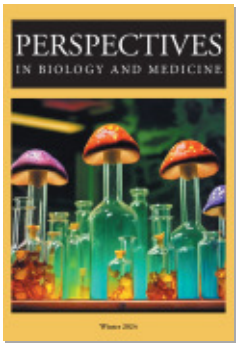
Euthanasia and End-of-Life Decisions: From the Empirical Turn to Moral Intuitionism



Marta Spranzi

Perspectives in Biology and Medicine, Volume 67, Number 1, Winter 2024, pp. 73-87 (Article)

Published by Johns Hopkins University Press
DOI: https://doi.org/10.1353/pbm.2024.a919711

Euthanasia and End-of-Life Decisions

from the empirical turn to moral intuitionism

Marta Spranzi

ABSTRACT Most medical learned societies have endorsed both "equivalence" between all forms of withholding or withdrawing treatment and the "discontinuity" between euthanasia and practices to withhold or withdraw treatment. While the latter are morally acceptable insofar as they consist in letting the patient die, the former constitutes an illegitimate act of actively interfering with a patient's life. The moral distinction between killing and letting die has been hotly debated both conceptually and empirically, most notably by experimental philosophers, with inconclusive results. This article employs a "revisionary" intuititionist perspective to discuss the results of a clinical ethics study about intensivists' perceptions of withhold or withdraw decisions. The results show that practitioners' moral experience is at odds with both the discontinuity and equivalence theses. This outcome allows us to revisit certain concepts, such as intention and causal relationship, that are prominent in the conceptual debate. Intensivists also regard end-of-life decisions as being on a scale from least to most active, and whether they regard active forms of end-of-life decisions as ethically acceptable depends on the overarching professional values they endorse: the patient's best chances of survival, or the patient's quality of life.

History, Philosophy, and Ethics of Medicine, Université de Versailles Saint-Quentin-en-Yvelines (UVSQ); and Clinical Ethics Consultant, Center for Clinical Ethics (AP-HP), Paris.
Email: marta.spranzi@uvsq.fr.

Perspectives in Biology and Medicine, volume 67, number 1 (winter 2024): 73–87.

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.

—Henry Sidgwick (1895)

SINCE PRACTICES OF WITHDRAWING and withholding of treatment have become morally acceptable and legal, in both the United States and in most European countries, albeit under strict conditions, doctors are not only allowed but required to stop certain treatments—or not to initiate them—when they can be considered as "futile" or "potentially inappropriate" (Truog et al. 2008). Doctors are thus encouraged not to overstep the supposedly natural boundaries of medical practice and to avoid being carried away by the illusory promises of a particular treatment. However, active euthanasia, understood as the administration of a lethal substance by a health-care professional to a competent patient who requests it, is still considered off limits in most countries, with the notable exceptions of Canada, the Netherlands, Belgium, some Australian states, and most recently Spain.

The "discontinuity thesis," which affirms the radical ethical difference between euthanasia and decisions to withdraw or withhold treatment, has been endorsed by many prominent medical learned societies, most notably in the context of intensive care. For example, the French Society of Intensive Care (Société de Réanimation de Langue Française, SRLF) states: "In hopeless situations, the decision to limit or to end therapy can be the only ethical alternative to 'therapeutic obstinacy,' which is contrary to the medical code of ethics." The text continues: "These practices are in no way equivalent to euthanasia, but they aim at restoring the natural character of death" (SRLF 2010). This moral distinction is based on a fundamental ethical premise: "letting" patients die—unlike killing them—is acceptable because it does not imply directly tinkering with death. Despite the strong discontinuity position taken by medical learned societies, the controversy rages on among bioethicists, although in a somewhat repetitive way: from an ethical point of view, are withhold and withdraw practices really different from "active euthanasia," or are they just another, slower and smoother, form of it?

KILLING AND LETTING DIE: DISTINCTION WITHOUT DIFFERENCE?

The discontinuity thesis is hotly debated both conceptually and empirically by philosophers belonging to different schools of thought, including the so-called "experimental philosophers." Although the arguments used to defend either position are extremely interesting in their own right, they have not resulted in any firm conclusion.

Conceptual Debate

The "continuity thesis," which states that euthanasia and withhold and withdraw practices (sometimes referred to as "passive" euthanasia) are identical from an ethical point of view, has been classically defended by utilitarian philosophers (Rachels 1986; Tooley 1995). They argue that the consequence of both practices is the same—the death of the patient—and their evaluation with respect to the conditions of the patient's death process might even favor euthanasia. The utilitarian perspective is that embracing the *dis*continuity thesis amounts to a form of moral cowardice. As Hopkins (1997) puts it: "Where we think the patient is better off unambiguously dead but are not willing to bear the moral taint of having killed, the appeal to a natural death gives us a way out" (36). According to these philosophers, the conclusion is beyond dispute: "Society and medicine should stop entertaining the fiction that killing and letting die are different from an ethical point of view" (Kuhse and Singer 2001, 60).

