle promote the formation of the Kingdom of Ends. It would likely

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<sup>149</sup> Guerrero, "Don't Know, Don't Kill," 86.

be possible to formulate a principle that successfully prevents harms without having any meaningful positive effects. It is important then to ensure that the principle does not merely function as some arbitrary rule, but instead aims to increase the deliberation and self-legislation within the agents of the ICU. A penultimate desideratum (3) is that the principle be applicable within the current medico-legal paradigm, which may prove difficult since I directly attribute that paradigm to causing much of the harm found in the ICU. However, in order for this principle to be more than just an idea it ought to be applicable in our non-ideal world, so that we can begin to build to an ideal world and case for its application. The final and perhaps obvious desideratum (4) is that the principle incorporate and make explicit the blocker found in chapter V in the face of the uncertainty described in chapter II. In short, this is simply a requirement that the principle be the summation of the critique given so far.

### **The Blocker and the Uncertainty**

I will begin my formal explication with desiderata (4) since it represents the formal requirements for a principle within Guerrero's framework. As previously suggested, the Kantian critique of the ICU will provide a broad blocker that exists in several forms with the general form of the risk of decreasing one's own autonomy or treating another as a means instead of an end in themselves. There will be specific ways in which this blocker exists, but broadly speaking the violations of the Formula of Humanity represent the core of my blocker. It should be noted that blockers could be discovered using the other Formulations of the Categorical Imperative since they are theoretically equivalent.<sup>150</sup> However, I will explain the blockers I have isolated in

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<sup>150</sup> See Chapter VII.

terms of the Formula of Humanity since I think it most insightfully captures what is wrong with the current state of the ICU.

As argued in chapter V within the modern ICU frequently patients are not treated as ends in themselves, but instead are treated as means to an end in various ways. A blocker is formally defined as “any state of affairs which, if it obtained, would make it morally impermissible to perform some action A, a ‘blocker’ with respect to A.”<sup>151</sup> Therefore, in this case the state of affairs that is at risk of being obtained is a state of heteronomy actualized through treating someone else as a means rather than an end, and additionally the harms that happen to the patient pursuant to the heteronomous actions. It is simply morally impermissible to treat another as simply a means, and morally impermissible to act in such a way that renders oneself not fully the author of one’s actions. Generally speaking then any action ‘A’ that would result in the aforementioned effect is categorically wrong, and if it was knowingly done then the agent would clearly be acting heteronomously in their harm of others. Most often agents are not aware that these blockers exist, but “what moral epistemic contextualism tells us about (BI1) cases<sup>152</sup> is that it will generally be unreasonable to fail to investigate whether the blockers for the actions (or intentional omissions) that one is performing obtain, at least for certain ‘obvious’ blockers for the particular action (or intentional omission) one is contemplating.”<sup>153</sup>

The actions taken by agents within the ICU then are most frequently and most clearly B1 cases. Being a family member or physician in an ICU is not easy, and the system makes it hard to take a step back and see that one’s actions really are causing the patient to be treated as a

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<sup>151</sup> Guerrero, “Don’t Know, Don’t Kill,” 73.

<sup>152</sup> (BI1) S never thought about whether F was the case, (a) it was reasonable for S not to think about this, (b) and S remained ignorant of F (Guerrero, “Don’t Know, Don’t Kill,” 67).

<sup>153</sup> Guerrero, “Don’t Know, Don’t Kill,” 73.

means rather than an end. Despite this the stakes at hand mean that it is not reasonable or acceptable for this ignorance to continue, for the family members and physicians have “epistemic obligations, stemming from moral considerations, to consider whether what [they] did was morally wrong or not before doing it.”<sup>154</sup> Hence it is fair to say it is unreasonable that a family member not realize that their actions to keep their loved one alive are really out of a fear of loss rather than on behalf of the patient. This happens every day, and both physicians and family members are culpable for not examining whether their actions at the end of the patient’s lives were treating the patient as an end in themselves. Therefore, it is clear that at the end of life that there is a blocker that exists, and that physicians and family members have a duty to investigate whether or not they risk obtaining the morally undesirable state of affairs expressed by the blocker.

However, a blocker alone is not enough for a principle of DKDNR, since alone a blocker is only a somewhat trivial way of rephrasing a sort of possible normative violation. What makes blockers interesting is how function in the face of uncertainty. If one knows about the existence of a blocker then one ought not to act, and to act in the face of a known blocker is obviously wrong. However, in cases of empirical or moral uncertainty Guerrero’s moral epistemic contextualism offers a wealth of resources for navigating this normative minefield. So, like DKDK, DKDNR will be “a principle about what we can non-culpably do in a specific kind of case of uncertainty. The epistemic state component and fact component together define the nature of the uncertainty.”<sup>155</sup> In the case of the ICU, uncertainty exists in several forms that

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<sup>154</sup> Guerrero, “Don’t Know, Don’t Kill,” 75.

<sup>155</sup> Guerrero, “Don’t Know, Don’t Kill,” 79.

builds up to the central uncertainty of what is the morally right course of action.<sup>156</sup> There is the empirical uncertainty that surrounds questions of the patient's condition and their prognostication. Furthermore, there is empirical uncertainty on what the patient's wishes would have been if they were still conscious.<sup>157</sup> There is the broad confusion that results from the Byzantine structure that the modern American healthcare system is, and this combines with peripheral practical uncertainties on the part of the family that arise from a system that can be economically burdensome upon patients and their families. Physicians, beyond the uncertainty of prognostication, can also be uncertain in terms of best practices for treatment. Family members may be uncertain of whether they are acting in their own interest or the interest of the patient. Ultimately, these forms of uncertainty build together to the ultimate moral uncertainty of what the right choice of treatment is. Together these things make it anything but clear what the right choice of action is, and accordingly it is hard to know one way or another whether or not a patient is being treated as a means instead of an end in themselves. This means that this is clearly a case in which a principle like DKDNR or DKDK can be useful since each agent must ask themselves how they ought to act in the deep uncertainty of the ICU in the face of possible blockers.

### **The Principle**

With that in mind, I would like to introduce my principle of Don't Know, Do Not Resuscitate formally:

**DKDNR:** If an agent with decision making power or influence over a patient in a critical care situation knows that she doesn't know whether their proposed aggressive interventions treat the patient as an end in themselves, it is morally

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<sup>156</sup> Refer to chapter II for a detailed description of the sorts of uncertainty.

<sup>157</sup> This is distinct from what the right course of action is.

blameworthy for her to pursue aggressive interventions, unless she believes that there is something of substantial moral significance compelling her to do so.

This then is my principle of DKDNR: in simple terms it suggests that if a family member or physician is unsure whether they are acting out of the best interests of their patient or not then they ought to avoid aggressive interventions. Its title imagines a situation in which a patient is coding, and the family and physicians are unsure what to do. I believe in cases of strong uncertainty and lacking strong moral justification to act despite this uncertainty that they ought, rather than beginning aggressive resuscitation, to act as if the patient had a DNR order. Broadly speaking then I think intubations, aggressive use of pressors, aggressive chemotherapy, aggressive, dialysis, radical surgeries, chest compressions, and other interventions should be avoided unless there's a pressing moral reason to act despite the possibility of a blocker. This will not always necessitate a DNR order (despite the title of the principle) I will examine what these conditions might be now as I break down my principle into its epistemic state, fact, action, and justification components in a manner analogous to Guerrero.

**Epistemic state component:** one knows that one doesn't know whether they are treating the patient as an autonomous person.

**Fact F component:** that an intervention treats the patient as a means rather than an end.

**Action component:** to perform aggressive interventions on the patient

**Justification component:** one believes that aggressive interventions are mandated by extenuating moral or empirical circumstances.

The epistemic state component can be understood with the fact component as it and “the fact component together define the nature of the uncertainty.”<sup>158</sup> That is to say that frequently the problems discussed in chapter II lead to a deep uncertainty at multiple levels and of multiple types throughout the ICU, which ultimately means that the agents DKDNR applies to, if questioned, would likely admit they are not fully sure what the correct choice of action is. This

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<sup>158</sup> Guerrero, “Don't Know, Don't Kill,” 79.

can be expressed in degrees of certainty and uncertainty, and Guerrero postulates some numerical scale that could be developed to quantify the appropriate range in which acting in the face of ignorance would violate my principle.<sup>159</sup> However, that can be considered outside of the current range of discussion, and I would suggest that to get lost in such details would risk getting lost in the weeds. Generally, as Guerrero argues, “not wanting to introduce precision where it seems unmotivated, I prefer the original DKDK formulation, but it is important to note that we could in principle increase the precision in the way indicated.”<sup>160</sup> Thus, the epistemic state component ultimately represents the agent's uncertainty about what the right choice of action in the ICU.

