Moral Disengagement – Mechanisms Propelling the Euthanasia/PAS Movement

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Abstract

The international movement that promotes the legalisation of euthanasia/physician-assisted suicide (PAS) is propelled by highly potent psychological mechanisms to overcome the resistance to its agenda. It is all about cognitive restructuring to justify inhumane actions. These are always in use when normal, well-socialised persons are coerced into accepting and participating in the killing of fellow human beings. Various scientific studies, pioneered by Albert Bandura, have shown that participators are able to endure their deeds by activating these powerful mechanisms of moral disengagement.

However, those who make use of such mechanisms pay a high price. These mechanisms have a personality-changing power that dehumanizes the perpetrators. For the society that has allowed itself to be manipulated by such mechanisms for the purpose of systematizing "death on demand", there are also serious consequences. These consequences can be described in terms of dehumanization and brutalization of that society as a whole.

Key Words: euthanasia, medically assisted dying, moral disengagement, dehumanization

1. Introduction

The euthanasia movement is propelled by highly potent psychological mechanisms to overcome the resistance to its agenda. It is all about cognitive restructuring to justify inhumane actions. These are always in use when normal, socially-adjusted persons are coerced into accepting and participating in the killing of fellow human beings. Various scientific studies, pioneered by Albert Bandura, have shown that participators are able to endure their deeds by activating these powerful mechanisms of moral disengagement. 1

But those who make use of such mechanisms pay a high price; these mechanisms have a personality-changing power that dehumanizes the perpetrators. For the society that has allowed itself to be manipulated by such mechanisms for the purpose of systematizing "death on demand", there are also serious consequences. These mechanisms affect the various institutions of society and lead to dehumanization and brutalization of that society as a whole.

It is well documented that the occurrence of moral disengagement presupposes inhuman behavior. One can therefore expect that where these mechanisms are recognized, inhumane deeds are also being advocated or defended. The clearer and the more articulate these psychological mechanisms are, the more serious is the action being concealed, and the mechanisms are thus indicative of a moral collapse that has already occurred or is imminent\(^2\). For this reason, these mechanisms are warning signals that should be carefully observed.

The following summary description of moral disengagement has been obtained from Osofsky et al.\(^3\) We will be using it as a reference, as we examine the euthanasia movement’s defense of medical killing, and we shall see that the rhetoric and arguments used are permeated with these mechanisms to disengage moral self-control.

Osofsky et al.: “Operating at the behavior locus are three separate disengagement mechanisms that convert the construal of injurious conduct into righteous conduct. In \textit{moral justification}, worthy ends are used to vindicate injurious means … Second, by the use of sanitizing \textit{euphemistic language}, injurious conduct is rendered benign … \textit{Exonerative comparison} with even more flagrant inhumanities is a third mechanism for cloaking injurious behavior in an aura of benevolence.

The second set of disengagement mechanisms operates at the agency locus by obscuring or minimizing the perpetrator’s agentic role in an injurious activity. Under \textit{displacement of responsibility}, people view their actions as stemming from the dictates of authorities rather than being personally responsible for them … Because they do not perceive themselves to be the main causal agent of their actions, they are spared self-condemning reactions. The exercise of moral control is also weakened when personal agency is obscured by \textit{diffusing responsibility} for injurious conduct…

The weakening moral control at the outcome locus is achieved by \textit{minimizing or disregarding the harmful consequences} of one’s action. As long as the injurious outcomes are ignored, minimized, or disbelieved there is little reason for moral self-regulation to be activated.

The final set of disengagement mechanisms operates at the locus of the recipients or objects of detrimental acts through \textit{dehumanization and attribution of blame}. Self-censure for injurious conduct can be disengaged or blunted by divesting people of human qualities, or by attributing demonic and bestial qualities to them … Blaming the recipients of injurious treatment for bringing suffering on themselves also serves self-exonerating purposes.”

\section*{2. Moral Justification}

The advocates’ primary argument for killing a fellow human being is the good purpose of eliminating pain in the final phase of an incurable disease. It is a prime example of \textit{moral justification} of an

\begin{itemize}
\item \textit{Ibid}, p.390, 1st paragraph: “In developmental analyses, level of moral disengagement predicts subsequent injurious conduct after controlling for prior level of injuriousness and other possible psychosocial contributors to such conduct (Bandura et al., 2001). Verification of relations between moral disengagement practices and inhumanities perpetrated under conditions of social strife and tyranny lend further support to the contributory role of moral disengagement.”
\item \textit{Ibid}, p.373 This is a model that was originally developed by Albert Bandura and that has been widely used in order to analyze people’s conduct in morally charged situations.
\end{itemize}
inhuman act, based here on the premise that the situation is meaningless and without hope. One must then make the unreasonable claim of possessing a flawless knowledge of the patient’s current condition and future. The mortal deed is portrayed as a merciful act, but based on and determined by an incomprehensible arrogance.

