

COMMENTARY

Invited Submission

“Moral Disengagement”- A Cautionary Lesson for Society and the Medical Profession

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A commentary in response to:

“Moral Disengagement – Mechanisms Propelling the Euthanasia/PAS Movement”

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As Samuel Johnson famously said, “hell is paved with good intentions.” The history of humanity is, of course, riddled with such ill-paved paths. Nor are professions exempted from this tragic and ironic pavement. The field of mental health has its own misadventures spawned by self-justifying noble intentions. For example, the leading figures of Canadian and American psychiatry participated with relish in the eugenics and sterilization movements in the first half of the 20th Century.¹ Seeing themselves as moral pioneers, believing they were rescuing the gene pool, and practicing preventative psychiatry in the face of inadequate curative treatments, psychiatrists sterilized over 65,000 developmentally disabled and mentally ill people in the United States alone. Heads of professional medical organizations and superintendents of hospitals, even in conjunction with celebrated heroes of jurisprudence (like U.S. Supreme Court Justice Oliver Wendell Holmes), were enthusiastic architects and implementers of these activities. Then, leading psychiatrists, heads of the major psychiatric organizations, chairmen of the venerated academic departments, and superintendents of the most important hospitals in Germany took it a step further. They helped to craft and deploy the “T4 Program,” which exterminated over 400,000 psychiatric patients, starting with children and progressing to adults.² Indeed, the killing methods later deployed in the larger Holocaust were actually developed by psychiatrists in service of this “T4 Program.” And of course, there were experimentations on concentration camp inmates by a wide variety of medical specialists. These physicians lost their ethical moorings, swept up in a torrential change of social mores that helped them construe these actions as virtuous, humane, progressive, and noble. The utilitarian justification of reframing actions previously seen as immoral allowed a sense of valuable wider purpose for society. They felt that they were boldly advancing the welfare of society at large by helping to end suffering in those whose lives were “unworthy of living” (a phraseology incidentally coined

¹ Dowbiggin, I.R. (1997). *Keeping American Sane: Psychiatry and Eugenics in the United States and Canada: 1880-1940*. Ithaca: Cornell University Press.

² Friedlander, H. (1995). *The Origins of Nazi Genocide: From Euthanasia to The Final Solution*. Chapel Hill: The University of North Carolina Press.

by the German psychiatrist Alfred Hoche³). Young doctors, eager to build their careers with mentors involved in these programs, joined in with enthusiasm. These and other physicians who swore the Hippocratic Oath to “do no harm” at their medical school graduations convinced themselves and each other that theirs were beneficent intentions, and they actually reframed these practices as fulfilling a beneficent Hippocratic purpose; the very antithesis of maleficence. They felt themselves to be compassionate humanists at the cutting edge of progressive ethics.

Leo Alexander, the great American psychiatrist charged with investigating such physicians for the Nuremberg Doctor’s Trial, wrote up his observations in his iconic *New England Journal* article in 1947, in which he charted the moral trajectory of the Nazi doctors and the shifting moral fulcrum that evolved over time:

“The beginnings at first were a merely subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere . . . was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted, and finally all non-Germans. It is important to realize that the infinitely small wedged-in level from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitatable sick.”⁴

So, medical ethics, like all human ethics, is vulnerable to groupthink, reframing, and the echo chamber of a loudly enunciated social ethos that proclaims itself virtuous, penetrating the medical professionals who live in that society, luring them to heed contemporary sirens’ calls. We see this phenomenon again afoot in the practices of voluntary euthanasia over the last few decades in Belgium, the Netherlands, and Switzerland, and now newly emerging and accelerating in Canada and the U.S. Physicians are literally producing (as opposed to allowing) death in their patients to the tune of about 4% of every death the Netherlands⁵ and nearly 2% in Belgium⁶, often administered by the patients’ longstanding treating physicians. In these countries, patients do not need to be terminal, and some are found to qualify for euthanasia who

³ Binding, K., & Hoche, A. (1920). *Allowing the Destruction of Life Unworthy of Living: Its Measure and Form*. Republished by Suzeteo Enterprises, 2012.

⁴ Alexander, L. (1949). Medical Science Under Dictatorship. *The New England Journal of Medicine*, 241(2), 39-47.

⁵ Report of Dutch Regional Euthanasia Commission, 2017. Retrieved from <https://www.euthanasiecommissie.nl>

⁶ Murphy, S. (2017). Euthanasia reported in Belgium: Statistics compiled from the Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie Bi-annual Reports. Protection of Conscience Project (August 2017).

suffer exclusively from psychiatric conditions, or even social discomforts, such as unwanted homosexual impulses, gender dysphoria, autism, or intellectual disabilities.⁷

It is critical to try to understand the psychological dynamics of these remarkable developments that interplay between the psyches of the doctor, the patient, and their ambient societies. The social psychology of modern medical euthanasia bears resemblance to the aforementioned developments in the first half of the 20th Century. To this remarkable phenomenon comes Fabian Stahle's helpful article, which calls upon the ideas of the celebrated Canadian psychologist Albert Bandura and his concept of "moral disengagement." Along with other psychologists like Stanley Millgram and Phillip Zimbardo, Bandura has made vital contributions to understanding emergent changes in moral behavior that radically depart from an individual's normative baseline or that of his or her profession. This is of particular importance when the moral transformation involves recasting the value of a full human life as less desirable than how it was previously seen. Stahle deftly reviews Bandura's construct of "moral disengagement" to deepen our understanding of the modern medical euthanasia and assisted suicide phenomenon that has taken many observers off guard, especially surprising and disturbing those who are not immersed in these cultures that are producing this moral juggernaut.

