The International Library of Bioethics 96

Stacy Gallin
Ira Bedzow *Editors*

Bioethics and the Holocaust

A Comprehensive Study in How the Holocaust Continues to Shape the Ethics of Health, Medicine and Human Rights

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Foreword

The publication of *Bioethics and the Holocaust: A Comprehensive Study in How the Holocaust Continues to Shape the Ethics of Health, Medicine and Human Rights* represents the end of an era and the beginning of the next. For many decades, the dominant theme of scholarship in this field was whether scholars could overcome deeply ingrained resistance to the acknowledgement of the role medicine and science played in fueling the rise of Nazism. That matter is settled. One of the proudest moments of my life was securing the first formal apology from the German Medical Association for the crimes of the Holocaust. These sorts of official apologies mean denial is much harder to achieve.

A related issue has been whether bioethics can ever come to grips with its own long history of ignoring the Holocaust in its scholarship, teaching, and textbooks. While some disagree, I believe that bioethics did not really connect to the grim history of German medicine, science, and ethics until well into the 1990s. It is sometimes said bioethics was born out of the ashes of the Holocaust. We know that is not true. There is a much larger story to tell, which this book seeks to uncover. Many horrible experiments abusing and killing vulnerable populations went on in America and other nations while war was being fought against the Nazis and long after the issuance of the first judgements at Nuremburg by the war crimes tribunal in 1946. And in terms of scholarship of the sort represented in this book, it was not until the 1980s and 1990s that serious work was undertaken with either enthusiasm or in any real volume. In fact, it could be argued that the true engagement of bioethics with the Holocaust did not occur until the publication of my book, *When Medicine Went Mad* that appeared in 1992!

While my book set the mark for recognition and engagement, this book serves as the catalyst for the new era of incorporation of the lessons of the Holocaust into bioethics, medical, and public health profession education. The topics presented in this book, ranging from analyses of Nazi medical ethics to the role of doctors in specialty areas such as psychiatry to the bearing of the Holocaust on contemporary debates such as assisted suicide and human rights controversies, show that the battle over whether to deny the importance of incorporating the Holocaust into the field of bioethics is over. The importance of studying the Holocaust is clear. Rather than just haggle over the morality of using information from long ago Nazi medical experiments or whether only incompetent doctors were leaders in Nazi medicine (that is now known to be far from true), we must now wrestle with the challenge of how to incorporate the moral legacy of Nazi medicine and science into contemporary bioethical debate.

One key factor that permitted virulent Nazism to incorporate German social Darwinism from the 1910s and 1920s was racism. The subjects of the concentration camp and anatomical studies were dehumanized, viewed as less than human and deserving of no respect due to their religion, ethnicity, gender-orientation, political views, or status as prisoners according to Nazi race theory. Author after author in the chapters collected here notes how Nazi racial views distorted the ethics of doctors so that they did not feel they were violating the interests or rights of "human" beings.

It is important to try and connect the racism of German science and medicine that led to Rassenhygiene and the politicians who sought to utilize applied biology to the Holocaust. How does the long, dismal history of racism in American medicine and science and for that matter, society, continue to shape the practice of medicine and science today as well as our racially divisive politics? While this book does not answer these questions directly because it is beyond its scope, nevertheless some answers can be found in these pages and the book opens the door for these discussions to occur in medical and health care education. But much more work remains to be done to link the impact of slavery, the hatred of immigrants, the exploitation of indentured workers, Jim Crow, segregation (formal and informal), and the ridiculous battles over teaching critical race theory or simply how our long history of racially informed assumptions about groups shapes how we think about clinical care, access to care, trust, and autonomy in medicine now. Racism has long infected every aspect of life in America and medicine is no exception. All one must do is look at who is underinsured and uninsured, who lacks ready access to providers, and who gets rapid access to care in emergencies and the point is very clear. But it also clear that racist views drawn from science and medicine have shaped American politics and policy and those interactions merit more analysis and debate.

One other area requiring more inquiry is the role played by the shift during pandemics to public health ethics. While critics of mandates and quarantines often draw crude analogies to both Nazism and communist repression, the reality of how to manage community needs in a culture that adores autonomy in its medical care and its public behavior remains unresolved. German medicine, again as many contributors here note, took the people or the "Volk" as their patients. How can public health learn from that experience as it tries to grapple with pandemics and poverty?