It is this claim to omniscience that the proponents offer the respondents in the opinion-polls they are constantly referring to. The respondents are put in a position where they know with complete certainty that the disease really is incurable and that the patient is really dying and – with the often hidden premise – very soon. The respondent is thus provided with a foregone conclusion that rarely exists in the real situation, and hence the answers are highly related to the way the questions are phrased. Neither is there any room left for the possibility that the time leading up to natural death could be profoundly meaningful – that it could be a time for healed relationships and answered questions.

3. Exonerative Comparison

An example of exonerative comparison is when it is emphasized that the alternative to euthanasia/PAS is a dying process filled with torment and anguish. By use of this contrast effect, participating in the premature death of a fellow human being then appears as an act of the utmost goodwill.

Another example of exonerative comparison is when the advocates claim that if we do not legalize euthanasia/PAS, sick people will in their desperation take their own lives, using much less safe methods, and that the consequence of that will then be greater suffering.

It was precisely this disengaging maneuver that the Supreme Court of Canada resorted to for the purpose of removing legislation prohibiting assisted suicide. The court’s obscure reasoning included the argument that suicide assisted by a physician cannot be prohibited on the grounds that:

“…, the prohibition deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.”

The court was unable, or rather unwilling, to realize the ironic consequence of its decision – that such legalization has the exact opposite effect, as it will most likely cause a far greater number of individuals to take their lives prematurely with the help of doctors, than the number that would have done so completely independently in the same situation. When you use this exonerative comparison, it is also a denial of the fact that a wish to die most often is an expression of depression that can be treated with far better methods than a lethal prescription.

4 Dr. Ann Marie Chiasson, Los Angeles Times, May 12, 2016: “The reasons I won't participate begin with the Hippocratic oath I took when I became a doctor — 'First do no harm.' I have also seen too many late-breaking healed relationships and radical changes of heart in my patients' last days to think that taking a prescription in advance of the end is the best way to die.”

In the Netherlands, the use of *exonerative comparison* is becoming increasingly transparent to all – except to those who have gradually become accustomed to these misdeeds. The minister for health and the minister for justice are now (October 2016) promoting that all elderly people who are "tired of living" should be offered medical assistance to die\(^6\). In support of the proposal, Edith Schipper, Health Minister, describes how beneficial it is for many elderly to die, as compared to continuing to live. She proffers an assurance that the practice would be safeguarded by strict regulation preventing abuse – an unfathomable contention in the Netherlands, where for more than a decade they have been engaged in notorious crimes against their own regulations governing euthanasia. Or rather to the contrary – have adjusted the legislation to fit the constantly expanding practice. Was this a cynical statement by Schipper? Probably not. Presumably, she believed what she was saying, which makes it all the more frightening. This indicates that the disengaging mechanisms are potent not only to sedate the conscience but also to cloud the mind – where the latter may well be a fruit of the former.

Advocates of the Oregon Model frequently emphasize how comforting it is for the patient to know that the deadly drug is available to them. By *exonerative comparison*, it is thus claimed that the prescribing of a lethal poison is in fact of great benefit to the patient, as he or she would otherwise suffer from anxiety. In this way, one negates that a patient’s anxiety about the future is many times an expression of a depression that can often be treated successfully with drugs, instead of a deadly poison.

4. Euphemistic Language

Bandura: “Language shapes thought patterns on which actions are based. Activities can take on very different appearances depending on what they are called. Not surprisingly, euphemistic language is widely used to make harmful conduct respectable and to reduce personal responsibility for it. Euphemizing is an injurious weapon.” \(^7\)

Yes, *euphemizing* is a deadly weapon in the euthanasia movement’s arsenal. Its rhetoric and mission description are totally saturated with corrupt language usage that aims to camouflage the true meaning of its agenda. The advocates' brutal abuse of our common language is a clear sign that a powerful moral disengagement mechanism has been activated to consolidate their ideal image. It is all about verbal engineering used to convince themselves, as well as to influence general opinion, that something which initially fills most people with a sense of disgust is in fact something indicative of high moral standards. If that were not so, why not use adequate terminology? No, this is all about abominable deeds that have to be sanitized with the use of *euphemisms*. Through linguistic creativity, fatal deeds are made to appear as beneficial, curative treatments.

The examples of euphemisms are legion. Their frequent use in the rhetoric of the euthanasia movement is a clear indication that it is an inhumane activity that is being advocated.