Stahle asks us to recognize that the circumstance of "socially adjusted persons...participating in the killing of fellow human beings" is indeed a towering change in any society, especially by those who are traditionally designated as bringers of healing and comfort — physicians. Indeed, when activated, the psychological mechanisms of moral disengagement which allow this to occur in a society might be an ominous barometer, says Stahle, that is "indicative of a moral collapse that has already occurred or is imminent."

The article takes us through the horsemen of moral disengagement: moral justification, euphemistic language, exonerative comparison, displacement and diffusing responsibility, minimization of harmful consequences, and dehumanization. These mechanisms, described in detail in the context of modern medical euthanasia, MAID, and assisted suicide, not only permit the participating health care professionals to live with their actions, but also permit their societies to invest these professionals with a sense of virtue and heroic burden in conducting their euthanizing services. The now-regretful pioneer of euthanasia in The Netherlands, Doudewijn Chabot M.D., observing society's inability to constrain euthanasia to its originally envisioned applications, has observed that, "a culture has emerged in which performing euthanasia is considered to be virtuous behavior."⁸ The mechanisms by which a previous immoral behavior doesn't just lose its stigma, but becomes virtuous, is illuminated by Bandura's ideas. Moreover, these ideas show how practitioners and their social milieu do not just live more comfortably within the new moral landscape; they even come to celebrate it.

⁷ Tuffrey-Wijne, I., Curfs, L., Finlay, I., & Hollins, S. (2018). Euthanasia and assisted suicide for people with an intellectual disability and/or autism spectrum disorder: An examination of nine relevant euthanasia cases in the Netherlands (2012-2016). *BMC Medical Ethics*, 19:17.

⁸ Chabot, B. (2017, June 16). Disturbing culture change around self-chosen death. *nrc.nl*. Retrieved from <http://tinyurl.com/ycg3jav4>

Indeed, these mechanisms of moral disengagement behind such reframing can help explain the way that conscientious objection to MAID by physicians is starting to be called callous, uncaring, abandoning, and even cruel. We now see the emerging phase of “Euthanasia 2.0”—courts, laws, ethicists, and professional societies starting to designate physicians’ and institutions’ conscientious objection as morally indefensible, both legally impermissible and sanctionable.⁹ Canadian ethicist Marie-Eve Bouthillier, PhD, has designated physicians’ conscientious objection to MAID to be “emotional” rather than “moral,” and urged the need to “change the medical community’s mindset through education” to help reframe the profession’s morality as mere vulnerable sentimentality. Physicians’ venerable assertion of moral objection is re-envisioned by this scholar as a mere “loophole” for the squeamish to avoid a distasteful, but honorable duty.¹⁰ Bandura’s processes are at work before our eyes.

Stahle illuminates an important shadow side to the moral pioneering that propels euthanasia advocates, exposing an inherent arrogance, particularly when the idea of a “terminal” condition is a focus: “there is [no] 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.” This is actually the basis of an emerging intervention in end-of-life contexts. Working with 100 patients in a home-based palliative care program in Australia and Canada, researchers utilized techniques to “invite patients to discuss issues that mattered most, or that they would most want remembered.” The outcomes of such “dignity therapy” showed that 75% of patients developed a heightened sense of dignity, 68% an increased sense of purpose, and 47% increased their will to live,¹¹ all accomplished without carrying these patients over the profound moral switch-point of offering doctor-provided death. Frankly, these kinds of conversations are in the skill-sets of trained mental health professionals. Yet, those specialists are currently relegated to the sidelines of “competency evaluation” and optional psychiatric treatment — should MAID evaluators happen to raise questions of capacity or wonder about the presence of a psychiatric disorder. Even then, in no jurisdiction is there any legal requirement that psychiatric treatment be attempted. Nor is anything approaching such evidence-based “dignity therapy” required to be offered, that could turn around a death wish, prior to being given lethal means. This is the case in the U.S., Canada, Belgium, and the Netherlands.