So, celebrate the achievements of those whose work is represented here. It forms the foundation for the next few decades of continued learning about medicine, science, and the Holocaust.

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Preface

The Maimonides Institute for Medicine, Ethics and the Holocaust was founded on the premise that the only way to truly preserve the legacy of those who perished or whose lives were changed irrevocably at the hands of Nazi medicine is to use the lessons of the past to inform how we can and should act today; to foster a personal and professional ethos that values the protection of human rights and the central principles of ethics first and foremost; and to empower the next generation to understand the necessity of standing up and speaking out whenever injustice is present.

One of our primary goals was to create unique educational offerings that would use the Holocaust as the historical framework for exploring the ramifications of placing scientific and societal progress over the promotion of individual welfare and human dignity. These materials would provide a mechanism for encouraging people to recognize the systemic issues within healthcare and society that continue to create a hierarchy of human life and empower them to explore their role as active agents of social change who will advocate for equality and social justice in health care.

The Holocaust is often taught solely as part of history specific to a particular group of people: Jewish or German, political or military. However, its lessons transcend these types of traditional boundaries. Holocaust education can and should be universally relevant and serve to promote justice and tolerance, equality, and human dignity for all people. The purpose of this book is to make it easier to achieve this type of inclusive and meaningful Holocaust education by providing a primary text that outlines many of the major areas of medicine, ethics, and the Holocaust as an academic discipline. Though it would be impossible to cover every aspect of the field, it is our hope that this book will serve as a tool for those who want to teach and learn about the contemporary relevance of the topic. We have organized the book to make it easy to use in a university or post-graduate setting based on the number of weeks in a semester, and even piloted it with a group of students enrolled at a medical school in the United States.

As editors, we want to acknowledge the wide range of views regarding contemporary issues presented by the contributing authors. While these perspectives do not necessarily represent our personal beliefs, we feel it is important to show the broad spectrum of opinions surrounding the use of the Holocaust in current bioethical debate. This speaks to the relevance of the Holocaust and the ways in which it continues to shape the ethics of health, medicine and human rights. In keeping with the theme of this book, we believe that our role as editors is not to attempt to persuade the audience to agree with our position on some of the more contentious issues by only offering a one-sided view. Rather, we have included internationally recognized scholars who can provide a balanced academic approach that will motivate the reader to form his or her own opinion.

While this idea for this book was conceived long before COVID-19, this global pandemic has called into question our core ethical values, resulting in proposed modifications to basic moral principles at varying levels within healthcare politics, public policy, the media, and society as a whole. Systematic inequalities that emphasize the hierarchy of human life—long present in society—have come to the forefront of debate. At the same time, we are experiencing a troubling rise in racial, ethnic, and religious hate crimes as well as a lack of knowledge regarding the Holocaust. At this defining point in human history, we face an unprecedented challenge. We must be able to use the lessons of the past—those from another defining moment in human history—to inform our actions, shape our present, and create a better future.

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Chapter 1
The Question of Relevance

Michael Berenbaum

1.1 Would That the Holocaust Was Irrelevant

A personal word: many years ago, when we were first developing the United States Holocaust Memorial Museum, we struggled with the issue of how to end the permanent exhibit. We had come up with an appropriate beginning that would serve the function of taking visitors off the National Mall, taking them back what was then fifty years in time, moving them a continent away and introducing them to a European event that we knew they would be seeing primarily through American eyes. Responding ever so subtly to the question of what this event has to do with the American experience, we decided to begin at the end of the Holocaust with the American troops entering the concentration camps, encountering its survivors as well as its evil. It worked because we could conclude this transitional beginning by asking the question those troops who entered the camps asked: how this could have happened?

The rest of the Museum was a response to that question.

But how was the Museum to end?

What transition could we make between the capital of the United States and the world of the Shoah—what survivors and scholars of the Holocaust had named "*l' universe concentrationaire*, the planet of Auschwitz," what Elie Wiesel, who was deeply committed to maintaining, "*that* world is not our world… the Holocaust was a world apart," often called the "Kingdom of Night?".