The action component along with the factic component together have already been discussed extensively as well. Together they represent the culmination of the discussion in chapter V, which ultimately paints a picture in which uncertain agents act in ways that risk violating a blocker frequently faced within the ICU, for as Guerrero argues “for DKDK-type principles, the issue in question in the fact component will typically be a possible source of blockers for the action described in the action component.”<sup>161</sup> Specifically, because of the epistemic uncertainty some action is of questionable moral standing, namely, aggressive interventions on patients in the face of moral and empirical uncertainty. The relevant blockers demand caution in the face of uncertainty, and in this case then demand that less aggressive measures be used unless certainty can be reduced.

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<sup>159</sup> Ibid.

<sup>160</sup> Ibid.

<sup>161</sup> Ibid.

Finally, the justification component renders the principle practically applicable though allowing that there will be cases of uncertainty in which action ought to be either allowed or even demanded. Without that this principle would be a paralytic force on agents who took it seriously, and it would overstep its purpose in preventing a far larger set of actions than intended. In an ideal world people would only act under complete certainty; however, as I have suggested we do not live in an ideal world, and ideal principles applied to strenuously to a nonideal world can be harmful. The question is then: in which situations is action justified in spite of caution? With Guerrero, I believe that there are three primary relevant components of justification: the belief component, the motivation component, and the compulsion component.

All the components emphasize different parts of the same idea that: “what is relevant for DKDK is just that the person in the situation believes that there is something of substantial moral significance compelling them to act.”<sup>162</sup> The emphasis then differs between what is a sufficient belief, what the content of that belief is, and what that compulsion is. In regards to the first part, Guerrero leaves the question of what a sufficient belief is somewhat open between demanding a justified true belief or just general doxastic content. He puts forward an articulate defense of the latter, which I prefer. It simply requires that “they must have made a reasonable effort to think about whether the thing apparently compelling them to act actually was of substantial moral significance. If they believe that it is, after having met their epistemic obligations, then that is sufficient to meet that part of the justification component.”<sup>163</sup> It may seem strange to prefer the less demanding version; however, it is important to remember the question is not whether the action is objectively right but rather “that we are only concerned with moral culpability; it

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<sup>162</sup> Guerrero, “Don’t Know, Don’t Kill,” 80.

<sup>163</sup> Ibid.

remains an open question whether an individual is objectively wrong or not.”<sup>164</sup> Therefore, in terms of the belief component it is sufficient that the agent seriously believe she is obligated to act and has done her due diligence in terms of epistemic investigation.

The second component is more straightforward, simply stating that “it is not enough that the person feel that there are non-moral considerations in favor of acting.”<sup>165</sup> That is to say that the possibility of gaining an inheritance on the death of a loved one to purchase a new car obviously does not count as sufficient justification to stop treatment. The content of the belief in question must be centered on a question of obligation. In Kantian terms this means that the agent must believe that they risk violating either the Formula of Humanity or the Formula of the Universal Law by not acting. What some examples of situations in which an abundance of caution would risk violating the Categorical Imperative will be discussed in the next section of this chapter.

Finally, in terms of the last component it is essential that there not merely be a moral belief that one should flaunt the principle, but that morality *compels* one to ignore it. Guerrero discusses several ways to interpret this, and rightly rejects this phrase being interpreted as treating moral considerations as “what is required is that the person believes that failure to act in this case has higher expected moral disvalue than acting.”<sup>166</sup> Therefore, it can be seen as sort of a utilitarian balancing of moral value, as “the notion of compulsion at work here is something like rational compulsion: given that one is trying to act morally, one is rationally compelled to act in the way that is likely to maximize moral value.”<sup>167</sup> Guerrero finds this impractical, and I find that

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<sup>164</sup> Ibid.

<sup>165</sup> Ibid.

<sup>166</sup> Guerrero, “Don’t Know, Don’t Kill,” 81.

<sup>167</sup> Ibid.

such weighing of obligations conflicts with my neo-Kantian framework. Ultimately, I prefer the formulation that Guerrero suggests in which “it is something like ‘the balance of moral reasons (and prudential reasons, insofar as we are morally permitted to take these into account) tips in favor, and perhaps heavily in favor’”<sup>168</sup> of ignoring the cautionary principle. In this interpretation moral compulsion functions in such a way in which reasons are considered holistically rather than numerically. Again in Kantian terms this will be the case when it becomes clear the DKDNR cannot be universalized as if it was a natural law or would clearly result in disrespect to the dignity of the true person.

I believe then that there are situations in which it would be wrong to follow DKDNR, and explicitly these occur when as with DKDK “one believes oneself to be morally compelled to kill the organism, despite being ignorant of its moral status, and aware that one is ignorant.”<sup>169</sup> In terms of my principle these situations will have the general form of in which the moral risk of allowing a patient to die would outweigh the risk of any intervention treating them as a means rather than an end. I will examine specific situations in which I think this occurs in the next section after I have shown how I think the principle should generally work in practice. This portion of my principle is particularly important to emphasize, because a central objection that I am concerned about is that my principle will be perfectly happy to let people die who otherwise may have lived out of the fear of violating some abstract Kantian imperative. I do not think my principle demands such a thing when properly applied; however, as the triumph of “autonomy” in bioethics suggests, bioethical principles have a particular tendency to be operationalized at their lowest common denominator. Accordingly, I will spend a significant amount effort in the

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<sup>168</sup> Ibid.

<sup>169</sup> Guerrero, “Don’t Know, Don’t Kill,” 82

next section of this chapter and my next chapter attempting to empty the set of concerns people may have concerning the risk of letting people die who had years of life to live if only some “heroic measures” had been pursued.

### **Analysis and Explication of the Principle**

So what does the principle practically demand then? What does it mean to take a principle of DKDNR seriously? In a non-technical sense it means that when family members and physicians are faced with a patient who might be approaching end of their life that they should not consider the default to be aggressive interventions. The current method of caring for people at their end of their lives is typically to ramp up care initially then after this is decided to be futile to move to comfort care only at the very end. My principle suggests that perhaps those early aggressive efforts are inappropriate, and certainly aggressive efforts as a person passes through the singularity of death are. Currently, in the face of uncertainty we feel the natural response by physicians ought to be to do everything until more certainty arrives; however, all too often by the time certainty is found it is far too late. Dignity is lost. My principle aims to prevent this loss of dignity from happening in the first place.

Formally, my principle demands that if there is normative or empirical uncertainty then aggressive interventions should be considered only in particular circumstances. Efforts ought to be made to decrease this uncertainty, but should these efforts fail or be too slow then the default most often should be to only do those interventions that treat and improve the patient's symptoms, or, if curative, have a minimal or low side-effect profile. Interventions that are painful, uncomfortable, dehumanizing, and disorienting should be avoided. If the patient happens to get better then that is deeply fortunate; however, if the patient passes they can be said to have

died with as much dignity as possible. Ultimately, death is an essential part of being human, and our society has forgotten how to die. As the funeral service rites in the Anglican *Book of Common Prayer* famously declares: “From ashes to ashes, from dust to dust.” What my principle ensures is that the death of a patient is not preceded by a period of suffering that is not their desire or to their benefit. Those treatments that are appropriate to pursue in these cases then are those that are chosen with the full acceptance that in some cases less is more. In short, my principle suggests things like palliative care or comfort care ought to be pursued more often. More often than not this sort of care will prove to be better for the patient, the family, and the physicians and nurses for whom the current approach causes much suffering. Furthermore, palliative care has been found to actually extend life;<sup>170</sup> this suggests that concerns that my principle will let people die premature deaths are unfounded.