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\(^7\) Bandura, "Moral Disengagement In The Perpetration Of Inhumanities" [http://journals.sagepub.com/doi/pdf/10.1207/s15327957pspr0303_3](http://journals.sagepub.com/doi/pdf/10.1207/s15327957pspr0303_3)
5. A Really Dangerous Trio of Mechanisms

Osofsky again: “This trio of mechanisms [moral justification, exonerative comparison and euphemistic language] is especially effective in disengaging moral self-sanctions. Investing injurious conduct with high social and moral purpose not only eliminates self-censure but also engages self-approval in the proficient service of the activity." Bandura: “People then can act on a moral imperative and preserve their view of themselves as a moral agent while inflicting harm on others.”

The euthanasia movement's highly intensive use of these three mechanisms therefore provides a reasonable explanation for its successes and for the proponents' sincere belief that their activities are expressions of high moral standards. Here it is important to understand that the advocators generally are not cynical and hard-hearted. On the contrary, they are usually very caring and considerate people. Their moral disengagement is selective – it applies only to people in certain vulnerable situations. And, for these people the caring consideration of the advocates is perverted into a deadly compassion. With the support of this trio of mechanisms, they can thus maintain their self-image as persons of high moral standards along the entire slippery slope, due to the gradual dulling of their better judgment. Moral disengagement mechanisms are certainly no harmless toys. Those who make use of them for the purpose of killing a fellow human being also harm themselves. It begins with a moral justification; the patient should not have to suffer. It continues with some euphemisms; it is a dignified death, it is aid-in-dying and absolutely not suicide. Finally, there is the exonerative comparison; it is much better than that the patient should take his/her own life independently. By this time, one is ready to step across the threshold and kill the first, terminally ill patient. But once that step has been taken, the next step comes from logical necessity. Hesitations are dismissed and any objections are effectively silenced by the mechanisms that are becoming self-propelled. Deadly deeds are swept in an aura of compassion. At the same time, the practitioner and the society that sanctions the practice are being cloaked in a moral cloud and – as telling signs show – an intellectual fog.

6. Displacement of Responsibility and Diffusing Responsibility

When using the catchphrase "personal choice", the responsibility is transferred to the patient (displacement of responsibility). It is the patient's own decision, they say, but the patient may often, even subtly and unconsciously, be guided in one direction or the other by doctors and relatives. In addition, legalization in itself implies pressure, since society thereby proclaims that suicide is a recommended measure in certain situations. In an assisted suicide, it is also the patient himself/herself who has to take the death drug. By way of this arrangement, one is able to transfer the responsibility for the act to the patient. This effectively lowers the threshold for legalization. It becomes more palatable for the doctor than to give a lethal injection, and the doctor does not even

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9 Bandura, “Moral Disengagement In The Perpetration Of Inhumanities” http://journals.sagepub.com/doi/pdf/10.1207/s15327957pspr0303_3
need (in Oregon) to be present when the patient takes the death drug. This arrangement has been the successful strategy of the US advocates, something our Swedish advocates also want to adopt. That the doctor “only” prescribes the poison and the patient himself/herself takes it is an example of diffusing responsibility. One can argue that the prescription in itself is harmless. However, with the prescription, a deadly substance is made available and the patient is recommended to use it. Furthermore, the physician consults with another physician. That is presented as a safety measure for the patient, but at the same time it means that they together take the decision to approve the patient's request, which is another example of diffusing responsibility. All the parties involved can then distance themselves from their personal moral responsibility. In Oregon, they are also completely exonerated from all legal responsibility through the "good faith" rule that protects all the participants.

7. Minimizing or Disregarding the Harmful Consequences

This is yet another type of mechanism for moral disengagement that can be traced in the rhetoric of the advocates. The consequences are minimized by referring to the mortal deed as a comfortable way of falling asleep. It also minimizes the fatal outcome by claiming that the allegedly strict regulations ensure that no one dies by mistake. Furthermore, the consequences of approving the physician-assisted suicide (in Oregon) are denied by claiming that the patient can always withdraw the request and, in addition, does not have to take the lethal dose. One denies the fact that it is a matter of assistance to commit suicide, and any talk to the effect that a person’s life is being taken is dismissed. To support this assertion, it is emphasized that the patient is going to die shortly anyway – i.e., is dying. Giving the patient access to a poison is to make the dying easier, is the argument.