I knew the ideal ending. We could simply say, "This is how twentieth century humanity behaved toward one another. We, however, do not behave this way, nor should we." Unfortunately, that is not something we could say; it would neither be credible to our visitors nor to ourselves. Thus, we ended by presenting a lightly narrated film of survivors telling their stories—fragments of memory—to serve as

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a bridge between that world and our world. As survivors, they have lived in both, and they had made the transition between the two worlds. We had little interest in showing the transition that the perpetrators made from being staff at Auschwitz or from the killing fields of Ponar to living ordinary lives as post-war citizens of Germany, Austria and other perpetrator countries- even in the United States.

My dream today remains the same as it was then: that someday the Holocaust will become irrelevant and the people of that era could look back upon it as an aberration and a warning, a lesson in how individuals, societies and governments should not behave, the negative example *par excellence*. We could also learn from the all-too-few who lived through the Holocaust but, nevertheless, present a positive model of human behavior. My hope is that someday we can utter the words "Never Again" neither as a cliché nor with shame, but with a sense of achievement in a world transformed.

I am not alone in these sentiments. Speaking at the commemoration of the 75th anniversary of the liberation of Auschwitz at Yad Vashem, the President of Germany, Frank Walter Steinmeier, said:

> I wish I could say that our remembrance has made us immune to evil.
>
> But...the spirits of evil are emerging in a new guise, presenting their anti-Semitic, racist, authoritarian thinking as an answer for the future, a new solution to the problems of our age. I wish I could say that we [Germans] have learnt from history once and for all.
>
> But I cannot say that when hatred is spreading.
>
> Of course, our age is a different age. The words are not the same. The perpetrators are not the same. But it is the same evil.
>
> And there remains only one answer: never again! *Nie wieder!*

As a religious but somewhat disbelieving Jew, the easiest affirmation that I make is that "this is a world that is not redeemed." While the more pious, the more faithful, await the Messiah daily, I live in an unredeemed world, one in which the Holocaust still has abiding relevance. With the rise of antisemitism, racism, authoritarianism, and fascism in recent years, everyone in this field is challenged with the question, "What have we learned from the Holocaust?" In a polemical talk for the Tikvah (Hope) Foundation, Ruth Wisse, a Harvard Professor Emeritus of Yiddish, questioned the very necessity and utility of Holocaust education.

1.2 The Curse of Abiding Relevance

Still survivors and scholars of the Holocaust are routinely asked to comment on parallels between current events and the Holocaust. Non-sophisticated students often confuse analogies with equivalences as if comparing two events makes them identical. As we learned early on in our high school education, we must both compare and contrast; only when we do both can we understand the distinctiveness of each event. During the ongoing COVID-19 pandemic, survivors and scholars, myself included, were often asked what we can learn from the Holocaust that sheds light on the pandemic. Clearly the two events are dissimilar, but still there is something that can be learned.

Survivors, who spent years in hiding from an all too visible enemy, spoke of their experience with newly isolated and quarantining students and adults hiding from an invisible enemy-the virus. These students and adults wondered how survivors passed the time and dealt with the isolation and loneliness during the Holocaust, when they were without the use of the internet, email, television, telephone and Zoom, all of which have been readily available to this generation. The conversations were interesting, the engagement lively as one generation began to understand the other.

In the last months of 2020 and most especially after the infamy of January 6, 2021, many of us have been asked if we are living in 1931, 1933, or 1938. We are living in 2022, and the challenges of this age are unique to the tools of this age. The internet and social networks, multiple and often conflicting sources of news and information have led to disagreements about basic facts and even whether there is any type of objective truth. We face problems specific to this moment in time: the health crisis, the economic crisis, the social justice crisis, the leadership crisis and the climate crisis.

After the storming of the Capitol on January 6, 2021, analogies were made to the Reichstag Fire of February 1933 or Kristallnacht, the November 1938 Reich pogroms. Most people understand that the analogies are inexact; history does not quite repeat itself, not directly, but the past has echoes in the present and the Holocaust has by now assumed its place at the “Negative Absolute” (Berenbaum 2003, 46) of our age.