Thus, if a physician is uncertain about whether they are treating the patient as an end in themselves, they ought to ensure that they act in such a way that does not prejudice the family against less aggressive care. They certainly should not frame the issue in terms of “giving up,” and instead frame the issue as the possibility giving a loved one that last full measure of devotion in allowing them to die with dignity. In short, they should simply be honest and unbiased while demonstrating the choices available to the patient. This is what Korsgaard means when she discusses concepts like respect and reciprocity. For the physician to respect the family as legislating members of the Kingdom of Ends they must overcome the problematic avoidance of discussions of death as found by Kaufman. They need to meet them as persons worthy of respect,

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<sup>170</sup> Jennifer Temel et al. "Early Palliative Care For Patients With Metastatic Non–Small-Cell Lung Cancer" *New England Journal of Medicine* 363 (2016) 733-742.

and in doing this they must be cognizant of the fact that their suggestions will have a great influence over patient care. Accordingly, they must not sugarcoat the situation, and out of duty to themselves, to the family members, and most of all to the patient they ought to be cautious about aggressive intervention if they are uncertain whether it is appropriate medically or normatively.

Family members must be similarly cautious: when they feel the impulse to have everything done for their loved one they need to be sure that it will be medically useful and is what their family member actually would want. If they are unsure of this fact then my principle applies, and if they know this is not the case then there is no circumstance under which they may pursue aggressive interventions. They have the power to allow their loved one to pass peacefully, and thus their default should be to only pursue aggressive treatment when they are sure it will result in a good outcome for the patient and that the patient desires such an intervention. Simply put, if they are uncertain then they should hesitate before asking the physician to do everything. As with the physician this demonstrates respect for the noumenal personhood of the patient, and in doing so represents an effort to gain shared reasons and to truly be self-constituting legislators in the Kingdom of Ends. My principle gives them the framework to step back and make the right choice (or at least avoid a bad one).

With that in mind it now falls to examine whether this principle meets its four desiderata:

- (1) The principle does not itself treat the patient as a means instead of an end in themselves.
- (2) The principle ought to promote the formation of the Kingdom of Ends.
- (3) The principle ought to be applicable within the current medico-legal paradigm
- (4) The principle incorporates and makes explicit in the form of blocker found in chapter V in the face of the uncertainty described in chapter II.

The formation of my principle I think successfully fulfills (1) in its wording as it explicitly disallows material exceptions in the justification component, and it explicitly treats any

occasion in which the patient is treated as a means rather than an end as a blocker. Furthermore, the justification portion of the principle allows for cases in which (1) would be at risk to overrule the principle. This fact means that the principle in its application explicitly avoids treating the patient as a means to an end, while ensuring that the patient is not harmed as a double-effect in the overzealous application of the principle. In other words, in any situation in which (1) would be at risk of being violated the justification component allows the agent to ignore the principle if they are morally compelled to.

As suggested in the above paragraphs my principle also helps promote the beginnings of a Kingdom of Ends in the ICU (2) through stopping a positive harm and laying the groundwork for positive progress to be made within the ICU. In other words, it helps overcome the limited autonomy promoted by the bargain bin version of autonomy derived from Mill and operationalized through informed consent requirements as described in chapter V. It forces everyone to slow down, and realize that the paradigm that they are currently working almost inevitably treats the patient as a means to an end. Currently, the medico-legal paradigm is based around such empty requirements of informed consent, and it is called autonomy. This may provide some false comfort to physicians and family members who can claim they did everything by the book; however, any close and honest examination of the ICU will reveal how empty this is. DKDNR is like a stoplight in this way in that it demands that people take a step back and realize that the actions they felt were justified despite the normative and empirical uncertainty present in the ICU actually are failures to respect the patients as an end in themselves. Under DKDNR the empty version of autonomy used currently loses its legitimacy, and thus may possibly be overcome and replaced with a principled version of autonomy.

Similarly, (4) is achieved through the form of the principle explicitly being focused around the idea of aggressive intervention against the patient's will being the central action and fact component. Therefore, in its efforts to promote the formation of the Kingdom of Ends through its effort to prevent the realization of blockers it can be said to meet (2) and (4).

My principle furthermore meets (3) through how I believe it ought to be operationalized, which is explicitly within the current decision making framework of the day. It recommends that physicians simply avoid hiding the fact from the family and themselves that the patient may die, and instead speak frankly about what they think should be done. Inversely, if they are overly zealous and want to press forward then it ask them to take a step back. It simply demands that patients when presented with these options exercise caution before deciding upon aggressive measures. For example, it cannot be said to demand that physicians overstep their role into paternalism, because that would violate the current way in which decision are made by patients in legal terms, let alone the moral problems that arise through physician paternalism. I cannot see any way then that my principle would be found to be not operationalizable within the modern medico-legal paradigm.

### **Operationalizing the Principle**

Now it remains to illustrate some practical examples of how the principle would work both when it recommends caution and when a sufficient justification overrules it. Additionally, I will examine in brief some practical ways the principle can be brought into actual use in the real ICU, and what I generally think the future of my principle ought to be. I believe the examples of caution are more clear so I will accordingly spend more time focusing on cases in which there is sufficient moral justification to compel one act in the face of uncertainty. What exactly justifies

this will be left somewhat up in the air as it is impossible to cover every possible case, but what I intend to show is the gist of the principle's justificatory exception so that the reader understands how I think the principle should be applied. Others may find the justificatory exception bar lower or higher than I do; however, where exactly the bar should be can be worked out elsewhere. What is important here is the general form of the principle, not every single detail and process for its application.

My archetypical example for its application is when an elderly individual with chronic health issues (COPD, CHF, etc.) or a younger individual with terminal illness (ALS, metastatic cancer, etc.) presents with an acute exacerbation of their disease process to the emergency department and then are brought into the ICU. The question of whether they are on the verge of dying may be open, and what care is appropriate may not be clear. It is in both these sorts of cases that I want a principle of DKDNR to apply, and suggest that less aggressive care should be strongly preferred in light of the uncertainty. The general characteristic of this archetype is that the ultimate question of whether death is inevitable is not uncertain. In either the old or young example here it is clear that at some point in the not-so-distant future they will die, but what is uncertain is when exactly in that not-so-distant future it will be. Therefore, the uncertainty is of whether it is justifiable to forgo more aggressive "curative" measures in favor of those that are more "palliative." My principle then suggests that the latter is the better course, since to pursue the former risks it being done not entirely for the patient's sake. This is the ideal case in which DKDNR should apply. It will prevent unnecessary and unwanted interventions from occurring in someone for whom death is approaching.

The more interesting and complex case is that of when death is not expected as the result of a specific disease process, but instead a certain illness or trauma comes suddenly in middle-age, young adulthood, adolescence, childhood, infancy, or even pregnancy. These are all cases in which typically or apparently healthy people do not expect to die, and due to either some unknown problem or some acute trauma or infection their health is rapidly compromised and the question of their survival enters into question. How does a principle of DKDNR apply here?

The broadness of this question makes it more difficult to answer, and I want to suggest that this sort of case is the kind in which one can rightly believe there is some compelling moral reason to pursue aggressive intervention. There are people in this broad class of age ranges and illnesses who if treated aggressively may survive and live relatively normal lives. It is difficult to talk about each case intelligently without making overly broad generalizations that would ultimately prove unwise or untrue. Therefore, I will suggest that these be taken on a case by case basis since each different disease process, each different age range, and each different combination of the two will produce different results. I believe that a child who suddenly develops cancer should be treated more aggressively than an elderly man with stage 4 colon cancer because many childhood cancers while often fatal are sometimes also survivable in a way many adult pathologies are not. To give a child the possibility for a whole life is worth the risk that they may not want further treatment. It may be suggested here that the child is also not fully autonomous; however, that does not resolve the greater problem of how a Kantian can justify this. Another example might be that it could be justified to treat a young victim of an industrial accident more aggressively despite the normative uncertainty, because, as with the child, of the compelling moral value that the possibility of giving someone an entire life represents.

However, generally speaking each of these cases ought to be considered individually and each of the various compelling moral stakes made clear. One important thing to note here is that if there is a clear chance of not only maintaining life but actually saving it then that will always be a compelling moral reason to continue aggressive treatment. Frequently, the line between them is blurred so it may be difficult to separate the two; however, I believe enough of the time enough of a difference can be made clear to either apply or not apply the principle accordingly. Generally speaking, even in these complex situations in which it is not clear whether DKDNR should apply or not, an important secondary effect of DKDNR is to simply start the conversation sooner about whether aggressive care is appropriate or not. This beginning of a conversation alone is deeply important, since it introduces a question which under the modern paradigm is not brought up ultimately until it is far too late.

