Responsibilities for Healthcare

Kantian Reflections

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Introduction

Many have complained that Kant's ethics provides little specific guidance as to how we should act. In contemporary healthcare, professionals act in large-scale organizational contexts, with complex reward structures, and in many cases belong to professional bodies that determine the ethical obligations associated with particular roles. These facts pose additional problems for an individual healthcare professional considering how to act in Kantian terms. Furthermore, it is not obvious how a Kantian approach can deal with pressing questions about whose duty it is to meet healthcare needs, how the division of labor within an organization should be achieved, and how professional roles should be determined. We argue, however, that Kantian insights can be helpful in understanding the complexity of acquired duties to participate in the institutions of healthcare and in the determination of the duties attached to a professional role.

Some Problems in Applying Kant's Ethics to Modern Healthcare

The categorical imperative may generate some straightforward prohibitions against coercion or betrayals of trust.[1] But if we were to look to it for concrete guidance as to what responsibilities individuals have to care for others—and in particular, to care for their health—we would be looking in vain. At most, it seems we are required not to adopt maxims of utter indifference to one another's well-being. Moreover, because the categorical imperative is framed as a first-person test of maxims, it also seems ill suited to provide any guidance as to what collective arrangements we should enter into to organize healthcare. These problems remain even when we consider Kant's developed moral theory in the *Metaphysics of Morals*. Here Kant argues that we are required to adopt certain "maxims of ends," that is, that we must endorse two obligatory ends: our own moral perfection, and others' happiness. But these ends are much too indeterminate to point to any positive course of action—let alone to generate particular duties to provide care or medical assistance.

However, to feel disappointment at this fact would arguably reflect a false expectation of philosophical ethics and its relation to our practical activity. For example, Paweł Łuków has recently argued, with regard to Kant's ethics, that we

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should rather look to philosophical reflection to illuminate the moral sensitivities built into a field of activity.[2] In this article, we would like to develop this line of thought and supplement it with the following consideration: when we consider duties to promote health, and indeed professional duties in general, we need to examine the patterns of moral sensitivity built into *institutions*—the institutional frameworks that structure professional activity and healthcare in particular.

Thus one of the most obvious facts about contemporary healthcare is that almost all healthcare provision depends on large organizations. To a limited extent, something analogous has always been the case: even in the far-off days of Hippocrates, medical practice depended on knowledge and skills that were only gained and transmitted by quite wide cooperation. Under modern conditions, however, it is truly exceptional for any medical care to be provided on a one-to-one basis; those providing and receiving healthcare depend on an immensely complex web of organizations that provide knowledge, skills, materials, and infrastructures—and that depend in turn on socially structured financial mechanisms. We argue in the following that one important implication of this is that we need to consider the maxims of those involved as those of participants in collective enterprises.

A second implication of this should also be striking, given the preeminence that Kantian ethics grants to individual motivation. Almost all healthcare is provided by persons who are rewarded for their efforts. If modern institutions have changed anything, it is only that the person in need almost never makes payment directly to those who supply her care. But, of course, neither of the fundamental aspects of Kant's ethics—the categorical imperative and the doctrine of obligatory ends—is indifferent to individual motivations. Although we occasionally expect genuine selflessness on the part of those with specialist medical skills—for instance, to practice even during contagious epidemics, and to bear limited duties of rescue in emergencies—we do not normally expect healthcare practitioners to act on the basis of unselfish and unrewarded virtue. To the contrary, doctors are among the most highly paid of professionals.

Kant himself says little about professional roles or the remuneration that attaches to them. In "What Is Enlightenment?" he speaks of officials who "carry out another's commission," such as civil servants: "For many affairs conducted in the interest of the commonwealth a certain mechanism is necessary, by means of which some members of the commonwealth must behave purely passively."[3] These role-holders are "part of the machine" and should, therefore, make merely "private use of reason." We might paraphrase this by saying that they are to exercise powers of reason only in order to better fulfill a task set by another, as the civil servant is meant to carry out policies set by politicians. This may seem to present the holder of a professional role as a variant on the *Groundwork*'s honest shopkeeper, doing what she should do (and what she is told to do) because others make it worth her while and will cease to do so if she does not comply.