The discontinuity thesis, however, has many advocates, and it is based on equally powerful arguments, which focus on the difference between the intentions behind the two procedures and on the different causal links between different medical practices and the patient's death (Gorsuch 2009). As Daniel Callahan (1992) argues: a lethal injection would kill anybody, whereas withdrawing treatment only causes a very sick person to die, thus showing that what causes the patient's death is the underlying disease, rather than the action of withdrawing life-saving treatment.

The controversy has recently taken an additional twist. Whereas euthanasia is a form of doing, and withholding treatment is a form of allowing, where does withdrawing treatment stand? Clearly, in order to withdraw—as opposed to withhold—something, doctors have to engage in a series of actions. Thus, although these actions supposedly result in returning the patient to the status quo—understood as the moral baseline—rather than altering it, they might seem to contribute more actively to the patient's death rather than simply abstaining from any action. Thus, the old controversy about the continuity/discontinuity between active euthanasia and withholding or withdrawing treatment has recently been joined by a second controversy, one that centers around what has been called the "equivalence thesis" (Ursin 2019): are withholding and withdrawing epistemologically and ethically equivalent? And if not, would it be ethically preferable not to initiate a treatment at all, or to start and then withdraw it?

The supporters of the ethical equivalence between withholding and withdrawing of treatment—a position that is also endorsed by many medical professional recommendations—argue that both beneficence and justice would be violated if withholding treatment were considered as morally preferable to withdrawing it. If patients are not given access to life-saving procedures, for fear of having to

withdraw those procedures later, patients may risk losing a precious, albeit hypothetical, opportunity to survive. Further, given a context of limited resources, if we consider that it is morally preferable to withhold rather than to withdraw treatment, a patient who might profit from a life-sustaining treatment may not have access to it, because this might necessitate withdrawing it from another patient for whom it has become ineffective (Wilkinson and Savulescu 2014).[1]

Both the discontinuity and the non-equivalence theses draw on the more general moral distinction between doing and allowing, a distinction defended long ago in a seminal paper by Philippa Foot (1967). Foot argues that causing harm by doing something would be morally worse than causing the same harm by letting it happen, as it implies a higher level of personal responsibility and infringes a fundamental right not to be directly harmed. However, the conceptual debate underlying the two theses risks being inconclusive, since it depends on crucial meta-ethical assumptions that cannot be demonstrated beyond all doubt and that presuppose fundamental intellectual choices and different visions of what ethics is about (Glover 1977). For example, do intentions matter for the evaluation of an action? Or are the consequences of the action the only relevant consideration? Does justice imply the preservation of acquired rights? What is the most appropriate definition of causality?

Empirical Evidence

If rational arguments seem insufficient to settle the contested issue, what about empirical evidence? Experimental philosophers Joshua Knobe and Shaun Nichols (2008) have engaged in a vast program to test normative claims empirically by measuring the reactions of "normal" people (most often university students) to hypothetical cases presented to them by way of simplified vignettes controlling for several variables. These so-called "Trolley experiments" have provided prima facie empirical evidence to the effect that bringing about the same harmful effect by *doing* something rather than by simply *allowing* it to happen is more frequently judged as unacceptable. The results of these experiments have been endlessly discussed and contested, in what has come to be known as the Trolley research industry.

It is doubtful, however, that this kind of empirical evidence could settle a normative debate. One can argue that responses to thought experiments merely reflect the theories they are supposed to justify, insofar as the same response can be interpreted in different ways. Ruwen Ogien (2011) notes that "Two theories can be incompatible with each other and compatible with the same intuitions . . . . Appealing to intuitions does not allow us to know which one is better" (306). For example, the common intuition that it is morally unacceptable to throw a man off a bridge in order to stop a train from killing five people can be interpret-

[1]This discussion is not purely academic: it has been very relevant during the COVID crisis.

ed both as respecting the Kantian imperative of not making an instrumental use of human life, and as corresponding to an incompatible sentimentalist approach that attributes this reluctance to the strong inhibiting feelings raised by the action of pushing somebody. More generally, why should spontaneous judgments due to evolutionary adjustment strategies of our brain have moral relevance? Isn't this a form of misconstrued "naturalism"?