In short, DKDNR is a flexible principle and while it is difficult to say exactly how it ought to be best applied in every situation a few general guidelines can be found for its application. First, that it should always at least be considered even if it is quickly overruled in favor of more aggressive treatment. Second, generally the younger and healthier the patient was before they got sick the less likely DKDNR will apply; however, if their illness is particularly grim then this rule itself may no longer apply. Thirdly, what a compelling moral belief is may vary and it is impossible to predict all of them; however, if one does appear it is important not to blindly accept it but instead to use it to begin a discourse. Finally, it is important to remember that like a Kantian imperative, DKDNR ought to be used as a general framework for thinking about end-of-life decision making and not as a textbook on how to do it. It is a tool, not a guidebook. Its goal is not to direct every decision, but instead to help agents within the ICU to

act as self-legislating members of the Kingdom of Ends. Therefore, a solution to every problem would be inappropriate, and would lose one of Kant's insights which is namely the process of moral reasoning matters equally as much as the result.

It is conceivable that further, more radical, cases in which DKDNR is overruled can be found, and these will typically rely on factors external to the patient. For example, it is conceivable that a patient with terminal cancer enters into a situation in which DKDNR becomes relevant. He has children who could use their sick father's inheritance to pay for college, which they need desperately or they will be forced to drop out and possibly not be able to support themselves.<sup>171</sup> Does this count as a compelling moral reason to ignore DKDNR? In a Kantian framework, this is not compelling moral reason since to allow one's father to die to gain an inheritance that would serve a noble cause still would be treating the patient as a means to an end in violation of the Formula of Humanity.<sup>172</sup> With examples like this, it is hard to respond broadly to them since they rely on manipulating complex and possibly unforeseeable factors to create a moral quandary. If an example is made radical enough either DKDNR will be forced to "bite the bullet" or forced to admit some flexibility. In other words, DKDNR could be made inflexible enough to demand something that seems *prima facie* wrong or admit that it's not an absolute principle. I prefer the latter course, and argue that in these cases Korsgaard's use of Rawls' double-level theory discussed in chapter IV can apply here and suggest a way out. Thus, in these sorts of nonideal examples DKDNR ultimately I believe offers agents a means to take a step back, think, and reassess in the face of a system that railroads agents to certain outcomes. Thus, the core of the principle remains intact, which is that we ought to not merely accept our current

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<sup>171</sup> My thanks to Dr. Moland for this example.

<sup>172</sup> Some of Korsgaard's double-level theory distinction could possibly apply here and yield a different result.

Millian autonomy as a sufficient protection for the patient and instead to slow down, try to learn more information, deliberate internally and with others, and reason universally in concert with others.

Finally, the question remains how this principle can enter into practical application. Can it be made into some sort of legal principle? Can it be plastered all over the walls of the hospital? Can famous people get on talk shows and discuss this radical new movement sweeping medicine? How can DKDNR make a difference and what would this difference look like? This is a difficult question to answer, and the path from the ivory tower to the wards of the ICU is not clear. Pragmatically speaking, my hope is that this principle can gain some attention within the circles of academic bioethics, and then like the rebellion against paternalism in the 80s filter downward into the practice of everyday physicians and into the public consciousness. The risk here is that like with the proliferation of “autonomy” that my concepts are emptied and replaced by vacuous platitudes designed to make people feel morally comfortable instead of morally challenged. This is not unique to my principle, and is instead likely a general feature of the human moral psyche. My principle, in asking agents to slow down and step back before acting is protected from the risk of this. Thus, perhaps instead of this process of trickle down philosophy (which works as well as trickle-down economics) DKDNR could enter into institutional or legal practices as a mandated conversation. Like ‘time-outs’ before procedures where surgeons and the staff make sure they are performing the right procedure on the right patient’s correct organ, DKDNR could become a sort of mandated conversation that should occur before certain aggressive interventions or admission to the ICU. However, again this risks making DKDNR like the vacuous informed consent requirements that are moral crutches today. Therefore, I will

leave the application of DKDNR as a somewhat open question, but my ultimate hope is that DKDNR could be part of a larger conversation about what it means to die and how as a society with amazing technology we should use that technology to heal and improve lives.

### **Conclusion**

DKDNR is a principle of caution. It simply says that when physicians and family members are not sure what the right course of action is when a patient or loved becomes critically ill that the default should not necessarily be aggressive care. This principle aims to undo the harm that the empty Millian version of autonomy has caused many people, and in doing so lays the groundwork for increased reciprocity and respect within the ICU. In short, it lays the groundwork for the creation of a Kingdom of Ends in the ICU. It does through being strict yet flexible when appropriate, and allowing cases for where important other moral considerations may overrule it; however, when it applies it does so in a forceful and unbending manner that defends the dignity of the patient. My hope is that this principle could find its way into the minds of physicians and family members, and when the time mattered it could force them to take a step back and consider whether the traditional default is not necessarily the best choice. In doing this perhaps we will, as a culture, learn how to die again.

## **Chapter VII**

### *Some Objections to Don't Know, Don't Resuscitate Considered*

DKDNR is a powerful principle, and I think one that, if applied, has the potential to prevent a lot of unnecessary and unethical interventions in the ICU while forming the groundwork for the positive development of a space for discourse. However, I do not deny that it is a controversial principle for multiple reasons, and in anticipation of this fact I will anticipate several objections that may arise. The first set of objections concerns my use of Kant, namely that my principle may suggest that sedation until death or even euthanasia are morally appropriate, a suggestion that seems directly to conflict with Kant's understanding of his own principle. Additionally, I will consider whether it might be possible to arrive at a different conclusion than my principle. Following that I will reexamine how objections, briefly mentioned chapter III, that Guerrero raises about DKDK might impact DKDNR. Then following the general structure of my thesis I will conclude by examining objections directly related to DKDNR.

#### **Kant, Suicide, and 'Letting Die'**

One objection that I anticipate to my principle arises from Kant's own moral theory, in which he claims that suicide is categorically wrong. He defends this claim through multiple Formulations of the Categorical Imperative, and within his own work it is quite clear that within a pure Kantian framework there is no room for suicide. This could spell trouble for my principle considering the same arguments that Kant frames against suicide could easily apply to DKDNR, since it might demand no action be taken in the face of grave illness. Essentially, some may object there is little distinction between suicide and allowing a patient to die. Additionally, comfort care measures that reduce all consciousness to prevent pain could also be viewed as objectionable in a Kantian framework. This then could be placed in the same category as suicide,

in that DKDNR might say doing everything to preserve life might not be morally appropriate. Therefore, it is important to understand whether Kant's moral theory produces unrectifiable conflicts with DKDNR, and whether Kant's own interpretation of his theory might be either limited or flawed.

It is important to note here that DKDNR, at the most, only *directly* recommends passive euthanasia. It is not within the content of the principle itself to directly call for active euthanasia or physician-assisted suicide. These are separate issues that I believe require separate treatment, and accordingly I do not want to stake a position on these issues here. It may be possible that DKDNR could allow for active euthanasia; however, on another interpretation it is possible that the spirit of the principle would disavow active euthanasia for exposing agents to the same moral risk that aggressive curative intervention does. I tend to lean towards the latter interpretation, because I think active euthanasia presents an equally serious risk as allowing someone to suffer against their will. To be clear, I distinguish between active euthanasia and physician-assisted suicide by the involvement of the agency of the patient. Active euthanasia typically happens when the patient cannot respond, and is framed as an act of grace by the physician. Physician-assisted suicide is when through discussions with physicians and mental health professionals a patient is given the means to end their life under the supervision and care of a physician. Physician-assisted suicide, under the argument I will advance in defense, can be viewed as permissible under DKDNR, since any ethically acceptable instantiation of physician-assisted suicide requires the explicit and serious consent of the ailing party. Therefore, it avoids the blocker entirely, if suicide can be shown to be not necessarily disavowed by a Kantian framework. Ultimately, physician-assisted suicide is outside of the scope of this work; however,

to write about end-of-life care without mentioning it would be to invite criticism and leave readers curious. What is important is to remember that physician-assisted suicide or active euthanasia, while deeply important, are outside of the direct scope of DKDNR.