For all these reasons, then, we might doubt that Kant's ethics can help us get a handle on modern healthcare, especially as it relates to duties of virtue—as opposed to, say, a mechanistic system of contractual obligations in which health-care professionals appear as "passive members" rather than moral agents acting on their own account. In the remainder of this article we want to suggest, nonetheless, that Kantian ethics can provide helpful resources for articulating the moral structure of collective healthcare arrangements, and their associated moral demands.

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Coordinating Our Moral Efforts

In this section, we want to develop the thought that neither the maxims nor the ends of those working in modern healthcare can be understood on an individual basis. To avoid misunderstanding: This does not mean that those persons' actions lack maxims. Notwithstanding his comments about the need for "a certain mechanism" in order to enable collective action, Kant could hardly—indeed, explicitly does not[4]—regard role-holders as mere functionaries or cogs in a machine. To locate action or responsibility only at the collective level would be to sacrifice both the spirit and letter of Kant's ethics.[5] Our thought is rather that when a person acts as a participant in a collective enterprise, the only tenable way to understand her principles of action is with reference to that participation.

To see the issue, we can start with one objection often laid at the door of Kant's ethics when we consider the test of universalizability. Told that Kant demands that our maxims of action must be capable of being adopted by all, alert students naturally object that not everyone can, for example, play tennis on Thursday, or drive outside the rush hour, or shop in the sales. One response, of course, is to point out that such an objection misconstrues the nature of the maxim involved. A maxim abstracts from concrete particulars to isolate the morally salient aspects of an action—in the examples just mentioned, to spend one's time or money in accordance with the balance of one's opportunities and wishes. Put this way, universalization is clearly unproblematic, not least because certain opportunities will dry up, the more other people wish to avail themselves of the selfsame opportunities.

Something similar, but more morally interesting, is at stake when we consider what principle is followed by a person who devotes her working life to healthcare—or indeed, to one small set of healthcare needs for a restricted group of people (for instance, palliative care in a particular nursing home). Naturally, it is hardly possible for all persons to do the same thing. Similarly, if everyone were to adopt, as a maxim of ends, the improvement of one another's health, the result would be utter craziness—we would become a sort of collective version of that most unattractive character, the health nut. If we all focused largely on promoting one another's health, which is at least perhaps conceivable, we would neglect many other important values, which is certainly not something that a finite being with many different needs could will. Just as obviously, however, if we were all to pay no heed to healthcare, we would neglect a central aspect of human need—again, something that we can hardly will as finite beings.

There are many divisions of labor involved in all professional activities: one person cares with regard to health rather than general well-being, one cares for a particular set of patients or tries to prevent causes of ill-health in a particular population, one cares during a particular time period and then hands over to others for the day or night shift, and so on. We make these obvious points to emphasize how immensely detailed is the division of labor involved in healthcare—both externally, as other roles cater to other aspects of human need and want, and internally, as other role-holders cater to other groups or other aspects of a given person's care. In the *Metaphysics of Morals*,[6] Kant contrasts *innate rights*—to one's own person, that is, to bodily integrity—with *acquired rights*—most prominently, property as a right to use certain things and to exclude

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others from use of that thing. Plainly, everyone can enjoy an identical innate right to his or her own body without this generating any possible conflict. (Moreover, because the noumenal entity that is a person is, phenomenally speaking, just a living human body, to allow that persons could acquire rights to one another's bodies would necessarily give rise to conflicting claims. In other words, it would not be possible as a universal law.) Acquired rights such as property are much more complex, however, because any given object might belong to anyone or no one. That is, it need not belong to any particular person. Yet many objects must be granted such a status because persons need to make use of them. That is, they need to acquire rights over them—and such rights are, in their simplest form, rights to exclude others from the use of them. A right to a given object can conceivably belong to any person, but—as a right to exclude—it can belong only to one person. Acquired rights only make sense when we conceive of distinct claims distributed across different persons: in its particular matter, each right claim is therefore precisely *not* universalizable.