8. Dehumanization and Attributing Blame

Finally, a mechanism is employed that excuses the mortal deed by reducing the human dignity and integrity of the patient. The action is justified by claiming that the patient's quality of life is so low that death is a better alternative. The inference is that it is not a life worth living, anyway. This way of emphasizing the sick person’s limitations and reduced possibilities for an independent life is tantamount to dehumanization. It is the degradation of a human being into a sub-human object with a lower protection value, in order to make it easier to participate in the person’s death. This devaluation effect is very obvious everywhere that euthanasia/PAS has been legalized. In the same societies where one otherwise shows great respect for human life and where there is serious work being done in the area of suicide prevention, people who are presumed to be “tired of living” are killed after absolutely minimal investigations and without any supervision worthy of the name. Dehumanization is certainly a very powerful mechanism for disengagement of moral self-control. Another example of how the same mechanism serves the purpose of killing in the name of mercy is the practice implemented in Oregon. With the passing years, it has now become increasingly rare that the doctor is present when the patient takes the prescribed death drug. The doctor is thus spared the unpleasantness of following the death process close up. This reduces the self-control that operates through emotions of empathy and compassion. The distance thus contributes to the dehumanization of the patient. Bandura: “It is easier to harm others when their suffering is not visible
and when destructive actions are physically and temporally remote from their injurious effects."\textsuperscript{10} One can also \textit{blame the patient} by emphasizing the emotional and/or financial burden he or she is causing the relatives and society at large. In this way, the patient is \textit{declared guilty and sentenced to death} due to all the inconvenience, discomfort, and dismay the person is causing. This is the ultimate rejection of a weak and needy person!

9. Dehumanization of Attendant Physicians

An absurdity that the euthanasia movement has managed to hide from the attention it should warrant is that it wants to impose on society and, in the long run, the individual physician \textit{an obligation to contribute to the death of a fellow human being}. This is a staggeringly arrogant demand, since it entails a horrendous violation of the doctor's integrity as a human being and as a professional.

A normally-socialized person, and especially a physician, is protected by their conscience from deliberately killing another person, the most serious crime of all in our moral perception. No one can participate in this without it having serious psychological consequences.

A number of studies confirm that doctors pay a high psychological price for their involvement in mortal activity. Dr. Kenneth R. Stevens, Oregon, USA, has compiled physicians' experiences from many different sources.\textsuperscript{11} His review concludes “that the emotional and psychological effects on the participating physician can be substantial ... can have significant effects on many participating physicians.” As one of many examples, he refers to a television program reporting a euthanasia case. The Dutch physician who performed euthanasia noted that: “To kill someone is something far reaching and that is something that nags at your conscience. . . . I wonder what it would be like not to have these cases in my practice. Perhaps I would be a much more cheerful person.”

What do these strong reactions that doctors have after their actions testify to? After all, helping an incurably sick and dying patient to die prematurely is considered an expression of high morality by most people. The opinion polls have assured us of that, haven't they? But as the theory of moral disengagement shows, the disengagement increases in proportion with the distance from the action – which is at its maximum in an opinion poll.

But for the doctors who were close to a living patient and who performed the mortal deeds – not just theorizing about them – for those doctors it turned out that they could not free themselves from the sense that these were gravely serious deeds they were carrying out, when they participated in people's premature deaths. It was a deeply experienced feeling that could not be avoided, despite all the assurance that they were only doing good deeds.

The reactions are based on the fact that the act is an infringement of the humanitarian respect for human life. It is a violation of the norm of humanity that cannot be violated without causing a

\textsuperscript{10} Albert Bandura, “Selective Moral Disengagement in the Exercise of Moral Agency”, Stanford University, USA, p. 108

\textsuperscript{11} Kenneth R. Stevens, Jr., M.D., FACR*, “Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia on Participating Physicians”, http://www.pccf.org/articles/art44.htm
psychological crisis, even though it may be legally authorized. This *humanitas* norm, which causes us to have respect for human life and to feel empathy and compassion for other people, is something that is strongly embraced by doctors and healthcare professionals in particular, whereby their violation of this norm brings with it a particularly high psychological price.

This also applies to physicians in Oregon who "only" prescribe the death drug and especially if they were present when the patient took the drug.

For many of the participating doctors in Oregon, there had been only one case during the years 2001-2007.\(^\text{12}\)

Of a total of 154 doctors, 101 prescribed only 1 lethal dose during those years. The reason for this is not known, but on the basis of the testimony above, one can reasonably assume that the psychological price for continuing to participate proved too high for many of these doctors.

The other extreme is the 10 doctors of the above mentioned 154, who prescribed more than 10 lethal doses each and together 185 doses. That is an average of more than 18 doses per doctor.