First, it is important to examine why Kant feels that suicide cannot be allowed by any Formulation of the Categorical Imperative. Under the Formula of the Universal Law Kant suicide is disallowed because Kant argues that any maxim whose content allows for suicide is inherently self-contradictory. Kant believes this is the case because “one sees at once a contradiction in a system of nature whose law would destroy life by means of the very same feeling that acts so as to stimulation the furtherance of life.”<sup>173</sup> Therefore, Kant believes suicide is inherently self-defeating, and accordingly cannot be willed as if it were a universal law of nature. Furthermore, under the Formula of Humanity Kant believes suicide is treating oneself as a means to an end rather than an end in oneself. This is the case for Kant because “if he destroys himself in order to escape from a difficult situation, then he is making use of his person merely as a means so as to maintain a tolerable condition till the end of his life.”<sup>174</sup> Thus, in short for Kant humans have a perfect duty not to commit suicide either actively or through simply giving up on life.

While Kant is firm in his prohibition of suicide, recent scholarship has suggested that his theory may not necessarily demand the strict prohibition of suicide he believes it does. Ian Brassington argues that the ‘self-love’ that Kant believes leads to the contradiction in terms of the Formula of the Universal Law is misinterpreted by Kant as “a native feeling of self-love may

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<sup>173</sup> Immanuel Kant, *Grounding for the Metaphysics of Morals* trans. James Ellington (Indianapolis: Hackett Publishing, 1993) 31.

<sup>174</sup> Kant, *Grounding for the Metaphysics of Morals*, 36.

be sufficient to prevent me from killing myself; if, however, I do kill myself, this indicates nothing but that my native feeling of self-love is no longer sufficient.”<sup>175</sup> Therefore, the contradiction Kant believes to be present in the motivation of a maxim of suicide is not actually problematic. Additionally, it may be argued that there is “a case for there being more than one kind of self-love and for these kinds of self-love being able to come into conflict.”<sup>176</sup> In this case then it can be argued if one form outweighs another then it is possible to envisage the sort of self-love that causes one to desire to end one’s suffering to overcome the self-love that promotes the continued life. Accordingly, the prohibition of suicide by the Formula of the Universal Law is overcome without significant theoretical problems.

Therefore, it remains to see if the Formula of Humanity is more intransigent in its prohibition against suicide than the Formula of the Universal Law. Brassington argues in line with Kant’s belief in the ontological site of personhood that “I need not restrict respect for the personhood within a person to respect for personhood as it appears in that person; the personhood is transcendent. But if personhood transcends the individual, whereas killing a person may indicate a refusal to respect personhood, [killing a person] does not have to.”<sup>177</sup> In other words, a human body does not represent the Kantian person, which without entering to the complexities contained within *The Critique of Pure Reason*, Kant believes exists in an ontological position outside of the world of appearances. Instead personhood transcends this and is found in the noumenal realm, outside of the reach of the mechanical physical world.

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<sup>175</sup> Ian Brassington, “Killing people: what Kant could have said about suicide and euthanasia but did not,” *Journal of Medical Ethics*, no. 32 (2006) 572.

<sup>176</sup> Ibid.

<sup>177</sup> Brassington, “Killing people: what Kant could have said about suicide and euthanasia but did not,” 573.

Therefore, it need not be that killing the phenomenal representation of personhood is necessarily equivalent to killing the actual person. In other words, Brassington argues:

The point is that, in killing the person that I am, I have set that individual life at a price. But in doing so, I am not necessarily making any dent in the integrity, dignity or value of the personhood therein, because I can claim that my experience of my individual personhood is importantly separable from the non-individuated reality thereof, and it is the noumenal, non-individuated personhood in an individual person that makes the creature that he is worthy of respect.<sup>178</sup>

This means that the eternal and true personhood is not necessarily disrespected by suicide since the physical body lost and the noumenal person are not equivalent. Therefore, Brassington argues that “there need be no clash between respect for autonomy and absolute inner worth, and it would, in fairness, be surprising if there were a clash—the two are, after all, ways of making sense of the same noumenal characteristic.”<sup>179</sup> It cannot be said that the Formula of Humanity then necessarily disavows suicide, and under certain interpretations it is easily possible to “reasonably easily out-Kant Kant”<sup>180</sup> and find space for suicide and associated actions like DNR orders. In other words, it is possible with Kant’s framework to overcome Kant’s own objections to suicide. An interesting question arises here in relation to the question of the interaction between pain and the noumenal self, and generally what the noumenal self is. These questions would demand a technical examination of Kant’s critical metaphysics, and accordingly cannot be answered here.<sup>181</sup> However, it must be noted, ignoring possible metaphysical and metaethical objections that the normative objection is overcome. Therefore, the fear of allowing someone to die as a violation of the Categorical Imperative is not troubling. Now it remains to examine more

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<sup>178</sup> Ibid.

<sup>179</sup> Ibid.

<sup>180</sup> Brassington, “Killing people: what Kant could have said about suicide and euthanasia but did not,” 574.

<sup>181</sup> In short, I believe the suffering of the noumenal person must be assumed as a practical postulate subsumed under the regulative idea of freedom.

specifically an approach to palliative sedation until death, which similarly to the question of suicide enables me to draw out some interesting points that further strengthen my position.

Jeroen Hasselaar examines this question specifically in “Palliative Sedation Until Death: an Approach from Kant’s Ethics of Virtue,” where he dissects the various moral components of such an action within a Kantian normative framework. Hasselaar finds that continuous deep sedation until death (CDS) clearly does not violate the duty of self-preservation because “intentional lowering of consciousness until death does not in itself destroy those rational capacities of the patient”<sup>182</sup> and thus accordingly escapes any risk of falling to the same category as suicide. In other words, while sedation decreases the ability to exercise rational thought, it does not destroy the faculty itself. However, even if it did, as demonstrated above, this is not necessarily a problem. He also examines the role of promise keeping, so that CDS is not applied arbitrarily or against the patient’s wishes. Given the nature of DKDNR this risk of violating the duty to keep promises is minimal since DKDNR’s function is to, in some sense, fulfill the same duty in the face of uncertainty. That is to say that CDS should only be practiced in line with patient wishes, and the explicit function of DKDNR is to protect the ability of patients to dictate their own care. Finally, he examines the imperfect duties relating to CDS, specifically the conflict between the physician’s duty of beneficence and the duty of self-improvement. Simply put, CDS while attempting to fulfill the former can stymie the latter. This is to say that while CDS may preclude the ability of the patient to improve themselves, it may be necessary out of the duty of beneficence if patient suffering reaches a certain point. Accordingly, these must be balanced, and this can be done on a case by case basis, something which DKDNR encourages.

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<sup>182</sup> Jeroen Hasselaar, “Palliative sedation until death: an approach from Kant’s ethics of virtue,” *Theoretical Medical Bioethics* 28 (2008) 391.

Therefore, fears about DKDNR allowing people to die and this conflicting with Kant's positions are unfounded. It is possible to defend suicide within a Kantian framework, and within Kant's ethics of virtue one finds a toolset for discussing when palliative care options like CDS are appropriate. DKDNR does not "let people die," rather it forces moral agents to evaluate whether their actions preventing death from occurring are actually violating the spirit of the principle in which one cannot destroy themselves or another "by mutilating, damaging, or killing him."<sup>183</sup> Kant could not have anticipated the power of modern medical care, and accordingly he could not have predicted that sometimes one must choose between pointlessly damaging someone in an effort to keep them alive or allowing them to die. This internal conflict in Kant's claim represents a gap in Kant's vision that I think my use of DKDNR covers. It shows that sometimes allowing someone to die is better than mutilating them, and that the moral risk of this action in the face of uncertainty is grave. Ultimately, as Kant argued that action which is of the greatest moral worth is that which conflicts most with inclination, and today that is clearly allowing a suffering patient or a loved one to die instead of pointlessly continuing aggressive intervention.

### **What about the Formula of the Universal Law?**

A consistent theoretical question with any Kantian work of normative ethics is whether, given a certain conclusion, other Formulations of the Categorical Imperative would yield equal results. This is important because Kant holds that each of his Formulations are theoretically equivalent and simply represent different ways to achieve the same result. Kant argues that "the aforementioned [Categorical Imperatives] are at bottom only so many formulations of the very

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<sup>183</sup> Kant, *Grounding for the Metaphysics of Morals*, 36.

same law: one of them by itself contains a combination of the other two.”<sup>184</sup> Therefore, it is philosophically interesting to see whether through using the Formula of the Universal Law if someone could arrive at a conclusion opposed to mine. In order to examine whether this is possible or not, I will first demonstrate how DKDNR could be theoretically grounded on the Formula of the Universal Law. Once I show this is possible, I will then examine whether any objections could be made to the alternative formation of DKDNR.

