Moral intuitions, end-of-life acts and empirical ethics

A research project to be submitted to the Safra Center in Tel Aviv

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The research context

Moral intuitionism is enjoying a controversial renaissance today, thanks to the wealth of studies in evolutionary and moral psychology: an empirical and democratic intuitionism has replaced a rationalist elitist one. It is a fact that moral judgments often present themselves to the agents themselves as immediate and vivid judgments. An easy definition of intuition is thus one which precisely highlights these two aspects, immediacy and strength: An intuition is "Felt attraction to, or inclination to believe a certain claim whose attractiveness does not depend on any conscious inference" (Sinnott-Armstrong 2008, p. 209). Appearances to ordinary men are taken at face value; missing from this definition is the sifting through and selection of valuable, as opposed to spurious, intuitions, and a strong epistemological notion of self-evidence.

One of the main attractions of intuitionism consists in taking these immediate and strong judgments seriously and consider them as final thus protecting foundationalism against the infinite regress argument and/or rational disagreement. As Henry Sidgwick writes: "It is as true of the intellectual as of the physical life that living somehow is prior to living ideally well: and if we are to live at all; we must accept some beliefs that cannot claim Reason for their source" (1895, cited in Hardin 1992, p. 159n10). Intuitions provide a bedrock for moral principles and individual judgments. One of the most famous—some may say infamous—intuitions is the moral difference between doing something and allowing it to happen (Unger
This distinction is also considered as the foundation of the moral gulf which is supposed to exist between active euthanasia (killing) and passive euthanasia (withdrawing and withholding of care). In medical ethics, debates have been raging on this issue for several years (Steinbock and Norcross 1994).

However, intuitionism, in the form endorsed by contemporary moral psychologists, can be criticized in several ways. One first line of attack consists in undermining the objectivity and universality of moral intuitions (Sripada and Stich 2006). Even though some universal moral intuitions might be identified, they may well count towards a reconstruction of a naïve ancestral morality, but are too general to serve as normative guides (Appiah 2008). The doing/allowing distinction is too simplified to account for the moral difference between different end-of-life acts. A second line of criticism consists in showing that moral intuitions are only illusions produced by psychological processes which are not moral in any way. Prospect theory for example has been cited as an explanation for the doing vs allowing moral difference. Consequentialists like Peter Singer advance a third major criticism: intuitionism consists in taking seriously superficial and irrational emotions and thus it is dangerous insofar as it fosters prejudices. Therefore it has to be fought even though it might be true. Many philosophers have argued that the moral difference between killing and letting die is a hypocritical stance at best, leading to immoral consequences—more suffering—at worse.

Aims and methods of research

The current project has three components: a theoretical component (moral intuitionism), an empirical component (medical ethics and end-of-life decisions) and a methodological component (the interaction between normative concepts and theories and empirical data). It has three objectives:
1. Theoretical result: to defend a form of moderate critical intuitionism against the objections cited above, and redefine moral intuitions in a way that is better adjusted to the moral experience of ordinary agents, and philosophically defensible: In the light of these considerations we may give a different definition of genuine moral intuitions: *Moral intuitions are immediate and robust first-person judgments about right and wrong which are consistent across finely defined contexts of action and sensitive to reasons.* It is as empirical and democratic as moral psychology, as selective as classic intuitionism, and less conservative than both.

2. Medical ethics objectives: to better analyze medical intuitions on what I call “end-of-life acts” and to draw a few practical recommendations.

3. Methodological objectives: to identify a novel and productive approach on “empirical ethics”, which is different from both “applied” ethics and “experimental ethics”. The heuristic rather than justificatory appeal to experience, and the use of real-life decision makers faced with individual particular decisions.

As to the ultimate justification of moral intuitionism, especially in the face of deconstructing psychological mechanisms and rational normative theories, must be understood as practical rather than theoretical: by taking seriously the moral experience of moral agents, it allows our moral prescriptions to have a hold on practice. As the classic intuitionist W. D. Ross writes: “To ask us to give up at the bidding of a theory our actual apprehension of what is (prima facie) right and what is (prima facie) wrong seems like asking people to repudiate their actual experience of beauty, at the bidding of a theory which says ‘only that which satisfies such and such conditions can be beautiful’” (1930, p.40).

**Implementation of the project**
For each of the three objectives, I will briefly sketch preliminary results that have already been obtained and the stages of the research project.