Additionally, experimental subjects' moral judgments can easily be deconstructed, and solid moral beliefs seem hard to come by. Some argue that the preferences they express are due to mere psychological biases. Closer to the point, the preference for letting a harmful effect happen rather than causing it might be explained by appealing to the status quo bias, or to our natural aversion to loss: the loss would be perceived as greater when the default situation is that the patient is alive (the killing situation) than when the patient is supposed to be already dying (the letting die example) (Horowitz 1998). Moreover, these judgments seem to be relatively independent of the rational arguments invoked to justify them, some of which are manifestly irrelevant and inconsistent, thus casting doubt on their robustness. This is why Knobe and Nichols (2008) promote a negative objective for experimental philosophy: "The ultimate hope is that we can use this information to help determine whether the psychological sources of the beliefs undercut the warrant for the beliefs" (7).

Finally, the experimental approach has to face a more radical objection. Insofar as these thought experiments involve reactions to artificial situations, they do not correspond to the way we normally evaluate concrete situations we are likely to encounter, and therefore they cannot constitute a reliable test for what Jeff McMahan (2002) calls "deep morality." Indeed, as Elster (2011) explains, "our moral competence is first and foremost used when we encounter morally challenging situations in the real world" (253).

The Empirical Turn in Bioethics and Intensive Care

Might the judgments of people involved in real choices be more robust and have a greater significance for normative debates? To answer this question, it is necessary to consider the so-called "empirical turn" that has taken place in bioethics:

> This alternative bioethical literature has methodological roots in the social sciences and uses methods such as case studies, surveys, experiments, and participatory observation. The common objective is the gathering of qualitative and quantitative data about ethical issues. Unlike studies of ethical dilemmas via a priori ethical theories, principles, or rules, empirical studies focus on "ethics-in-action." (Borry, Schotsmans and Dierick 2005, 51)

Despite the existence of a variety of approaches, a minimal consensus has emerged: empirical bioethics "denies the autonomy of ethics, at least in its stron-

ger forms. It denies that the exploration of value must proceed without reference to the phenomena that scientists study, the causal system of the material world, the framings of our nature" (Appiah 2010, 184). Thus, philosophical experiments are neither the only, nor the best, way to bring empirical data to bear on normative claims. Instead, qualitative studies inspired by the social sciences can provide a more fine-grained and nuanced understanding of the ethical issues underlying medical practices (Hedgecoe 2004).

Intensivists and the Discontinuity Thesis

Some empirical bioethics studies provide prima facie evidence against both pillars of ICU ethical recommendations: the discontinuity between euthanasia and decisions to withhold or withdraw treatment on the one hand, and the ethical equivalence of withholding and withdrawing treatment on the other. Intensivists are at the forefront of both issues because a high, and rising, percentage of deaths occurring in intensive care departments (up to 80%) result from conscious and negotiated decisions to withdraw or withhold treatment (Sprung et al. 2019). Are these decisions perceived as identical to acts of euthanasia? And are decisions to withhold and to withdraw treatment perceived as equivalent?

There is some evidence that intensivists' intuitions on these issues are at odds with both the discontinuity and the equivalent theses. A recent study based on in-depth interviews with intensivists, confirms that withhold and withdraw practices are a source of intense moral distress for them (Ledger et al. 2021). This casts doubt on the morally neutral nature of these decisions and their radical difference from euthanasia, which is presupposed by the discontinuity thesis.[2] Moreover, the results of several empirical studies, mostly conducted through surveys of doctors' reactions to fictional clinical cases, challenge the officially backed equivalence thesis of all withhold and withdraw practices. Withdrawals, for example, seem to be viewed as more difficult than withholdings (Beck, van de Loo and Reiter-Theil 2008); extubation is perceived as more difficult than terminal weaning (Cottereau et al. 2016); withdrawal of long-term treatments (like insulin) is less easy than the withdrawal of newly introduced drugs (Ursin 2019); and withholding ordinary drugs like antibiotics is more difficult than withholding more invasive life-saving procedures (Asch et al. 1999). Despite this evidence of practitioners' unease about the equivalence thesis, ethicists often react by claiming that these spontaneous judgments are due to "irrational" emotional biases and widespread disregard for the relevant norms, both of which could be redressed by a proper education (Beck, van de Loo and Reiter-Theil 2008).

[2]It should be noted that the Ledger study focuses on the circumstances that makes those decisions morally taxing—such as conflict with family members or lack of resources—rather than on the impact the decisions themselves have on the patients' lives.

Evidence from a Clinical Ethics Study

For my part, anecdotal evidence from clinical ethics consultations that withhold and withdraw decisions were sometimes, and surprisingly, described as "active" inspired me to initiate a qualitative study conducted with other members of the Center for Clinical Ethics (AP-HP) in Paris (https://ethique-clinique.aphp.fr/) from 2017 to 2019. (The complete results are in the process of being published.) Unlike previous studies, we asked intensivists to recount a particularly difficult case they recently had to deal with and to analogically explore other situations, focusing on the relevant similarities and differences. Whereas the fictional nature of the cases used as prompts in experimental philosophy studies makes them liable to "framing effects," a first-person approach has allowed us not only to explore practitioners' inner moral experience, but also to probe their judgments by delving into the reasons they might give for the moral distress certain withhold and withdraw decisions might provoke.