As previously stated, the Formula of the Universal Law is that one must “act as if the maxim of your action were to become through your will as a universal law of nature.”<sup>185</sup> This willing is successful if one is able will this without contradiction in the maxim.<sup>186</sup> Therefore, it cannot be the case that one can will a maxim like the following: “If I want something, I’ll steal it.” This is the case because such a maxim is self-defeating since if everyone adopted this maxim then it would defeat itself since there would be no concept of personal property. In short, it can only be willed particularistically, not universally, and accordingly does not aid in the process of self-constitution. With this in mind we must now ask ourselves whether a maxim can be formulated that functions with DKDNR like the Formula of Humanity. Accordingly, I will suggest a maxim, and then examine it to see if it functions.

I will suggest that DKDNR can be reached by the classical Hippocratic maxim “Do No Harm,” which has the function of balancing the need for intervention in cases in which failing to act would do a positive harm and between those in which acting too aggressively is a harm in

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<sup>184</sup> Kant, *Grounding for the Metaphysics of Morals*, 41.

<sup>185</sup> Kant, *Grounding for the Metaphysics of Morals*, 30.

<sup>186</sup> More information on the function of the Formula of the Universal Law can be found in Korsgaard’s essay “Kant’s Formula of the Universal Law.” See Christine Korsgaard, “Kant’s Formula of the Universal Law” in *Creating the Kingdom of Ends* ed. Christine Korsgaard (Cambridge: Cambridge University Press, 1996)

itself. This can be universalized within the context of the medical profession, since stipulating that an action's harm should not outstrip its benefit is clearly a requirement of any action. Thus, 'do no harm' is a maxim that a physician can will universally. It would be absurd to imagine that there would be an instance in which a physician would undertake an action that was only harmful. It is important to be clear here in what I mean by harm, since it could be objected that certain procedures and medicines may cause harm as a side effects that can be construed as harm. However, this is a sophistical understanding of the principle, and it is more appropriate to understand 'do no harm' as meaning that no intervention's harm should outweigh its benefit. For example, an injection of a vaccine may cause "pain," but the benefit of immunity from disease that results clearly cannot constitute a harm. A harm, simply put, can be understood as an action that leaves the patient worse off after the intervention than they were before, thus it is clearly true to say a profession dedicated to healing should not leave its clients worse off after treating them.

Therefore, under a maxim of 'Do No Harm' the blocker then becomes the possibility of violating this maxim. In other words, in the face of uncertainty over whether an action would constitute a harm to the patient or not, caution should be taken, and accordingly under the Formula of the Universal Law and the Formula of Humanity DKDNR is exactly the same. Aggressive intervention at the end of life ultimately serves no great benefit to the patient; however, it clearly can be seen as prolonging or causing pain and being additionally dehumanizing. Therefore, if a physician or family member is uncertain whether or not an action on a critically ill patient or loved one will harm or benefit then they should assume a stance of caution unless external factors justify intervention despite this uncertainty. This then results an equivalent principle whether the Formula of the Universal Law or the Formula of Humanity is

used, so any fears that Kant's maxims necessarily conflict when applied within DKDNR are unfounded.

This is made especially clear if one imagines how a non-universalizable maxim like 'resuscitate at all costs' would look like if adopted. This would result in a battle with death in which no ground would be given by the physicians that death did not earn, and this battlefield would be the human body of the patient. Accordingly, like any battlefield where two great forces meet it would be trampled and maimed. Perhaps, death may be occasionally driven back, but its leviathan force ultimately always carries the day. Therefore, to commit to always fighting this bitter battle to the end would be to treat the patient as if they were an expendable territory to be fought over. This engagement would clearly yield no benefit to the patient whose body would be wracked with torturous medical interventions before the inevitability that is death. Accordingly, the functionality of the maxim of 'do no harm' is highlighted by the horror that the above maxim would cause.

Thus, it can be clearly seen that DKDNR can be made to function with alternative formulations of the Categorical Imperative. It may be the case that someone would formulate a contradictory maxim that would mean a principle derived from the Formula of Humanity and the Formula of the Universal Law would conflict. However, I think this would require a certain amount of twisting of the spirit of Kant's Categorical Imperative, and ultimately a cautionary principle must be generated by Guerrero's framework. Therefore, any principle that demanded more aggressive action out of caution would inevitably contradict itself, since a cautionary principle that demands action in the face of uncertainty really is not much of a cautionary principle. My principle does not demand inaction. It demands caution before action. Therefore, it

may be possible to twist the Categorical Imperative into such a form that it demands that caution be thrown to the wind; however, this twisted version of the Categorical Imperative cannot be made to function within Guerrero's framework.

### **DKDK Related Objections**

Accordingly, I will now mention some objections to Guerrero's framework itself that may arise and are particularly germane to DKDNR. I cannot defend Guerrero's principle in its entirety, but I will defend his framework from the most obvious attacks. Accordingly, I will highlight what he thinks are possible weaknesses in his principle and his responses to his imagined critics. The particular objections I consider relevant that Guerrero mentions are that his principle might result in hypervigilance due to the enormous amount of uncertainty that exists in life, and that someone may be particularly uncertain but acting in a way that seems morally permissible. These are essentially two sides of the same problem that stem from a misunderstanding of the principle. Additionally, I will reexamine an interpretation of DKDK imagined by Guerrero in which when it is applied within a Scanlonian framework it demands that comatose patients cannot be removed from life support for fear of killing a living organism who might still have moral status.

One possible problem for Guerrero's principle, as discussed above, is that uncertainty is relative to a particular agent, so he imagines "a hyper-vigilant individual who worries that literally everything might have significant moral status—bacteria, viruses, bricks, trucks."<sup>187</sup> This would have the effect of meaning she could not kill or take an action tantamount to killing anything, and thus she, the agent, would be paralyzed by DKDK. Similarly, it is possible to

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<sup>187</sup> Alexander Guerrero, "Don't Know, Don't Kill: Moral Ignorance, Culpability, and Caution" *Philosophical Studies* 136 (2007) 86.

imagine DKDNR having a similar effect in which physicians and family members are afraid to pursue any treatment. For example, a child having a tonsillectomy could suddenly begin bleeding post-op and the hyper-vigilant otolaryngologist could, due to the fact the child did not explicitly mention they wanted to survive the operation, fail to act thereby allowing the child to die.

Objections like these clearly have an air of absurdity about them, but they act to highlight an interesting part of Guerrero's framework. The weirdness of these objections is dissolved once the fact that the complaint of DKDK against the hypervigilant agents here "is that they are failing to take into account moral reasons they believe are present."<sup>188</sup> That is to say that DKDK blames these hyper-vigilant agents, not for being hyper-vigilant, but for failing to countenance their own moral standards and acting despite these. In the case of DKDNR, the hyper-vigilant surgeon also can be charged with a failure to understand the justificatory component that should have given her the license to stop the bleeding. However, like DKDK, in DKDNR acting as a hypervigilant agent in spite of the vigilance, despite the absurdity of the hypervigilance, still means one is acting despite what one finds to be serious moral objections to one's action. Guerrero argues one reason why we worry about hypervigilance is that "we feel sorry for the hyper-vigilant individual—after all, his life will be very difficult if he actually is uncertain in these ways, how can we also hold him morally blameworthy if he doesn't live up to his own standards!"<sup>189</sup> Thus, we may critique this individual for failing to live up to their own standards, and DKDNR/DKDK are applied with typical amounts of uncertainty "to the extent that we are unsure, and to the extent that there are alternatives about which we are sure, it seems that we should avail ourselves

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<sup>188</sup> Guerrero, "Don't Know, Don't Kill," 88.

<sup>189</sup> Guerrero, "Don't Know, Don't Kill," 89.

of those alternatives.”<sup>190</sup> However, for individuals who are so incredibly hyper-vigilant, the strangeness of possible results from either theory result “in large part because the person now starts to seem somewhat unintelligible to us, perhaps failing to meet general conditions of rationality and sanity that seem necessary for attributions of culpability to make sense.”<sup>191</sup>

Therefore, the hypervigilance objection fails.