By analogy, we might speak of innate and acquired *duties*. Kant's ethics supposes that certain duties belong to each person innately, as it were, by virtue of living as one rational agent among others. Everyone must abstain from coercion on his or her own behalf except, for example, in cases of immediate self-defense. But most of the duties that concern us when we think of a given person's responsibilities are acquired. This does not necessarily mean that they are chosen or voluntarily incurred.[7] To describe these duties as acquired means that they could in principle be or have been borne by others. Another person could bear my specialist role in the medical team, or nurse these patients. Somehow or other, though, the duty has devolved onto me. When we say that something is *mine* to do, we explicitly make an analogy with property rights. Like a property right, this acquired duty corresponds to a duty on all others (not to usurp this duty). Perhaps more interestingly, and unlike a property right, it corresponds to some other persons' more specific duties, to perform complementary tasks.[8] In other words, acquired duties make possible all sorts of cooperative endeavors; they constitute any organization that is based on a division of roles and responsibilities.

Note one obvious difference between acquired rights and acquired duties. Of themselves, unowned objects present no moral or practical difficulties.[9] By contrast, unowned duties present an enormous moral hazard. If a person is in need of medical care but no one possesses the duty to provide that care, then there is a need that calls out for action, without there being anyone who must answer. This issue corresponds to an important problem concerning positive rights claims on which Onora O'Neill has frequently insisted.[10] To speak of a right to healthcare is not yet to say anything about who in particular should satisfy that right. Duties without an owner are, at least in this crucial respect, no duties at all. Unfortunately, all experience teaches us that the more extensive such unowned duties are, the less clearly their call will be heard. Healthcare professionals' efforts need to be effectively and justly distributed across the many persons who need them, and this involves an enormous coordination problem—one that has so far proved insuperable even in such a wealthy country as the United States.

Neither the categorical imperative nor any maxim of ends helps address these problems. However, what these key Kantian ideas do point to, plausibly, is the

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basic building block on which such distributions must operate: that is, *obligations to participate* in practices and institutions that effectively distribute duties, in order that we may, as Onora O'Neill emphasizes, reject systematic injury and indifference to others and, as Kant himself says, promote others' happiness. Of course, such an obligation to participate in a collective division of labor remains highly indefinite; it tells no particular person what she should do. Indeed, it is not even an injunction to participate in whatever collective practices already exist. For example, where institutions are ineffective, sclerotic, or corrupt, this obligation may support (although, once again, it does not specify) duties to participate in ways that do not correspond to any existing institutional setup—as a campaigner for radical reform or the founders of a new organization may do (consider the actions of AIDS activists in the early days of the epidemic)—or even to go against established organizational demands—as does the whistle-blower.[11]

At this point, it may be helpful to recall our opening contention, that it represents an unrealistic expectation of any normative ethical theory that it should dictate duties to individuals. Fortunately, human beings are never required to address problems of cooperation ex nihilo; we might even regard it as hubristic for a moral theory to offer prescriptions as if such a thing were possible. Collectively speaking, we always inherit many practices and institutions. Individually speaking, we always come into the world in a particular place, relating to particular people and groups. In this light, our collective task is not to create de novo but rather to adjust, revise, or maintain existing practices and institutions, and our individual task is to participate, often in ways that adjust and revise.

In the next section, we contend that the nature of a professional role implies some responsibility to consider the exact duties that should comprise that role, and that this requires role-holders to take account of the collective division of labor that lends that role its integrity—or in some cases, deprives it of this.

Problems of Practical Judgment and Moral Knowledge

One of the more prominent and less plausible contentions of Kant's ethical writings is the basic simplicity of moral knowledge. "I do not . . . need any wide-ranging acuteness to see what I have to do for my willing to be morally good . . . I just ask myself: can you also will that your maxim become a universal law?"[12] No one experienced with life amid complex modern institutions can share Kant's optimism here.

One notorious set of doubts about Kant's claims concerning the simplicity of moral knowledge arises because we often feel duty-bound to take account of others' wrongdoing—a point memorably dramatized by Kant's example in "On a Supposed Right to Lie from Philanthropy."[13] What we have said previously concerning our institutions' specialisms and divisions of labor should indicate that there is a second systematic set of reasons why "to see what I have to do for my willing to be morally good" is no simple matter. At the most abstract level, a person may seek to act on a readily universalizable maxim such as "participate in an institution that promotes part of an obligatory end" (for example, health as a key element of peoples' happiness). But what it is to follow that maxim varies enormously, depending on one's position in a division of roles. Moreover, as anyone familiar with modern institutional life can attest, the two sources of difficulty are often combined. Some role-holders have specific duties to tackle

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failings on the part of other role-holders—that is, to hold them responsible. Even when a role-occupant does not do so, there often seem to be moral reasons to tackle or make up for others' wrongdoing or for institutional shortcomings, even if one's hands do not feel entirely clean for doing so. (Think, for example, of the ways we often finesse procedures and requirements in order to meet what we see as more fundamental responsibilities.)