The results show that only a minority of doctors adhere to the official doctrine stating that those decisions are passive, insofar as they consist in taking away something and letting the natural course of the disease get the upper hand. By contrast, the great majority of intensivists consider withhold and withdraw decisions to be active in the "thick," normative sense (Williams 1985). These decisions are described as "active" insofar as they contribute to bringing about the patient's death, and they are, precisely for this reason, morally salient and thus potentially problematic. Interestingly, in justifying and analyzing the reasons for perceiving withhold and withdraw decisions as active, physicians do not mention the existence of an "intention" to help the patient die. "The intention to bring about death never exists!" one doctor insisted. Rather, physicians appeal to a counterfactual notion of causality: decisions to withhold or withdraw treatment are active because if they had not been implemented, the probability of the patient's death would have been lower. Intensivists regard different withhold or withdraw decisions as more or less active according to the extent to which they decrease the probability of the patient's survival. The most active is the decision to sedate patients before extubating them, a practice that leaves no chance of survival whatsoever. As one intensivist put it: "I have the impression that I do nothing but take away a pipe, but on the other hand when I take it away and she dies right away, I have the impression that I am not giving her a chance." Thus, insofar as they describe decisions to withhold or withdraw treatment as active, intensivists sometimes perceive them as euthanasia-like, albeit still different from euthanasia proper. In France, where medically assisted death is still illegal, they view withholding or withdrawing treatment as a more brutal and rapid form of physician-assisted dying, and as a question for the society at large to settle rather than as a medical issue. Euthanasia is not only active but is described by these practitioners as "very active," more "clear-cut," and "violent." "In euthanasia," one doctor stated, "it is more than the intention, it is the will to take the patient's life."

However, in our study the distinction between more or less active forms of withholding or withdrawing treatment does not neatly match the difference discussed in the literature about the equivalence thesis, where withholdings are usually described as less problematic from an ethical point of view (Ursin 2019). Even though withholdings are statistically associated with a lower probability of patients' death, this is not necessarily the case. For example, if one decides to withhold a dialysis treatment from a patient who needs it, the probability that he will die is the same as if dialysis had been withdrawn, and therefore intensivists tend to consider both decisions as equally active.

Most importantly, the results show that physicians who view withhold or withdraw decisions as active fall into two groups, according to the different overarching professional values they embrace. Some knowingly accept taking the risk to shorten a patient's life in order to spare her a poor quality of life. As one doctor put it, "In order to decide whether to continue life-sustaining treatments I have someone describe me the patient's life," and "when there is no quality of life as it is usually understood . . . the decision is not difficult to make," although it requires a certain amount of courage. Physicians argue that in these cases, a decision to withdraw ventilation amounts to a form of euthanasia, and that it would be "hypocritical" not to acknowledge the fact: "It is euthanasia: technically we have voluntarily put her to sleep and we have hypo-ventilated her, but it does not strike me as unacceptable." These physicians tend to make end-of-life decisions earlier rather than later, and they prefer withdrawals to withholdings, insofar as they are more clear-cut and allow for quicker resolutions that minimize the maleficence of life-sustaining treatments themselves. Other physicians, on the contrary, fear patients' loss of opportunity to survive most of all, they delay withhold or withdraw decisions as long as possible and make them reluctantly, even at the cost of letting a patient survive with a poor quality of life. They argue that this is not for them to judge, since such considerations are veiled in a somewhat reassuring uncertainty, which allows them to downplay their own responsibility for the patient's death. "Even though they have serious [neurological] sequelae," one doctor explained, "if they survive it is not up to me to decide. There is a measure of uncertainty." These value-based personal differences might well explain, at least partly, the well-documented variability of withhold or withdraw decisions in intensive care departments that many ethicists find so troubling (Wilkinson and Truog 2013).

But what do we make of the fact that these results seem to call into question the validity of the officially backed ethical principles: the fundamental discontinuity between euthanasia and withhold or withdraw practices and the equivalence between all forms of withholding and withdrawing treatment? And what do we make of intensivists' different value-based attitudes towards these critical decisions? These questions raise the time-honored issue of how we can breach the "is versus ought" distinction (de Vries and Gordijn 2009). Indeed, we cannot

simply infer what we would like reality to be from the way we ascertain it to be. On the other hand, a large distance between what is and what ought to be is detrimental to an effective implementation of norms and does not do justice to our moral life.[3] If we argue that the normative and factual dimensions should tend towards consistency and attain a form of what Rawls (1971) calls "reflective equilibrium," which one should give way, and why? Walking a fine line between the rock of spontaneous judgments and the hard place of professional recommendations puts us at risk of remaining in an unsatisfactory midstream. Surely if there is a discrepancy between agents' moral perceptions and the corresponding norms, it is not enough to argue that norms should be adjusted to accommodate those perceptions. After all, morality cannot do away with an ideal dimension. But neither can one dismiss, or explain away, those spontaneous but well-argued judgments by pretending that they merely correspond to regrettable psychological tendencies that should be won over by bona fide moral arguments. As Ursin (2019) states, "it is *ambitious* to say that two acts that are widely perceived to be morally different in reality are morally the same. It is also quite ambitious to say that widely shared assessments of medical personnel rest on confusions and mistakes" (27).