In a world of relativism, where facticity is challenged and truth often abandoned, the Holocaust has come to serve as a pivotal point of reference. We do not know what is good and what is bad, what is truth or fiction, but we do know that the Holocaust was evil, absolute evil, even the “gold standard” of evil. It is therefore the “go to event” when people want to call attention to a violation of human dignity or human rights, to mass murder, inhumanity, persecution, discrimination, racism, and genocide. It is for this reason that some want to deny the event, to purge that evil, while others, who seek to mimic it or repeat it, invoke its symbols, and provoke by using its iconography. And in times of crises, we hear echoes of the Holocaust again and again as fear, as a warning, and sometimes, sadly even as aspiration.

1.3 Science in the Service of Ideology, In the Service of Politics

Readers of this book certainly know that the judges at the Doctors’ Trial at Nuremberg established ten principles—perhaps Ten Commandments—which have served as a cornerstone of contemporary medical ethics. Among them are the right of the patient to be *informed* of their treatment and to *consent* to it, and the right of the patient to end treatment. These ten principles have been critical also in considering the ethics of human experimentation. So much has been learned from the Holocaust in the sphere of medicine—much, but not enough.

During the COVID-19 pandemic, we have seen the politicization of medical information, the falsification of medical data to advance a political agenda to the exclusion and even derision of scientific knowledge, the promotion of false information to satisfy the whims of political leaders, national and local. We have witnessed and been victimized by restrictions on publicizing information that could save human lives, as well as inform physicians in an ongoing medical emergency about best practices and what practices to avoid. We have seen the promulgation of needless optimism when realism and cautious restraint were necessary to protect human life. We have heard self-serving lies when truth would have been an important warning.

We have seen medical personnel affiliated with some of the great universities of the United States advance theories and policy recommendations contradicting the best medical advice available, subordinating themselves, their reputations, and exploiting their credentials to a political leader they supported. For example, Dr. Scott Atlas, a senior fellow at the Hoover Institution, a conservative think tank at Stanford University did not have a specialty in either infectious diseases or public health. Instead, his focus is on healthcare policy with a background in neuroradiology, which is the reading of X-rays, CT scans, and MRIs. He was given his position as a Special Coronavirus Adviser to President Trump not based on his medical qualifications but because he attacked those who challenged the President and offered without any known expertise in this area advice against lockdowns and masking (Romo 2020). Seemingly, this type of behavior, which is antithetical to the foundations of medicine, was without consequences in the medical community including discipline by medical boards or withdrawing of university affiliation or firings. At the same time, experts with the knowledge and skills to save human lives have been silenced. And others, responsible physicians such as Anthony Fauci and Deborah Birx, had to walk a tightrope, avoiding lies, saying just enough to inform the public but withholding unessential criticism and toning down their views in order to retain their jobs or not be sidelined. They knew that should that occur their successors would only be more ineffective and probably less honorable (Collins 2021).

The results have been that as of January 19, 2021, almost exactly one full year after the first case was confirmed in the United States, the nation surpassed 400,000 COVID-19 deaths (Crist 2021). Although accounting for only 3% of the world's population, the U.S. had as of the inauguration of Joseph Biden as President of the United States almost 20% of the world's COVID-19 cases, and the virus continued to surge throughout the country until the vaccine was widely distributed.

The scientific achievements of the vaccines, seemingly in remarkably record time, demonstrate what science can accomplish. The catastrophic handling of the pandemic by our leaders, empowered and legitimated by their medical enablers who subordinated their knowledge and talent to a manifestly political agenda—seemingly without professional consequences—demonstrates the perils of what can occur when medical personnel decide to be more faithful to politics, power, prestige, position, and fame than to medical knowledge and when that subservience directly contributes to the loss of life.

We have also witnessed the politicization of data collection. Some political leaders did not want to provide for adequate testing for fear the results would impose obligations to quarantine, to close bars and restaurants and businesses, even assembly lines at meat processing plants where a majority of workers got sick. Some also refused to release statistics for similar reasons or to support the perception—in the face of evidence—that the pandemic was under control. The former Governor of New York has been accused of requiring nursing homes to accept COVID-19-positive patients when New York's hospitals were overflowing, and then, to hide data about deaths of nursing home residents to maintain credit for handling the virus properly (Cohrs 2021). This happened at state and local levels and not merely on the national scene. It occurred in the U.S: a democracy, not a totalitarian state.