Even leaving aside the possible interactions between these two issues, the second set of problems points to a very complex task for practical reasoning. Just how are we to divide roles and responsibilities so that the agency of individual persons meshes into a coherent whole—so that we can really speak, for example, of an institution that provides healthcare to a given constituency? How serious a problem this is should be clear when we consider the many familiar ways in which institutions might fall short: in which cases fall through the gaps, in which the needs of some classes of persons are systematically neglected, in which mental or sexual health services remain poorly funded relations, or in which medical research is largely the province of companies with vested interests in discovering particular results. Or think of hospitals where emergency care or surgery is well resourced but basic chronic or palliative provision is partial and even parlous, or where managerial energy is continually spent in chasing ever-changing governmental directives and performance indicators.

In other words, insofar as we act within a complex division of roles, the relevant question is hardly ever the deceptively simple one of whether a particular maxim is universalizable or otherwise accords with Kant's formulations of the categorical imperative. Because each person's maxim can only be defined in terms of participation in a cooperative endeavor, we are never freed from the complex question of how well our combined roles mesh with one another to comprise a well-formed collective agent.

In our opening section we alluded to Kant's well-known distinction between the public and private uses of reason—in which public reasoning is addressed by a scholar to the world as a whole, and private reasoning represents the limited use of one's initiative to fulfill a task or to meet requirements that have been set by an authoritative institution. Neither of these uses of reason has the simplicity that Kant attributes to moral reasoning: both of them depend on long training and practice, while the public use of reason is explicitly required because individual reasoning is fallible, so that mutual criticism is needed to help us see whether others really can share our way of thinking about something. Given this complexity, one or both of these uses of reason might represent a more appealing model for the process by which people develop practical knowledge concerning how they ought to act within an institutional scheme of cooperation. This said, however, neither of them really corresponds to the position of a professional working amid the division of roles and responsibilities in a modern institution. We do not usually expect healthcare professionals to retire to their studies at the end of the day, to write as a "scholar" or "critic" for the world at large about the better arrangement of (say) healthcare institutions. (Of course they *may*, but they need not.) But neither do we expect them merely to "obey," to act "merely passively" as "part of the machine"[14]—making sure only that the demands upon them do not transgress conscience.

Important as this last caveat may be,[15] it is one of the familiar hallmarks of professional life that role-holders must do more, sometimes much more, than this. Professional roles are not jobs that involve no particular degree of commitment or

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responsibility. This is not just because they demand long training and specialist skills or knowledge. It is also because of the demands for moral judgment and professional responsibility made on role-holders. Although some of these issue from the duty to make proper use of specialist skills—hence Hippocrates' original oath—many others stem precisely from the fact that modern professionals work within a very complex division of labor, in institutions that are rarely as well formed as they might be and that must continually address very complex problems of collective action. In the following section, we ask how Kantian lines of thought can illuminate how organizations and individuals may address—or fail to address—some of the resulting issues.

Professionalism: Motivation, Opportunity, and Responsibility

One of the striking things about Kant's *Metaphysics of Morals* is its neglect of institutions. Only in his more occasional writings—"What Is Enlightenment?" as we have mentioned, or *The Conflict of the Faculties*—do professions and institutions come into sight. This corresponds to a second oddity in Kant's crowning ethical work: that it emphasizes two sources of motivation to the exclusion of all others. Kant says, "The very *concept of duty* implies constraint . . . *external constraint* or a *self-constraint* . . . (through the representation of the law alone)."[16] This remark is not accidental but the key to the book's structure: *The Doctrine of Right* is oriented by the threat of coercion in the form of state enforcement of legal requirements. *The Doctrine of Virtue* is oriented by individual virtue, as the adoption of obligatory ends that can only stem from a person's own commitment to morality. But it should be clear that these possibilities hardly exhaust the gamut of motivations that may lead us to act dutifully.[17] In decent social conditions, we create incentives for one another to live up to those demands—the emotional aspects of rewarding relationships, the material rewards of successful cooperation, and the complex forms of mutual accountability that make less worthy action not only known to us but less tempting too. We find most of these sources of motivation in worthwhile personal relationships; all of them are embodied in decent institutions.