I would argue that it is not only "ambitious" to use moral theory to clamp down on strongly felt moral perceptions, but that so doing relies on misguided ethical premises that disregard the fundamental normative role of moral intuitions. I would like to suggest that we should bite the bullet of the "is *and* ought" intimate connection, by embracing a form of moral intuitionism that would better account for people's moral experience and make their judgments—their "moral intuitions"—relevant for the evolution of norms. To this task we shall now turn.

Intuitionism and Its Critics

We often have a "feeling," which can be both immediate and very strong, that a possible action is morally wrong, without quite knowing why, or that an action is right in spite of obvious arguments to the contrary, or that of two options that at first glance don't seem very different, one imposes itself on us much more strongly than the other. A relatively broad definition of *intuition* encompasses all these "seemings" that are such salient features of our moral life. An intuition can be described as "a strong attraction, or inclination to believe a certain given proposition, which does not depend on any conscious inference" (Sinnot-Armstrong 2008, 209). Moral intuitionism consists in giving these immediate judgments the benefit of the doubt, thereby enabling us to avoid the infinite regress that threatens all argumentative proof. When we say, for example, that lying is wrong,

[3]Alistair MacIntyre (1966) has argued that Hume never expressed the impossibility of bridging the "is" and the "ought"; rather, he pointed out that by focusing on the distinction we could "realize how there are ways in which this transition can be made and ways in which it cannot" (261).

we can justify our judgment by saying that lying has harmful consequences, or that it constitutes a betrayal of a universal principle of mutual trust. While it is possible to use utilitarian or Kantian arguments to convince a potential opponent of its truth, neither of these arguments is going to be decisive unless we rely on a deeper and more immediate conviction or an unshakeable feeling that it can't be otherwise.

However, some philosophers who are hostile to intuitionism argue that moral intuitions often reflect emotions and prejudices that are as irrational as they are dangerous, and that trusting these intuitions can result in sanctioning an unfortunate status quo. One form of intuitionism takes at face value what "seems true and justified" to ordinary people. However, it lends itself to the damaging critique of extolling what Kass (1997) calls the "wisdom of repugnance" as the sole arbiter of well-founded moral judgments. Peter Singer (1974), for example, writes: "All the moral judgments we make intuitively are likely to derive from abandoned religious systems, from twisted conceptions of sexuality and physiological functions, or from habits that were necessary to the survival of the species under social and economic conditions belonging to the very distant past" (516). These philosophers argue that we should cultivate an attitude of systematic suspicion towards intuitions, even though they often correspond to widely held opinions and are, as such, empirically true.

Classical Intuitionism and Bona Fide Intuitions

This objection, however, does not leave intuitionists speechless. Classical intuitionists like Henry Sidgwick (1874) distinguished "philosophical" from "commonsense" intuitionism, arguing that the former is more selective and does not limit itself to validating the status quo. George Bealer (1998), who supports Sidgwick's philosophical form of intuitionism, asserts that true and reliable intuitions are based on the perception of a form of necessity. For all philosophical intuitionists, the truth and justification of certain intuitions is beyond doubt, provided they are "clear," "precise," and "coherent," and have been elaborated under the ideal intellectual conditions that only armchair philosophers could guarantee. While the idea of selecting valuable and trustworthy intuitions among all possible "seemings" can constitute a plausible answer to the damaging objection of sanctifying prejudice and justifying any unreflective judgment, this elitist form of intuitionism mostly concerns higher-order truths and principles and builds on professional philosophers' own intuitions. To this extent, it tends to be irrelevant for answering normative questions raised by everyday practices.

Revisionary Intuitionism and Concerned People Judgments

Recent "moderate" intuitionists like Robert Audi (2009) acknowledge the need to give certain seemings a privileged status, while avoiding philosophical intuitionism's dogmatic unpalatable consequences. Audi argues that not all judg-

ments that appear self-evident are necessarily obvious and true, and that intuitions are not impervious to reasons: "Intuitive moral judgments may have evidential grounds and, even though non-inferential, may be defended by inferences in many cases where a need for justification arises" (Audi 2008, 490, fn. 8). Following Robert Audi, Michael Huemer (2008) and Jonathan Weinberg (2007) define themselves as "revisionary" intuitionists and introduce the fundamental idea that intuitions are "defeasible" rather than true a priori. Huemer (2008) explains: "The key point in a properly critical intuitionist methodology is that not all intuitions are created equal. Intuitions that are controversial or that may easily be explained as products of bias have relatively little evidential value" (391).