1. My starting point is three hypotheses that would answer three objections to both democratic and elitist intuitionism: (a) Genuine intuitions are sufficiently consistent although not universally but across similar micro-contexts. Also, there is evidence that the different end-of-life acts are on a continuum between the least to the most morally problematic, i.e. from what doctors themselves call the least to the most “active”. (b) Genuine moral intuitions can be distinguished from psychological and emotional judgments insofar as they are "robust". In order to analyze the concept of robustness I will appeal to the notion of « moral distress » (Epstein and Hamric 2009), and identify criteria that distinguish it from other forms of psychological difficulty or reluctance. (c) Moral intuitions are “sensitive” to reasons and argumentation and, by being made explicit and exposed to public critique they can be made to slowly evolve. I will explore the question of “sensitivity to reasons” in the context of a meta-ethical discussion of the realism vs. emotivism controversy.

2. By means of an empirical qualitative study of doctors' intuitions I shall construct a “cartography of end-of-life actions”, and identify a complex set of actions that consist in withdrawing, withholding or administering several types of analgesic/sedative medications in different clinical contexts. There is evidence that the different end-of-life acts are on a continuum between the least to the most morally problematic, i.e. from what doctors themselves call the least to the most “active”. This part of the project will consist of 20 interviews of doctors involved in end-of-life decisions¹.

¹ To analyze the interviews contents, I shall use a data-driven methodology rather than a hypothesis-driven one, a form of the “grounded theory” as developed by Glaser and Strauss and further refined by Charmaz (2006). Grounded theory stresses the everyday context of medical decision-making over controlled situations, as well as
They will be asked to discuss real cases retrospectively. These semi-structured interviews will be conducted so as to: (a) classify several actions on a scale from the less to the most morally problematic; (b) identify the variables that contribute to generate moral unease. Anecdotal evidence from cases discussed in clinical ethics consultations show that the following variables are relevant: time of death, degree of certainty of death, length of treatment, level of patient’s consciousness, degree of integration between the body and the artificial device; c) to identify the clinical and institutional contexts which may contribute to a different perception of the same action. To this purpose, different medical disciplines will be compared: intensive care, rehabilitation, palliative care, neurology, geriatric care; d) to draw some general lessons about the relative importance of several normative approaches which might account for the intuitions about more or less active end-of-life acts. One of the main hypothesis underlying the doing vs. allowing distinction is the concept of nature and its normative relevance (Callahan 1996, Heyd 2003). Its different interpretations will be reviewed in the light of the results.

3. The methodological discussion will focus on the following topics: (a) The difference between relying on the intuitions of experimental subjects faced with fictional simplified cases and relying on the first-person intuitions of actual decision-makers faced with real-time decisions, both before the decision is made and afterwards; (b) A definition of relevant micro-contexts across which which intuitions should be invariant; (c) The definition of a new approach towards empirical ethics, centered on the heuristic, as opposed to the justificatory role of empirical elements.

Current state and schedule of the research project

the iterative creation of hypotheses from the data through a process of "constant comparison" between new theory and data.
First stage (already achieved) –

- I have already started the empirical analysis of doctors moral intuitions about end-of-life acts by drawing on my experience of doctors, arguments during the consultations in clinical ethics that I have performed as a consultant at the Cochin Hospital in Paris (seeSpranzi 2009).
- I have also approached the issue of the relevance of cases for empirical ethics (Spranzi 2012a).
- On the more general issue of the evolution of norms, I have shown the impact of moral intuitions in the solution of particular cases (Spranzi 2013a).
- I have explored many facets of end-of-life practices and I have analyzed the euthanasia debate (Spranzi 2013b)
- I have shown how the exchange of arguments can help and can provide reasons for theoretical change (Spranzi 2012b).

Second stage (2014-2015), Paris –

- Conducting an extensive literature review on the issues of empirical ethics, fictional vs. real cases, moral intuitionism, active vs. passive euthanasia, the notion of nature.
- Conducting 10 interviews with medical doctors in different disciplines in Paris Hopitals affiliated with the Assistance Publique des Hôpitaux de Paris (AP-HP).

Third stage (2015-2016), Israel –

- Conducting 10 interviews in hospitals affiliated with the Tel Aviv University
- Analyzing the results of the comparative empirical study.
- Writing a book summarizing my results and outlining the contours of a moderate critical intuitionism.

**Interdisciplinary and comparative perspective**
- The project involves a close interaction between philosophical theories and normative concepts and the technical medical decision. The originality is to join the two ends of very abstract philosophical discussions and particular clinical situations.

- The French-Israeli comparison will add a further dimension to the study insofar as it will help identify the elements of moral intuitions which are universal and those which have a cultural basis. The comparison is all the more interesting since the cultural differences between the two countries coexist with largely similar medical practices.

References


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