One way of trying to save Kant's stark divide would be to argue that all the incentives just mentioned lie on a continuum with the threat of coercion. In the final analysis, all of these motives relate to forms of inclination. They may each play a role in securing "a certain mechanism" in people's actions, but so far as virtue is concerned, they are one and all irrelevant.[18] We raise this issue because professional life and the collective organization of healthcare plainly do rely on just this complex set of incentives—and neither on the bare threat of coercive punishment nor, at least at first sight, on self-constraint through virtue alone. The work may be rewarding in itself; there are the rewards of status, of worthwhile relations with colleagues, and of recognition and gratitude, not to mention a salary. And all professionals are aware that fault or failure may attract a range of sanctions that fall short of bare coercion—from loss of post or of title to practice, to the closing of opportunities for promotion, to loss of professional esteem and others' willing cooperation.

Kant also neglects—though they are sometimes at work in his examples—the powers afforded to people by virtue of cooperative structures.[19] Thus one might also emphasize the ways in which institutions enable certain modes of action and disable others. A role-holder is empowered to do many things that a private

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individual never could. But these are highly specific enablements. Professionals are granted access to many resources—in terms both of spaces and materials and information and of others' time and energy and skill—in situations in which those resources are only useable in specific ways: for the care of *these* patients or research on *this* condition, for example.

In closing, we would like to propose a way of looking at these institutional incentives and enablements that is Kantian in spirit, if not in letter. One of Kant's fears concerning inclinations is that it is a quite contingent matter whether they support action that accords with duty. Sometimes my sympathetic urges will lead me to help others, although not necessarily the right others; sometimes sympathy will generate reluctance to do what I should—to have a crying child vaccinated, for example; sometimes sympathy will dry up, as with "the friend of humanity . . . beclouded by his own grief."[20] In other words, inclinations lack a rational structure, and it is one of our moral tasks—in the pursuit of our moral perfection—to develop our inclinations so that they are more supportive of duty. Nonetheless, Kant holds, quite plausibly, that inclinations will never attain a wholly dependable congruence with duty. Naturally, the same is true of my particular skills and talents or in general of my abilities to act; however carefully these are developed in support of rational nature, they still contain many possibilities for immoral action.

But if morality endorses this exercise in developing one's inclinations and talents—for example, by discouraging incipient desires that run counter to duty[21] or by developing abilities (say) to set people at ease rather than to embarrass them—then perhaps we can see a Kantian argument for doing something similar at the level of human cooperation. It should be obvious that the incentives and powers mentioned above have, in well-formed institutions, a moral and rational structure. This is just what we mean in referring to a salary as deserved or to professional esteem as well earned; likewise, when we hold that sanctions or reproach are merited. Similarly, the enablements attached to a role are provided in order for a role-holder to fulfill her responsibilities.[22]

Kant's account of the will is premised on the thought that we can never make someone actually adopt an end; that is something that only the person herself can do. At the same time, it is still true that a person can meaningfully participate in a practice or institution without having adopted the ends that finally animate it. If we imagine someone who responds only to the incentives and enablements we have been discussing, her actions may well—for many intents and purposes—correspond reasonably well to her duties. Of course, she would be no Kantian exemplar, and she would prove quite unreliable should the institutions around her become corrupt. She would not, as we might also say, live up to the notion of a professional.

One way of marking the distinction between a job and a profession might be to say that a profession depends on actors adopting ends, and not just acting as if they had those ends for the sake of other incentives. A good healthcare professional cannot be like Kant's shopkeeper, who is honest only for business reasons. Similarly, professional remuneration may be a condition of performing a role, because the role is situated within a cooperative structure of mutual aid, but it cannot itself represent the professional's motivation.[23] Unlike Kantian virtue, what counts as professional conduct is extremely complex and depends on the collective moral learning that is embodied in decent institutions and

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developed by them on an ongoing basis. Like Kantian virtue, however, professionalism only comes to pass when a person's sense of what is important and worthwhile is actively engaged. It depends on commitment—to making a role one's own and in taking responsibility for upholding not only one's role but also the integrity of that role. To act as if one has healthcare as an end can only finally follow from a person's actually adopting that end.