I would like to suggest that we can do justice to our moral experience and provide a suitable approach to reducing the distance between norms and practices by building upon the moral intuitions of concerned people, according to a particular form of "revisionary" intuitionism. First, while it is true that genuine moral intuitions are invariant, only their invariability relative to given micro-contexts is morally relevant. The moral intuitions of interest for a detailed analysis of our normative practices and theories are not universal and abstract, but rather rooted in a structured and evolving network of actions and representations.

Second, in order to single out valuable intuitions we must rely neither on the spontaneous responses experimental subjects give to controlled thought experiments, nor on the inner experience of well-trained philosophers. Instead, we must consider the judgments of "concerned people" placed in situations where they are faced with real decisions in a clearly defined context. Far from disqualifying their intuitions as "interested," it is precisely the fact that people are "concerned" that guarantees the reliability of their spontaneous judgments and gives us valuable information about what really matters to them, "what they care about" (Frankfurt 1982). Faced with a difficult decision whose consequences affect them directly, concerned people have to choose one particular scenario from a number of other possible ones. The fact of being faced with a dilemma forces a person, as it were, to inhabit an imaginary form of life, to consciously explore it in all its hidden dimensions and to evaluate it by invoking different and opposing arguments and values. For all these reasons, concerned people possess a precious "first person" kind of competence and expertise (Cowley 2005).

Third, genuine moral intuitions, as opposed to "thin" common judgments, are those that prove to be sufficiently constant and robust across the same micro-context: they persist over time, they resist attempts to undermine them by rational arguments, and they are liable to engender genuine "moral distress" if they are challenged (Epstein and Hamric 2009). Even if intuitions emerge independently of any reasoning, they are sensitive to reasons: they can be exposed to supporting and critical arguments both internally (by oneself) and externally (by others). This process serves two functions. On the one hand, intuitions that have survived this critical process can be considered as "corroborated," to use Karl Popper's term.

On the other hand, making the implications and hidden presuppositions of intuitions explicit can also allow their bearers to relate them to a structured network of reasons that can be traced back to more general normative outlooks that can either justify or challenge them. As Kwame Appiah (2010) writes, "Our moral theories have clashing ambitions: if their plausibility comes from their ability to accommodate our intuitions, their power comes from their ability to challenge still other intuitions" (76). Thus, people might be brought to realize that their own intuitions are contradictory or squarely unacceptable, and ultimately reject them.

CONCLUSION

The foundation of our moral life is not constituted by a deductive normative system ordered by principles and inference rules, but by a set of moral intuitions that lie at the heart of our moral experience. As James Griffin (1998) writes, if it is true that the purpose of ethics is allow us to think reflectively about our moral experience, then "one would expect ethical standards to display closer connections to our ordinary ethical thought, to our intuitions, than scientific standards do" (7).

After this long detour through a particular version of empirical bioethics and moral intuitionism, what can we say about the "discontinuity" thesis that lies at the heart of the medical normative framework regulating end-of-life decisions? The results of the Center for Clinical Ethics (AP-HP) study clearly challenge certain terms of the current conceptual debate. In order to determine whether a given judgment—in our case, a particular end-of-life decision—is morally acceptable, it is not enough to determine whether the technical action it involves is active or passive. And neither is it enough to focus on the intention that motivates it, which is by definition private and indeterminate (Quill 2019; Searle 1983). Nor is it sufficient to consider the degree to which a decision respects the patient's supposedly "natural" dying process as a measuring stick for its ethical acceptability since intensivists' intuitions resort to a counterfactual, rather than a process-based, notion of causality.

Does this mean that the discontinuity thesis should be considered as a useful "moral fiction" (Miller, Truog, and Brock 2010), fated to be reversed once society is ready to accept a moral revolution in which euthanasia and withhold or withdraw practices are recognized as morally indistinguishable? Intensivists' moral intuitions paint a more nuanced picture: all end-of-life decisions, including withhold and withdraw decisions, are active on a sliding scale, with euthanasia and extubation following sedation being the most active of all, insofar as they reduce the patient's chance of survival to zero. Modern medicine, however, cannot avoid tinkering with a patient's death, and neither can it resort to a supposedly natural state as a moral guide: its age of innocence is over. But precisely because medicine has acquired an accrued power to prolong life, it must also assume the

responsibility for consciously shortening a patient's life, through whatever technique best fits the patient's wishes and larger life situation.