Stahl quotes Bandura: “people... can act on a moral imperative and preserve their view of themselves as a [virtuous] moral agent while inflicting harm on others.” In this way, says Stahl, “they can thus maintain their self-image as persons of high moral standards along the entire

⁹ Fine, S. (2018, January 31). Religious doctors must provide referrals for medically assisted death: Ontario court. *The Globe and Mail*. Retrieved from <https://tinyurl.com/y72hekm5>

¹⁰ Touzin, C. (2017, December 24). Medical aid in dying: Many doctors refuse to administer it. *La Presse*. Retrieved from <https://tinyurl.com/y946z74n>

¹¹ Chochinov, H.M., Hack, T., Hassard, T., Kristjanson, L.J., McClement, S., & Harlos, M. (2005). Dignity Therapy: A novel psychotherapeutic intervention for patients near the end of life. *Journal of Clinical Oncology*, 23(24), 5520-5525.

slippery slope, due to the gradual dulling of their better judgment.” This process of “gradual dulling” is a remarkable and real phenomenon and has been shown repeatedly to be a psychological underpinning of acts that appear evil from the outside, or in historical retrospect.¹² Robert J. Lifton M.D., psychiatrist scholar of the Nazi doctors, articulated the concept of “malignant normality”. This is the product of moral disengagement developing over time to establish an idea as being acceptable and even self-evident, though it is actually “deeply dangerous and destructive.”¹³ The use of euphemisms, Stahle explains, is critical in this process. He quotes Robert Jonquiere, M.D., Executive Director of the World Federation of Right to Die Societies, who unselfconsciously stated: “I always refrain from using the term ‘killing.’ You ‘terminate life’ — and actually, more than that, you terminate the suffering... Get used to that idea, because it is counter-human a little bit.”

Stahle shows how the moral disengaging tool — “diffusion of responsibility” — is deployed by emphasizing that MAID is the *patient’s decision*, in the end, using an idealization of the patient as an autonomous human being whose decision is shielded from the values and biases of the treating and consulting physicians. Yet, doctors are the gatekeepers who can permit or restrict, encourage or discourage the patient. The attitudes and willingness of health care professionals to participate in MAID has been shown to be influenced by many factors, such as their personal religious beliefs, attitudes towards opiates for pain, knowledge of palliative care, availability of time to spend with suffering patients, and other factors.¹⁴ These biases, as well as feelings that the doctors have about their patients, are transmitted in the counseling and decision making around MAID.¹⁵ The widespread arguments of MAID supporters, focusing on the patient’s autonomy, shifts attention away from these factors, which are personal and idiosyncratic to the physicians and other members of the health care team. Diffusion of responsibility is an important dynamic. Family, too, can explicitly or implicitly inject their biases and wishes into a patient’s “autonomous” deliberations. In a notorious Dutch documentary, the mother of an autistic adult says: “Euthanasia is a sacred word for us. When we have passed away, for whom would [our son] Kees stay alive? His deepest wish is to go to sleep. He will be totally satisfied. Euthanasia is a wonderful option.”¹⁶ Families can thus diffuse responsibility for their own moral disengagement to the identified patient.

¹² Zimbardo, P. (2007). *The Lucifer Effect: Understanding How Good People Turn Evil*. New York: Random House.

¹³ Lifton, R. (2017). *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (2nd ed.), Basic Books.

¹⁴ Portenoy, R.K. (1997). Determinants of the willingness to endorse assisted suicide. A survey of 1137 physicians, nurses, and social workers. *Psychosomatics*. 38(3), 277-87.

¹⁵ Groenewoud, J.H. (2004). Psychiatric consultation with regard to requests for euthanasia or physician-assisted suicide. *General Hospital Psychiatry*. 26, 323–330.

¹⁶ Het beste Voor Kees (Best for Kees). (2014). Producers Niek Koppen and Jan de Reuite.

The core concept here — disengagement — is both an intellectual and emotional distancing from this most remarkable enterprise: one set of human beings is given license, and even appreciation, for killing another set of human beings. That the killing set happens to be physicians, of all possible groups, is clinically pragmatic, yet morally ironic. The intellectual mechanisms of disengagement are not new to MAID; they are well-used throughout history. But society, the ultimate keeper of moral rectitude, must deploy a level of vigilance over moral disengagement, proclaims Stahle. As Margaret Meade pointed out, society must offer some protection, not just to vulnerable patients, but also to the medical profession, which has always had unique skill sets that straddle the line between the giving of life and the giving of death; it covers both functions in a way that soldiers or executioners do not:

“The followers of Hippocrates were dedicated completely to life under all circumstances, regardless of rank, age, or intellect — the life of a slave, emperor, foreign man, defective child... This is a priceless legacy which we cannot afford to tarnish. But society has repeatedly attempted to make the physician into the killer... It is the duty of society to protect the physician from such requests.”¹⁷

Asking physicians to engage in MAID, Stahle says, is the ultimate moral disengagement by society itself, via medicalizing the deed and assigning it to someone else. It is not only the medical profession and its mission to heal and mitigate suffering that societies protect by heeding Margaret Mead’s admonition, but themselves, keeping the State from becoming the vehicle of moral disengagement — a misadventure seen far too often in recent history. In this sense, Stahle’s conclusions are preventative medicine for our confused society, that is once again radically moving the fulcrum that balances killing and healing.

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¹⁷ quoted by Nat Henthoff, “The ‘Small Beginnings’ of Death,” in “The Human Life Review,” Spring 1984 published as a series in *The Village Voice*. Retrieved from <https://tinyurl.com/y8g96277>