Nevertheless, by participating in institutions that support debate and reflection about their procedures and structures in light of the wider ends that animate and underwrite institutions, role-holders are continually invited to understand what they are engaged in—if you like, to come to appreciate the point of their activity.[24] In this sense there can be Kantian moral education—not just in the form of abstract reasoning about the obligation to adopt certain ends, or what is involved in doing so, but in the form of collective learning as to what it is to act together in the service of those ends. This can also, we would suggest, act as a stimulus for participants to actually adopt those ends.

It hardly needs saying that there is a reverse set of dangers to this institutionalization of moral practice. As the twentieth century's political experiences have so harshly taught, institutions, even institutions for healthcare and research, may become corrupt and may corrupt their members. Setting aside the horrific extremes, we know that if treatment is organized, for example, so that individual ability to pay becomes a decision criterion, then corrupting effects ensue. Those effects are hardly undone by codes of ethics or the goodwill of individual participants: neither codes of ethics nor individual conscientiousness obtain much purchase where institutional structures actively undermine just healthcare. Nonetheless, professionalism and professional organization represent important moral responses to these dangers. Thus there are very good reasons why healthcare workers are organized into professional associations that are tasked with upholding professional ethics—in the sense of not just providing more detailed guidance to individual role-holders but also promoting ethical debate and professional reflection. This represents a collective form of moral learning somewhere between Kant's public and private uses of reason—thus debates as regards healthcare ethics, discussions on the development of professional codes,[25] and wider debates about institutional modes of organizing healthcare and medical research.[26]

One implication of our reflections, we take it, is that this last aspect—concerning questions of organization and delivery—deserves greater prominence. The old chestnuts by which we introduce our students to bioethics focus too often on what individuals should do (in an already given institutional setup) or on abstract questions that float free of our institutions (for example, debates about euthanasia or abortion). We thereby do our subject matter a disservice, inasmuch as we take for granted the institutions, procedures, and politics that decide who should play what part in a complex collective enterprise, and where professional responsibility involves concern for our collective modes of caring for people's health.

Kant himself may not have much, directly, to tell us about how we should proceed here. This is hardly surprising, given that the institutional structures of modern societies were only beginning to form in his lifetime. But the simple, structural reflections we have offered here—on what it would mean to adopt a maxim of supporting others' healthcare needs or to serve the "obligatory end" of happiness by attending to some aspect of healthcare—indicate that the

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participatory structure that our institutions provide must take center stage in our thinking in this context. Rather surprisingly, perhaps, Kantian ethics points us directly to the complexity of our acquired duties to participate—both in the institutions of modern healthcare and in the practices by which we revise them.