Our clinical ethics empirical study has revealed that the moral acceptability of active end-of-life decisions depends on other professional values that each individual physician considers as crucial. Some intensivists are guided by the fear of reducing a patient's probability to survive, while others embrace a larger sense of professional responsibility and are more concerned by the patient's future quality of life. Health professionals in the first group perceive active end-of-life decisions as morally problematic, while those in the second group consider shortening a patient's life in the name of the patient's overall well-being as part of their duty. These results show that our moral life is not constituted by a series of discreet actions, but by an interconnected web of what Joseph Raz (2005) calls "life-building" values. Moreover, intensivists' variability is an intrinsic feature of their professional engagement, rather than a regrettable and contingent reality.

Finally, although moral intuitions are what revisionary intuitionists call "the data of ethics" (Audi 2008, 476), they are not fixed. Rather, they undergo a continuous evolution process as they are made explicit, analyzed, and possibly criticized by reasons and arguments. In this regard, intuitionism can be a positive motor for, rather than than an obstacle to, change even tough intuitions evolve through a process of moral reform (Ursin 2019) rather than by moral revolution. Since moral theories and arguments alone will likely be ineffective to undermine inappropriate moral judgments, giving moral intuitions pride of place looks like a more promising place to start. As classical intuitionist David Ross (2002) writes: "To ask us to renounce on purely theoretical grounds our apprehension of what is *prima facie* right or *prima facie* wrong, would be like asking people to repudiate their actual experience of beauty by telling them that this judgment does not fit some theoretical criteria of beauty" (40). Euthanasia will become an end-of life option when a growing number of physicians will find it as acceptable as other active end-of-life decisions that are already part all their daily practice.

References

Appiah, K. A. 2010. *Experiments in Ethics*. Boston: Harvard University Press.

Asch, D. A., et al. 1999. "The Sequence of Withdrawing Life-Sustaining Treatment from Patients." *Am J Med* 107 (2): 153–56.

Audi, R. 2008. "Intuition, Inference, and Rational Disagreement In Ethics." *Ethic Theory Moral Pract* 11: 475–92.

Audi, R. 2009. *The Good in the Right: A Theory of Intuition and Intrinsic Value*. Princeton: Princeton University Press.

Bealer, G. 1998. "Intuition and the Autonomy of Philosophy." In *Rethinking Intuition: The Psychology of Intuition and Its Role in Philosophical Inquiry*, ed. M. R. DePaul and W. Ramsey, 201–39. Washington, DC: Rowman and Littlefield.

Beck, S., A. van de Loo, and S. Reiter-Theil. 2008. "A 'Little Bit Illegal'? Withholding and Withdrawing of Mechanical Ventilation in the Eyes of German Intensive Care Physicians." *Med Health Care Philos* 11: 7–16.

Borry, P., P. Schotsmans, and K. Dierick. 2005. "The Birth of the Empirical Turn in Bioethics." *Bioethics* 19 (1): 49–71.

Callahan, D. 1992. "When Self-Determination Runs Amok." *Hastings Cent Rep* 22 (2): 52–55.

Cottereau, A., et al. 2016. "ICU Physicians' and Nurses' Perceptions of Terminal Extubation and terminal Weaning: A Self-Questionnaire Study." *Intensive Care Med* 42: 1248–57.

Cowley, C. 2005. "A New Rejection of Moral Expertise." *Med Health Care Philos* 8: 273–79.

De Vries, R. O. B., and B. Gordijn. 2009. "Empirical Ethics and Its Alleged Meta Ethical Fallacies." *Bioethics* 23 (4): 193–201.

Elster, J. 2011. "How Outlandish Can Imaginary Cases Be?" *J Appl Philos* 28 (3): 241–58.

Epstein, E. G., and A. B. Hamric. 2009. "Moral Distress, Moral Residue, and the Crescendo Effect." *J Clin Ethics* 20 (4): 330–42.

Foot, P. 1967. "The Problem of Abortion and the Doctrine of the Double Effect." *Oxford Rev* 5: 5–15.

Frankfurt, H. 1982. "The Importance of What We Care About." *Synthese* 5 3(2): 257–72.

Glover, J. 1977. Causing Death and Saving Lives. Harmondsworth: Penguin.

Gorsuch, N. M. 2009. *The Future of Assisted Suicide and Euthanasia*. Princeton: Princeton University Press.

Griffin, J. 1998. *Value Judgment: Improving our Ethical Beliefs*. Oxford: Clarendon.

Hedgecoe, A. M. 2004. "Critical Bioethics: Beyond the Social Science Critique of Applied Ethics." *Bioethics* 18 (2): 120–43.

Hopkins, P. 1997. "Why Does Removing Machines Count as 'Passive' Euthanasia?" *Hastings Cent Rep* 27 (3): 29–37.