These physicians had evidently incorporated lethal activities into their medical practices. The Dutch physician, Jonquiere testifies to what moral dilemma this may lead to.\(^\text{13}\) He describes his homeland’s dealings with the issue of assisted death in terms of its having reached a certain level of societal maturity: wherein euthanasia has now been normalized for those with terminal physical illnesses, which furnishes the Netherlands with the capacity to discuss more complicated scenarios, such as dementia or psychiatric conditions. In an advice to Canadian colleagues, expecting soon to be required to undergo a similar development, he describes how it is possible to alleviate their concerns. Jonquiere admits that helping someone to end their life places a heavy burden on the provider of such services, so he recommends that doctors *begin with the most obvious cases of suffering*. “I always refrain from using the term ‘killing.’ You terminate life—and actually, more than that, you terminate the suffering,” Jonquiere says. “Get used to that idea, because it is counter-human a little bit. It never will be a routine action.” [Author's emphasis]

Note how Jonquiere describes the action as “a heavy burden” and “counter-human”. However, through a gradual process of habituation and a sanitising choice of words, a continuing participation in the killing of people can become bearable – albeit never routine – for this doctor.

But for some doctors, it still appears to become routine, as evidenced by the official statistics from Oregon. Year after year, there have been individual physicians who have prescribed deadly doses to a number of patients. In 2015 there was one doctor who prescribed 27 doses.

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\(^\text{13}\) [http://www.macleans.ca/politics/assisted-death-the-difficulties-around-demnetia/](http://www.macleans.ca/politics/assisted-death-the-difficulties-around-demnetia/)
The doctors who are that “generous” with their prescriptions have obviously been reconciled with their mortal deeds. The only possibility for a human being, and especially a doctor, to engage in such a “conveyor belt death operation” is to deactivate his/her moral self-regulation. As previously described, there is a whole set of powerful psychological mechanisms that serve that purpose. A special aspect in these cases is the brief period of contact between the patient and the doctor. The doctor does not get to know the patient as a human being, but only as a person with a death wish – a wish that must be granted by the doctor as smoothly as possible. This situation contributes significantly to the dehumanization of the person who is to be killed.

In a society that legalizes medical killings, a large group of physicians will find themselves in the spectrum between two extremes: those who never have anything to do with mortal activity and those who do nothing else. But for those who want to avoid participating in the killing of patients prematurely, what will probably happen is that they will have to refer patients to colleagues who are willing to participate. They are then drawn into the system as passive supporters. All these doctors risk paying a high price for their more or less active involvement in something that is only possible to endure through moral disengagement, with their own dehumanization as the ultimate consequence.

A research report investigated how psychologists and psychiatrists are affected by participating in the death penalty procedure in the United States. The author, Judges, describes how the participation by these professional groups is made possible through moral disengagement mechanisms and focuses particular interest on the impact this has on their personality:

"The focus here is primarily on the self-inflicted dehumanization of capital punishment’s functionaries. This is because I believe that one of the ‘true curses’ of institutionalized authoritarian excesses is their dehumanizing effect on those who participate in them." 14

This serious statement has a bearing on all deliberate killing of human beings and is therefore also relevant for those doctors upon whom the advocates want to place an obligation to kill their patients prematurely. There are presumably those who protest against using the analogy of the death penalty, by emphasizing that the mortal deed in that case is aimed at people who will be executed against their will. What we are discussing here is something else, they assert; "Here it is the patient’s own decision and no one else’s." But the inevitable result of the euthanasia movement’s way of operating is that weak – and innocent – people will be under pressure to choose death instead of life.

Intentional killing of people cannot be done without serious consequences. One either has to harden oneself through the mechanisms of disengagement or be haunted by anguish.

How extremely heavy the responsibility over life and death can be is something that has been testified to by California’s former governor Edmund Gerald "Pat" Brown (father of the current Governor Brown). He was responsible for deciding in 59 cases whether the death penalty would be enforced or commuted to life imprisonment. Despite the fact that he granted pardon in 23 cases, he

14 Donald P. Judges, “The Role of Mental Health Professionals in Capital Punishment: An Exercise in Moral Disengagement”, University of Arkansas 2004, p.531
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was still overwhelmed by the weight of these decisions, when at the age of 83 he wrote:

“... the longer I live, the larger loom those fifty-nine decisions about justice and mercy that I had to make as governor... It was an awesome, ultimate power over the lives of others that no person or government should have, or crave. And looking back over their names and files now, despite the horrible crimes and the catalog of human weaknesses they comprise, I realize that each decision took something out of me that nothing—not family or work or hope for the future—has ever been able to replace.”

If Governor Brown, and he is not alone in the articles referred to, suffered such anguish over being involved in decisions about the death penalty, how can we treat with silence the moral implications for those taking an active part in a process resulting in the medical termination of the lives of innocent people? The alleged difference between force on the one hand and personal choice on the other is in fact a sham. But by persistent insistence that it is always the patient's own decision, even though the facts contradict this, one can disengage moral self-control – and one can blame the victim. Another explanation may be that the convicted criminals are often relatively young and healthy, whereas those applying for assistance to die are usually old and tired and have lost their vitality, their ability to perform and other external advantages. What can be seen outwardly can then be of advantage to the first group, while the other group may be subject to a deeper level of dehumanization.