Notes

1. We say "may." As Kant's own notorious essay "On a Supposed Right to Lie. . ." demonstrates, despite itself, the simplicity is misleading. In this article we are concerned with one structural reason for this: institutional structures introduce roles whereby people are authorized to act on behalf of a collective. Although coercion is prohibited to persons as private individuals, Kant's political philosophy provides a well-developed argument that persons who act on behalf of the state should possess limited authorizations to use coercion. This shows that there is a large and important question about how to characterize the maxims of persons who act on behalf of institutions or, more broadly, that individual maxims sometimes depend on structures of collective action.
2. Łuków P. What is "applied" in a Kantian approach to bioethics? Unpublished paper presented at the One-Day Kant Conference; 2009 May 1; Cambridge, UK.
3. 8:37f.
4. Hence his comments regarding the compatibility of making private use of one's reason with individual conscience, particularly in relation to the priest's religious convictions ("What Is Enlightenment?" 8:38), or his well-known examples of sovereigns who demand that a subject commit calumny (*Critique of Practical Reason*, 5:30, 155f).
5. Compare Hannah Arendt's discussion of Adolf Eichmann's invocation of Kant, Eichmann being the Nazi functionary who claimed to be a "cog in a machine" rather than "master of his own deeds": *Eichmann in Jerusalem: A Report on the Banality of Evil*. New York: Penguin; 1977:135–7, 289.
6. 6:237.
7. As Rawls seems to suggest in his parallel discussion of "natural duties" and "obligations": *A Theory of Justice*. Oxford: Oxford University Press; 1972:§§51f.
8. There is an analogy with property in this much: specific role-holders have duties to punish anyone who takes my property, and perhaps to ensure restitution or compensation so far as may be possible.
9. Notwithstanding Kant's rejection of the idea of a *res nullius*, that is, an object that *has to* belong to no one: *Metaphysics of Morals*, 6:246.
10. O'Neill O. *Towards Justice and Virtue: A Constructive Account of Practical Reasoning*. Cambridge: Cambridge University Press; 1996:chs. 5 and 6. Our overall argument is greatly indebted to O'Neill's focus on institutions as mediating between imperfect duties and realizable entitlements, thereby creating specific rights to healthcare.
11. Cf. *Lectures on Ethics* (Collins): "Although scholars as a class contribute collectively to the end of humanity, [none] can apportion himself a particular share in that, for every craftsman contributes something by his work to the purpose of humanity, just as much as any scholar does" (27:461).
12. *Groundwork*, 4:403. Further: "Acquaintance with what is incumbent upon everyone to do, and hence also to know, [is] the affair of every human being, even the commonest. Here one cannot without admiration observe the great advantage the practical capacity to judge has over the theoretical in common human understanding" (4:404).
13. For sophisticated attempts to show the resources Kantian ethics has to deal with Kant's own implausible conclusions here, see Tamar Schapiro's articles: Compliance, complicity, and the nature of nonideal conditions. *Journal of Philosophy* 2003;100:329–55; Kantian rigorism and mitigating circumstances. *Ethics* 2006;117:32–5.
14. "What is Enlightenment?" 8:37.
15. If sometimes problematic: we are much more familiar than Kant was with the difficulties posed by the subjectivity and relativity of conscience.
16. Introduction to the *Doctrine of Virtue*, *Metaphysics of Morals*, 6:380f.
17. One might try to save Kant's point by arguing that these are the only two absolute forms of constraint on the human will. Whatever plausibility this point may have, it is not one that Kant could invoke. As any reader of the second *Critique* knows, Kant's ethics is based on the "*factum*"

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that coercion, even the threat of capital punishment, is not an absolute constraint on the will: otherwise the will would not be free.

18. Differently put, it would be a conceptual mistake to categorize motives based on inclination alongside the fabled motive of duty, let alone to look for any sort of in-between ground, because Kant's account of the will does not rest on the Humean search for a motivating desire. This point is well made by Barbara Herman: Bootstrapping. In: Herman B. *Moral Literacy*. Cambridge, MA: Harvard University Press; 2007:154–75.
19. Readers of the *Doctrine of Right* may feel that this is too hasty, because contract and status rights (6:271ff, 276ff) constitute specific enablements. Kant's discussions, however, do not consider the organizational analogues of these.
20. *Groundwork*, 4:398.
21. Thus Kant's remarks on "concupiscence" in the *Metaphysics of Morals*, which Barbara Herman has recently analyzed so well: The will and its objects. In: Herman B. *Moral Literacy*. Cambridge, MA: Harvard University Press; 2007:230–53.
22. Or rather, this should be the case: One familiar source of stress in modern organizations is roles that lack the resources or powers needed to fulfill them properly—consider, for example, how nurses have historically lacked the authority to call attention to bad practice.
23. See Fleming N. The bonus myth. *New Scientist* 2011;210(2907):40–3.
24. Here we draw on an argument made by Kyla Ebels-Duggan. Kant on freedom and moral education. Unpublished paper at the UK Kant Society Conference "Kant: Morality and Society"; 2009 Aug 27–9; Lancaster, UK.
25. Cf. Davis M. Thinking like an engineer. *Philosophy and Public Affairs* 1991;20:150–67. See also Harris N. Professional codes and Kantian duties. In: Chadwick R, ed. *Ethics and the Professions*. Avebury: Aldershot; 1994:104–15. Against Harris, we are suggesting that Kantian ethics should not criticize professional codes for failing to be "universalizable" in any obvious sense.
26. Cf. Banks S, Gallagher A. *Ethics in Professional Life: Virtues for Health and Social Care*. New York: Palgrave Macmillan; 2009: 214–8.

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