Horowitz, T. 1998. "Philosophical Intuitions and Psychological Theory." *Ethics* 108 (2): 367–85.

Huemer, M. 2008. "Revisionary Intuitionism." *Soc Philos Policy* 25 (1): 368–92.

Kass, L. 1997. "The Wisdom of Repugnance: Why We Should Ban the Cloning of Humans." Repr. *Arguing About Bioethics*, ed. S. Holland, chap. 12. Oxford: Routledge, 2012.

Knobe, J., and S. Nichols. 2008. "An Experimental Philosophy Manifesto." In *Experimental Philosophy*, 3–14. Oxford: Oxford University Press.

Kuhse, H., and P. Singer. 2001. "Killing and Letting Die." In *Bioethics*, ed. J. Harris. Oxford: Oxford University Press.

Ledger, U., et al. 2021. "Moral Distress in End-of-Life Decisions: A Qualitative Study of Intensive Care Physicians." *J Crit Care* 62: 185–89.

MacIntyre, A. C. 1969. "Hume on 'Is' and 'Ought.'" In *The Is-Ought Question: A Collection of Papers on the Central Problem in Moral Philosophy*, 35–50. London: Palgrave Macmillan.

McMahan, J. 2002. *The Ethics of Killing*. New York: Oxford University Press.

Miller, F. G., R. D. Truog, and D. W. Brock. 2010. "Moral Fictions and Medical Ethics." *Bioethics*. 24 (9): 453–60.

Ogien, R. 2011. *L'influence de l'odeur des croissants chauds sur la bonté humaine: et autres questions de philosophie morale expérimentale*. Paris: Grasset.

Quill, T. E. 2019. "The Ambiguity of Clinical Intentions." In *Death, Dying and the Ending of Life,* vol. 2, ed. L. P. Francis and M. Battin, 15–16. London: Routledge.

Rachels J. 1986. "Active and Passive Euthanasia." In *Applied Ethics*, ed. P. Singer, 29–37. Oxford: Oxford University Press.

Rawls, J. 1971. *A Theory of Justice*. Cambridge: Harvard University Press.

Raz, J. 2005. *The Practice of Value*. Oxford: Oxford University Press.

Ross, W. D. 1930. *The Right and the Good*, ed. P. Stratton-Lake. Oxford: Clarendon Press, 2002.

Searle, J. R. 1983. *Intentionality: An Essay in the Philosophy of Mind*. Cambridge: Cambridge University Press.

Sidgwick, H. 1874. *The Methods of Ethics*. Glasgow: Good Press.

Sidgwick, H. 1895. "The Philosophy of Common Sense." *Mind* 4 (14): 145–58.

Singer, P. 1974. "Sidgwick and Reflective Equilibrium." *Monist* 58 (3): 490–517.

Sinnott-Armstrong, W. 2008. "Abstract + Concrete = Paradox." In *Experimental Philosophy*, ed. J. Knobe and S. Nichols, 209–30. Oxford: Oxford University Press.

Société de réanimation de langue française (SRLF). 2010. "Limitations et arrêts de traitement en réanimation adultes. Actualisation des recommandations de la Société de réanimation de langue française." *Réanimation* 19: 679–83.

Sprung, C., et al. 2019. "Changes in End-of-Life Practices in European Intensive Care Units from 1999 to 2016." Ethicus 2 study. *JAMA* 322 (17): 1692–1704.

Tooley, M. 1995. "Voluntary Euthanasia: Active versus Passive, and the Question of Consistency." *Rev Intern Philos* 305-322.

Truog, R. D., et al. 2008. "Recommendations for End-of-Life Care in the Intensive Care Unit: A Consensus Statement by the American College of Critical Care Medicine." *Crit Care Med* 36 (3): 953–63.

Ursin, L. Ø. 2019. "Withholding and Withdrawing Life-Sustaining Treatment: Ethically Equivalent?" *Am J Bioethics* 19 (3): 10–20.

Vincent, J.-L., et al. 2020. "Response to Ely, Azoulay and Sprung." *Intensive Care Med* 46: 145–46.

Weinberg, J. M. 2007. "How to Challenge Intuitions Empirically Without Risking Skepticism." *Midwest Stud Philos* 31: 318–43.

Wilkinson, D., and J. Savulescu. 2014. "A Costly Separation Between Withdrawing and Withholding Treatment in Intensive Care." *Bioethics* 28 (3): 127–37.

Wilkinson, D. J., and R. D. Truog. 2013. "The Luck of the Draw: Physician-Related Variability in End-of-life Decision-Making in Intensive Care." *Intensive Care Med* 39 (6): 1128–32.

Williams, B. 1985. *Ethics and the Limits of Philosophy*. Cambridge: Harvard University Press.