Through this comparison with the death penalty as an institution, we can see how powerful the disengaging mechanisms must be in order to systematize and practice medical killing of sick, weak, and extremely vulnerable people. Judges describes the dehumanizing effect on participants in systematic killing:

“I refer to these moral-disengagement moves as ‘dehumanizing’ because they involve forfeiture of important attributes of personal moral integrity that the individual otherwise would likely claim for himself or herself. In particular, I mean the shrinkage of humanitas, or an ethic of humaneness, such that a humanistically oriented individual thereby becomes less than the person he or she would otherwise probably claim to be. This is the dissociative aspect of moral disengagement. Integrity of the self is diminished, and hence dehumanization is produced, by these moves. Moral justification, through rationalization and denial, injects false premises into one’s undertakings while stubbornly insisting they are true and refuses to entertain evidence of their contradiction. Other moves, which deny the actor’s moral agency and affective response, arguably entail even greater self-abnegation because they negate important aspects of the actor’s very existence. And discounting the moral worth of the target has a similar consequence for that individual. The end result is dehumanization of the self by dissociation and the other by debasement.”

Yet another quote from Judges (page 566) about the death penalty that applies equally to PAS and

16 https://thinkprogress.org/how-it-feels-to-kill-62-people-963ff9f73afdf#cb3kxw90
17 Donald P. Judges, "The Role of Mental Health Professionals in Capital Punishment: An Exercise in Moral Disengagement", University of Arkansas 2004, p.531
euthanasia:

"To the extent that leading arguments in defense of ... participation in capital punishment reconcile conflicts with principles of humanitas by deploying mechanisms of moral disengagement, those professionals will have forfeited a constituent element of their professional identity. Their participation will have come at the price of professional dissociation."

Thus Judges emphasises that dehumanization can be described in terms of losses of such attributes that constitute both the personal and professional identity of the physician, which leads to personal as well as professional dissociation.

If Judges explains the impact of dehumanization on the personality of the perpetrator, the theory of moral disengagement throws light on the actual dehumanization process. As mentioned earlier, it is well established that moral disengagement predicts inhuman behaviour. On the other hand, as has been shown by Shu et al.\(^\text{18}\), an inverse relationship possibly also applies: that moral disengagement can be a consequence of unethical behaviour. The serious conclusion one may reach is that, where moral disengagement mechanisms are employed, a dynamic is created where, according to Shu et al.: “people could set off on a downward spiral of having ever more lenient ethics and ever more unethical behaviour."

Bandura describes the dehumanization process in another way: “Disengagement practices will not instantly transform considerate people into cruel ones. Rather, the change is achieved by progressive disengagement of self-censure. Initially, individuals perform mildly harmful acts they can tolerate with some discomfort. After their self-reproof has been diminished through repeated enactments, the level of ruthlessness increases, until eventually acts originally regarded as abhorrent can be performed with little anguish or self-censure. Inhumane practices become thoughtlessly routinised. The continuing interplay between moral thought, affect, action and its social reception is personally transformative. People may not even recognise the changes they have undergone as a moral self.”\(^\text{19}\)

This dehumanization process also clarifies an important driving force in the dynamics of the practice of euthanasia/PAS. The fact that legalised euthanasia/PAS inevitably leads to a slippery slope is convincingly explained by the “demand” perspective: If the right to receive euthanasia is to be granted to one group, how can one deny another group demanding the same right? There is therefore a pull from the “demanders” – but there is also a push from the “suppliers”, brought about by the dehumanization process they are undergoing.

Thus, next to those being killed, it is the doctors who pay the highest price in the society that systematically implements euthanasia/PAS, as they are thereby coerced into participating in actions that harm them in a very profound way. But what happens to society as a whole?

\(^{18}\) Lisa L. Shu, Francesca Gino, and Max H. Bazerman, “Dishonest Deed, Clear Conscience: When Cheating Leads to Moral Disengagement and Motivated Forgetting”

\(^{19}\) Albert Bandura, “Selective Moral Disengagement in the Exercise of Moral Agency”, Stanford University, p. 110
10. Dehumanization of Society

Osofsky et al.: It is important to recognize that selective moral disengagement operates not only at the individual level, but does so with even more profound and pervasive impact at the broader level of social systems. When corporate and societal practices enlist moral disengagement mechanisms they can cause widespread and devastating human harm.\(^{20}\)

First and foremost, these mechanisms, as previously explained, are at work in the advocates' propaganda, in everything from the leading questions in opinion polls to the bills they propose. By assuming the right to the formulation of the evidence one can direct the scenography in the drama of life and death, which is exactly what it is, when the issue is to be settled in the opinion polls, referendums, parliaments and legislative assemblies. Since this manipulative movement has as its aim to prepare the way for the easy killing of human beings, it cannot be exercised without having a dehumanizing effect on its practitioners.