The inverse of the hypervigilance problem is that it may be someone is acting in a way that is ostensibly morally acceptable but they are uncertain and thus DKDK and principles like it condemn them. This case again arises because of a confusion between the objective moral wrongness of an act and the intention that exists behind the act. The act can be completely moral, but if the agent is acting while believing they do not have sufficient grounds for their actions then it is only an accident that they are causing no harms. In legal terms it is the difference between a *mens rea* and *actus rea*. Even if the act itself is harmless, if the agent thinks they are acting immorally then what DKDK and DKDNR says is not concerning the act itself, it is concerning the epistemic state under which the act was undertaken. Simply put, intentions matter, and even if one’s epistemic assessments are incorrect and the actions one undertakes seem broadly acceptable to act in face of perceived fears that turn out to be false is still morally blameworthy. Good moral luck for people who act badly only goes so far.<sup>192</sup>

Finally, it should be noted that Guerrero briefly mentions how a Scanlonian contractualist account of morality might demand that a patient in a vegetative state be kept alive, because “in such a case, it seems quite reasonable to think that a principle like DKDK serves to protect our

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<sup>190</sup> Ibid.

<sup>191</sup> Ibid.

<sup>192</sup> The movie *Force Majeure* provides an entertaining example of this sort of example with the father running and abandoning his family on the approach of an avalanche. The avalanche was illusory, but his moral failing isn’t.

interests (rather minimally), given that we might end up in such a state, and might exit such a state.”<sup>193</sup> Scanlon’s normative theory can be summed up in its view that “an act is wrong if its performance under the circumstances would be disallowed by any set of principles for the general regulation of behavior that no one could reasonably reject as a basis for informed, unforced general agreement.”<sup>194</sup> Thus, Guerrero believes that his conclusion would be demanded by Scanlon’s greater regulatory project where those within the realm of the ICU might desire to be protected from being “killed” if they might have a chance to leave that state.

This would seem to derail my account of how DKDNR can be used to argue against such futile efforts; however, it does not for two reasons. Primarily, this is because the normative account that my DKDK derived principle will be based upon is Kantian. Scanlon’s project may be within the general framework of deontology; however, it lacks the explicit Formula of Humanity (and by extension the Formula of the Universal Law) that serves a strong protection for patient interests. Accordingly, regardless of what a Scanlonian account would determine a Kantian ethics functioning within Guerrero’s framework will produce my principle of DKDNR. As a secondary matter, I would like to suggest that Guerrero has not fully considered what death is like in an ICU, and accordingly is valorizing the singularity of death against what is actually right for the patient. His belief that one can simply emerge from a vegetative state with the aid of modern medicine represents the same system of belief that overstates the ability of modern medicine to save people at a certain point. Soap opera coma exits are simply not accurate. Thus, it may be the case that a Scanlonian account would demand a principle of DKDNR as well, but whether it does or not is outside the scope of this work. It can be briefly examined that under the

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<sup>193</sup> Guerrero, “Don’t Know, Don’t Kill,” 86.

<sup>194</sup> Thomas Scanlon, *What We Owe to Each Other* (Cambridge: Belknap Press, 1998) 153.

aforementioned summation of Scanlon's contractualist ethics that no involved party in the ICU would desire, on principle, to be a canvas for unnecessary medical intervention. Therefore, instead of being a stumbling block for my principle I would suggest it would be possible that DKDNR formulated in Scanlonian terms would rather similar to my principle.

### **DKDNR Objections**

Finally, I will consider objections to DKDNR itself in terms of how it functions, what it demands, and some possible side-effects it could have. There naturally will be other objections that will arise; however, I will examine two key objections that I feel are particularly powerful. It should be noted that I examined other smaller objections in the previous chapter as well. These two objections are that DKDNR could cause agents to feel as if their moral integrity is lost by an alien principle demanding an action they are not morally comfortable with. Secondly, I will examine whether my principle might make it either too easy to give up on people or similarly create the inverse of the current problematic situation.

One potential source of objection can be found in Bernard Williams's critique of utilitarianism in *Utilitarianism For and Against* where he argues that "while it may be acceptable that morality requires the agent to abandon certain projects, it is unreasonable for morality to demand that the agent abandons those projects"<sup>195</sup> that the agent finds central to their understanding of themselves. In other words, Williams is suggesting that it may be problematic for a moral theory, like utilitarianism, to demand something that conflicts with an agent's sense of moral commitments and personal identity. This critique can be easily applied to Kantian ethics, which are infamous for demanding actions that conflict with what the agent feels is

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<sup>195</sup> Elizabeth Ashford, "Utilitarianism, Integrity, and Partiality," *Journal of Philosophy* 97 no. 8(2000) 422.

important. In fact, Kant finds this to be a positive feature rather than a glitch in his system, because he argues that actions done against inclination have the most moral worth. However, like the concern voiced about utilitarianism, critics may worry an application of a Kantian DKDNR principle may demand that agents act in ways counter to how they perceive their moral identity. It may come to pass that DKDNR demands a physician who hates “giving up” and finds it essential to her identity that she gives it her all for every patient to take a step back and do less. It may come to pass that a family member who feels extremely loyal and protective to the patient must accept that sometimes aggressive intervention is not the best way to help a loved one. These and cases like these then represent a class of situations in which it seems DKDNR demands actions counter to agents’ sense of morality or their conception of themselves. Thus, as presented by Ashford, Williams’ critique rests on “the claim that it is a condition of the acceptability of a moral theory that it does not require agents to act in a way that contravenes their present self-conception, whatever that self-conception should consist in.”<sup>196</sup>

Elizabeth Ashford responds to this critique in her paper “Utilitarianism, Integrity, and Partiality,” and I will recount her response here because I believe it deftly addresses the concerns of those who feel a principle like DKDNR or a moral theory more broadly ought not to demand agents act in a way that contradicts their sense of self. Ashford argues that Williams’ critique can be interpreted in three ways, namely that it may either conflict with agents’ subjective integrity, their objective integrity in light of the current state of the world, or their objective integrity in the light of any possibly realizable state of the world. The first objection can be dismissed rather easily by simply pointing out that a moral theory demanding an agent to do something hard that

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<sup>196</sup> Ashford, “Utilitarianism, Integrity, and Partiality,” 423.

conflicts with how they view themselves is, again, a feature not a glitch. The fact that a moral theory like Kant's ought to cause a slave owner to feel a sense of conviction is not a failing of the theory, it is a failing of the agent. Subjective integrity then cannot override the reasoning behind DKDNR. The second two theories are more complex since they focus on the objective moral integrity of the agent rather than the subjective effects a moral theory might have on an agent. Ashford examines the fact that the world, or possibly any realizable state of the world, may not allow for objective integrity. The empirical reality does not permit integrity once objective and impersonal moral considerations are taken into account. This interpretation causes greater strain for utilitarians than Kantians, since utilitarian moral theory is entirely impersonal and places no value on individual autonomy in itself. In other words, utilitarians may value autonomy as much as it contributes to positive utility, but no dignity is placed on agents beyond this utility unlike Kantian ethics which gives agents an inviolable dignity. Therefore, I do not consider these latter two objections deeply problematic, but I will discuss the first of the latter two. It may be that within our current paradigm that DKDNR is hard to realize, and thus leaves agents in a state of objectively lessened integrity. This can be seen as problematic until one considers Korsgaard's use of the double level theory distinction, which can allow for DKDNR to become a guiding idea like the Kingdom of Ends. Thus, within DKDNR's Kantian grounding the integrity problem is alleviated so long as agents treat DKDNR as a guiding principle even if it cannot be realized. Accordingly, I do not feel the integrity objection is valid in either of its formulations.