Mass media has a considerable amount of influence, in part by its uncritically spreading the euthanasia movement’s disengaging propaganda, but particularly through close-up, glamorizing suicide reports that violate the World Health Organization WHO’s publishing rules.\(^{21}\)

The final outcome is that the same mechanisms begin to operate within the legal system. That is clear in the Netherlands, where the idea of allowing death to be a solution to the problem of suffering was first accepted, though initially only in very special, limited cases. The threshold event set in motion a development where this idea was expanded more and more through a series of rulings and prosecution concessions. The legislation was adapted to fit the practice instead of vice versa. Step by step, death was being considered as the solution to more and more types of suffering – even to the suffering of the surroundings.

Professor Theo Boer commented on developments in his homeland with these words: “What surprises me is that nobody is making any serious attempt to treat this as a problem...It seems inarguable to me that the law has led to a rise in incidences. But nobody seems concerned.”\(^{22}\) Boer should not be surprised. The indifference testifies to the dehumanization that Dutch society has undergone.

A death culture is on the march in a number of countries. In the Benelux countries, the development has gone so far that we no longer need to speculate about what it leads to.\(^{23}\) It is a movement that claims the individual's right to death on demand – the ultimate conclusion of which will be at any time, and for any reason. The demand is motivated by the right to avoid unnecessary suffering and

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the individual’s right to choose – “I’m entitled to my death”. It is portrayed as a completely private matter that no one but the individual himself/herself should have any say in.

But there is a very serious problem; **someone else** is employed in delivering the death. Society must take care of this and thus we are all drawn into a system where people are knowingly and actively killed. This is presented as a totally problem-free solution. If that were true, there would not be such strong resistance. It is not an expensive reform. On the contrary, it saves big money (which we don’t talk about). But there is resistance – articulated and intuitive. It is often an instinctive feeling that something is wrong. In what way do the advocates attempt to overcome this resistance? Is it with factual information?

No, the methods used to break down the resistance are powerful, morally disengaging mechanisms - the same mechanisms that are used to justify the death penalty, to form a lynch mob, or to execute terror attacks.

When multiple mechanisms are combined, they reinforce each other. In current propaganda the Oregon model is advocated. Since it is up to the patient to take the poison, **the responsibility is transferred** to the patient. By the fact that the doctor “only” prescribes the lethal dose and that another doctor is to participate in accepting the patient’s request, the **responsibility is diluted**. Through the practice of the doctor not needing to be present when the patient takes the poison, the patient is **dehumanized**. The poison is referred to using the **euphemism**, “strong sleeping medicine” and the consequences of taking it can then be **minimized** to mean falling asleep comfortably. The fatal outcome is also **minimized** by ensuring that the regulations guarantee that no one dies by mistake. The **consequences are denied** by claiming that the patient can withdraw his/her request and does not need to take the lethal dose. Instead, access to the drug serves the purpose of giving the patient peace of mind. Thus, in fact, it is a palliative measure, explained by yet another **euphemism**. The combination of these mechanisms effectively lowers the threshold for reaching the desired acceptance. It’s not such a big deal with this “cola light” version, one is tempted to think.

An important threshold-lowering measure is the actual **“medicalization”** of the killing. Since in the first instance it is said to apply to severely ill patients suffering torment on their death bed, it seems so natural and close at hand that it is the very doctor who will participate. However, since just around the corner the issue begins to concern several other ever increasing categories, we could just as well be considering a completely different type of actor. It could all be managed privately, as it is being done already – to a large degree – in the Netherlands, Switzerland and the United States by the death lobby. But, if in the initial stages such an arrangement would have been advocated, it would have given rise to invincible resistance to the euthanasia movement. No, in its propaganda this movement needs to take advantage of the positive reputation of the **medical profession** and the idea of it being healthcare. The **medicalization** of the killing gives an impression of care and compassion. It conjures up a picture of a beneficent medical procedure, which **minimizes the**

24 Commenting the rapid development in Canada Dr. Yves Robert, Secretary of the Collège des médecins du Québec (CMQ), asked the following question on May 10, 2017 in an article published on the CMQ website: “If the goal is euthanasia on demand based on a “right”, are we still talking about Medical Aid in Dying? Or simply Aid in Dying? And what, then, would the medical profession have to do with it?” [Author’s emphasis]
consequences of the killing. For the proponents, a very important aspect of the medicalization is that the person is killed in such a way that the dead body lacks any sign of external violence, or other attributes such as plastic bags or anything else giving rise to distress (no mess). But the end result is the same – a human being is irreversibly dead and dead prematurely.