Finally, it may be objected that DKDNR may make it too easy to give up on patients, and can cause people who would have survived with aggressive intervention to die. Alternatively, it may be feared that it could cause the inverse of the current problematic situation to arise i.e. too

much caution in the ICU arises. I believe this problem was dealt with in the previous chapter through the justification portion of the principle; however, because this portion of my principle is ripe for misunderstanding I want to re-emphasize my previous points. As I suggested in the last chapter, DKDNR is a principle of caution, and there are times it is important to throw caution to the wind. However, I do not believe that every time anyone might be reaching the end of their life caution should be thrown to the wind, especially in populations like the elderly or terminally ill in which the uncertainty is more centered around the question of “when” rather than “if.” Thus, there may be cases in which aggressive care is appropriate in the elderly, but it should not be default. Instead caution should be the default, and accordingly things like DNR orders should not be considered the exception. This does not mean anytime there is any uncertainty that no interventions should ever happen, but merely if there is uncertainty that physicians and family members should not treat doing everything possible as the default. This attitude harms patients, and is bad for the mental health of physicians, hospital staff (particularly nurses who often carry out the physician's orders) and family members.

Furthermore, I do not feel that there is any risk of the current problems of the ICU inverting into a place where everyone is too afraid to act. The opposite of doing everything unreflectively is not doing nothing unreflectively. The opposite and desired aim of DKDNR is simply that every action be taken then with appropriate amount of caution for the moral weight of the actions done by physicians and requested by family members. That reflective realization of the moral weight of aggressive intervention is not present, and it is disguised by paper thin informed consent requirements that leave family members and physicians with a false sense of moral integrity. DKDNR demands reflection, not an unreflective knee-jerk response to allow

anyone who may be dying to die without intervention for fear of treating them as a means rather than an end in themselves. Reflection, I think, will often demand less aggressive intervention, but this is not necessarily the case. Accordingly, the fears that DKDNR may allow patients who would have made it to die are unfounded at least in terms of intent. DKDNR only demands caution.

However, it may still be objected that cautious reflection will allow someone to die who might have made it with more aggressive intervention. I accept this as an inevitable result of DKDNR. As I have continuously argued, our present world is one where non-ideal situations for the application of an ideal theory dominate. Therefore, sometimes compromise in a theory will have to occur. In the case of DKDNR, the compromise is that by sparing a large number of people the railroaded style of default-to-aggressive end-of-life care that dominates in this country today that some number of patients may die earlier than they would have without DKDNR. That is the nature of uncertainty. However, this is not a critical failure of DKDNR, and can hardly be considered a failure at all. Each day physicians act in empirical uncertainty over what the correct course of treatment is, and with current science sometimes it happens that before the treatment it is unknowable whether a certain treatment decision is right. Similarly, it may be unknowable in certain cases whether DKDNR ought to apply or whether the justification component for aggressive intervention will be specific. Sometimes things simply will go wrong, and DKDNR will cause physicians and family members to be cautious and this caution will cause the early death of a patient. However, I believe the good done by a principle of caution in the ICU ultimately outweighs these losses, and until prognostication improves this is an unfortunate reality of the non-ideal world we inhabit.

### **Conclusion**

DKDNR is a principle that demands a radical departure from the status quo by demanding caution in the face of uncertainty before aggressive action is undertaken. I believe it is a broadly sound principle that is derived from a compelling normative theory and constructed to be practical yet uncompromising. However, with any large project some holes may appear. Kant's moral theory has armies of people who object to its assumptions, conclusions, and methods. Kant himself might object to DKDNR. Guerrero's principle, as mentioned, has its own theoretical difficulties. It may be possible that DKDNR does not function perfectly in all situations, and there may be cases in which DKDNR fails due to "operator error." There may be cases in which DKDNR utterly fails to function due to external factors, extreme circumstances, or other situations that typically cause philosophical theories to fall apart. Despite these potential problems I believe that if it is considered seriously the core motivation and reasoning of DKDNR is sound, and the principle itself offers a deft solution to a pressing problem.

## Chapter VIII

### *Conclusions*

Death happens to everyone, and it can happen in any number of ways. Some people die young. Some people die old. Some people die from illness. Some people die from accidents. Some people's lives are taken from them. Some people take their own lives. Some people die quickly. Some people die slowly. What is constant is that everyone who walks this earth someday shall pass. This fact applies to Americans; however, in the halls of hospital ICUs there is a distinct ritual that is repeated before death. That ritual involves aggressive treatment with the intention of preventing death from occurring, and sometimes it works and the patient leaves the hospital intact. However, more often than not, especially in the elderly and terminally ill, this aggressive intervention is quixotic. Its ultimate result then tends only to be that patients are tortured by needles, surgeries, CPR, ventilators, and other medical means before death. Physicians, nurses, staff, family members, and (if they could speak) the patients themselves bemoan such deaths, but they still occur anyway.

A core problem in these deaths is that the risk is always present that the patient's will is not being respected by such intervention and those with decision making influence and power are demanding intervention not for the sake of the patient but for some other reason. This is completely legal and accepted because since the 1980s fears of physician paternalism lead to the widespread adoption of "autonomy" as the paramount bioethical principle. The autonomy that has become dominant is typically merely the emphasis that patients should be able to pick from a list of provided options of their own free will and without coercion. Most often this takes the form of signing a piece of paper that indicates the patient was informed of potential treatments and their risks and benefits and that they consented to a single one. This form of autonomy then

can best be described as individualistic or laissez-faire autonomy. It is simply the ability to pick from some options, and because of the complexity of medical decision-making it ends up simply being something of an empty ritual of informed consent. It serves to protect patients from the great excesses committed in medicine's history such as the Tuskegee experiments; however, while this is deeply important it fails in that it fails to capture the greater potential of autonomy.

Autonomy is much more radically and meaningfully defined in the works of Immanuel Kant. Kantian autonomy focuses not on the ability to simply choose between illusory choices, but instead focuses on the necessity agents are forced to through action constitute themselves as authentic and unified actors. It is to give oneself the moral law in the face of inclination, and to act in accordance with that law. It constructs a self out of the chaotic torment of inclinations that is the human experience, and from this crafts something that is not simply a mere heap of disparate instincts. It makes you human. This autonomy is practically realized when moral decisions are made categorically and not merely hypothetically. This requires that one able to act with a maxim that could be made into a universal law for all people to follow, to treat people as ends in themselves and never merely as means to an end, and to act in the process of self-legislation to give the moral law as both a subject and legislator in a great Kingdom. Through these formulations of the Categorical Imperative it is possible to begin the creation of a Kingdom of Ends.

Accordingly, this Kingdom of Ends is not being realized in the current paradigm of individualistic autonomy that dominates the American ICU. Patients are frequently being treated as means rather than ends, and in large part this can be contributed to the massive uncertainty that dominates within the ICU. The uncertainty, both empirical and moral, causes individualistic

autonomy to fail drastically, and thus yields the undesirable results that leaves everyone dissatisfied. The root of the problem then is that aggressive medical care is considered the default as a result of cultural and institutional pressures, and when uncertainty reigns then aggressive care is undertaken without a second thought. Meaningful autonomy is lost. Patients risk not being treated as ends in themselves. Physicians and family members are failing to will universally and treat patients as ends in themselves. Something must change.

My principle, 'Don't Know, Do Not Resuscitate,' can help effect this necessary change. It is a principle of moral epistemic contextualism that at its most general asks that agents who do not know some empirical or moral fact to be cautious before undertaking actions rendered potentially dangerous by this ignorance. Specifically, DKDNR asks that agents with decision making power use caution at end-of-life situations because of the risk that their demands for aggressive intervention might treat the patient as a means rather than an end in themselves. Therefore, DKDNR demands that physicians and family members take a step back and consider their actions. It asks that the default not be aggressive care. It asks that the default be conscientious care that attempts to render agents meaningfully autonomous in a way that is not currently found in the ICU. If the agent finds that some justification demands that they act despite being uncertain, then they at least stopped and considered their actions. However, if they pause and find that another round of CPR might not be in the patient's best interest or imagined desire then they ought to stop. Simply put, DKDNR is a principle of caution in a world of protocol, illusory choices, and litigation that pushes against restraint.

If DKDNR is taken seriously by the medical community then what I hope results is a new Kingdom of Ends in the realm of end-of-life care. It will be difficult, and DKDNR is not a

perfect principle; however, its guiding ideal is one of careful and reasoned caution. Its guiding ideal is that agents be the authors of their actions, and that they ought to avoid undertaking such actions that would render them heteronomous. DKDNR does this by demanding that the deliberative process occur despite the pressures that make it difficult. If realized, DKDNR results in a world in which patients are not caused to suffer meaningless pain without significant moral justification and not merely as the default of what it looks like to die in America. DKDNR, in short, is a principle for the creation of a Kingdom of Ends.

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