For the euthanasia movement, this medicalization is a crucial disengaging maneuver in moving forward. But just this maneuver is especially harmful, by reason of the fact that it is aimed at the care-giving sector of our communities, which makes it a devastating stab wound in the very heart of a humane society.

Where legalization is achieved the ultimate price to be paid is the dehumanization and brutalization of the entire society, where our inherent respect and care for human life dies. It is the combination of social acceptance and a health care sector that has been numbed, along with financial priorities, that lays the foundation for increasingly radical applications. By taking this first step across the threshold, a snowball starts rolling that cannot be stopped. It does not happen all at once, but step by step. This progression can be rapid, however.

Through a process of gradual disengagement of society’s self-censorship a development takes place where deadly activities become successively normalised to apply to ever-increasing categories of citizens. Because the killings are being increasingly trivialised, those acts, originally considered quite abhorrent, eventually come to enjoy general acceptance and, yes, even respect. A development as serious as this also appears to be possible without any self-critical reflection worth mentioning. What Bandura expresses about the individual: “People may not even recognise the changes they have undergone as a moral self”, seems to apply even at the system level.

Voltaire has said that those who can make you believe absurdities, can make you commit atrocities. The first absurdity may be to claim, against better knowledge, that it is possible to construct a safe system for the medical termination of people’s lives. Once that absurdity has been elevated to truth status, you and those you have seduced into agreeing, can actually end up supporting an activity that you initially felt was abhorrent – now with hardly any regrets at all. The abominable thing has thus been normalized or even glorified. Black has become white.

Just in case someone believes that these are exaggerations, we will refer to a proposal in a scientific article by a group of Dutch and Belgian doctors. The article, “Legal and ethical aspects of organ donation after euthanasia in Belgium and the Netherlands” was published on March 24, 2016 in the Journal of Medical Ethics. The doctors are proposing legislative adjustments in both countries to facilitate organ donation from assisted suicide candidates. Their radical proposal is that it should become legally possible to harvest the organs from the still living body – this to ensure the high

25 Paul Kelly, in the article Legalise euthanasia, and compassionate society dies too, The Weekend Australian, October 2016: “Such optimism is heroic and typical of the euthanasia debate. It is echoed in nation after nation, year after year. It testifies to the deepest humanist conviction that mankind and wise governments can introduce euthanasia regimes with the necessary legal safeguards and the necessary regulatory protections to manage the promotion of death to ensure only net gains for the social order.

It is surely extraordinary that people skeptical of the ability of governments to get trains running on time fool themselves into thinking they can confidently manage a regime that sanctions the termination of human life.”
quality of the organs. They realize that the proposals may be perceived as controversial but emphasize that "public perception of this formerly abhorrent practice is increasingly positive: transplant coordinators in Belgium and the Netherlands notice a contemporary trend towards an increasing willingness and motivation to undergo euthanasia and to subsequently donate organs as well, supported by the increasing number of publications in popular media on this topic."[Author’s emphasis]

The fact that something so outrageously offensive – where a human being is considered as a spare parts depot – can be published in a reputable scientific journal, is the result of a gradual disengagement of self-censure, a step-by-step process of becoming accustomed to something absolutely abhorrent, which in Belgium and the Netherlands has only required a decade of a legalized medical practice of taking people’s lives.

11. Conclusion

Albert Bandura's theory of moral disengagement has been applied for a long time in in-depth analyses of various harmful activities. Nevertheless, the theory has not received much attention in the study of the euthanasia movement's activities. This theory has great significance in explaining the euthanasia/PAS phenomenon, and might have the potential to publicly de-mask the euthanasia movement.

This can be done by conducting an in-depth scientific analysis of the disengagement mechanisms in the euthanasia movement's various activities. Such an analysis would provide much clarity and depth of insight into an activity that is shrouded in deep obscurity and could be a contributing factor in exposing the actual driving forces behind its progress. A more thorough study should also be undertaken concerning the dehumanizing effect on the functionaries in the practice of euthanasia/PAS.

The results of the studies then need to be popularized so that they become digestible for mass media, politicians, authorities, and the general public.

But first and foremost, the medical profession should be informed about the implications of Bandura's theory on the entire euthanasia/PAS movement and of the harmful effect their participation will have on their personal and professional integrity.

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