We must realize that the subordination of scientific knowledge to the political agenda of the head of government—national, state and local—and his/her ideological enthusiasts was not restricted to Nazi doctors alone. It was also not restricted to medical personnel. This took place within a democracy with constitutional checks and balances and an independent judiciary. One can only imagine what could happen in authoritarian states or dictatorships where the consequences of opposing the dominant political position is imprisonment, exile and death, not just loss of position, prestige and political influence. The silence of international doctors who could have spoken up at the beginning of what was to become a global pandemic and their reluctance to share information in a timely fashion must be studied in the future.

These were observable violations of medical ethics. Over time we will come to understand that there were other significant violations as doctors and other medical personnel decided who shall live and who shall die, what priorities to give to treatment and who should be allowed to die by neglect. Others will write of the implications in new fields of genetics and the ability to attack certain diseases in vitro. The behavior of Nazi doctors should indicate that restraints need to be in place. Ethical norms need to be established, sustained, and defended-even in times of crisis.

Although the roll out of the vaccination program got off to a slower start than desired, there were a series of sustained, public, and serious debates as to who should get priority for receiving the vaccine and little dispute that the priorities are ethically valid, beginning with front line workers, then going to those in nursing homes and assisted living conditions, the elderly and those with underlying medical conditions before the general population. While these priorities have not been universally observed they make ethical sense and have properly enjoyed the support of the American public. We have also seen that minorities have been vaccinated less than others and among minorities, there is a greater suspicion as to the efficacy and safety of vaccines because of a greater distrust of government and of science (Recht et al. 2021).

Vaccine nationalism, now prevalent throughout the world, raises an interesting ethical dilemma since there has developed a gap between the wealthy nations and others. This is highly problematic because only global vaccination will lead to safety as borders are porous, and travel will spread contagion. The rabbinic sage Hillel admonished, "If I am not for myself who will be and when I am only for myself what am I? If not now, when?" This seems not only sound political advice, but the only policy that will starve the virus and return us to pre-pandemic normalcy.

1.4 Medicine in Extremis: Then and Now

As we have faced the greatest public health crisis of our time, what can we continue to learn from the Holocaust? Where is the relevance both to how we will judge our actions during the COVID-19 pandemic and prevent future social injustices related to health and medicine? To answer this question, let me turn to medicine *in extremis*. As I witnessed New Yorkers pausing at 7:00 PM each evening at the beginning of the pandemic and going out on their balconies to applaud for first responders, doctors and nurses, fire fighters and ambulance drivers, I thought momentarily of the doctors and nurses, pharmacists and other health care workers in the ghettos of German occupation, who, under increasingly dire conditions had to provide for their besieged Jewish populations.

I had been working on two books at that point, writing a review of Mark Smith's *The Yiddish Historians and the Struggle for a Jewish History of the Holocaust*, and assisting in editing the English language translation of a Ph.D. dissertation on the *Doctors of the Warsaw Ghetto* by Maria Ciesielska. The Yiddish writers of the Holocaust were committed to writing about how Jews lived and not about-or at least, *not only* about how Jews were murdered. Following their example, rather than write about Nazi doctors and Nazi medicine alone, in this chapter I have chosen to give a brief overview about what happened inside the ghetto as Jewish doctors tried to practice medicine *in extremis* and the parallels we can draw in contemporary society.

Germany invaded Poland on September 1, 1939, from the West; the Soviet Union invaded from the East on September 17; Poland was thus divided. In the weeks before the war, the Polish Army was mobilized and physicians who had been part of the Polish Army were called up into their military units. That left many Polish hospitals understaffed, presuming that the military would bear the brunt of the casualties, but as fighting became fierce and the attacks on the civilian population widespread, the civilian hospitals' abilities to handle the wounded overran the hospitals' capacities. During the initial stages of the invasion, doctors throughout Poland had to practice triage in choosing their patients. This was due to the fact that the German army did not merely attack military targets but attacked civilian targets and the general population as well. They, therefore, had to balance treating military personnel, who required medical treatment and were also needed by the Armed Forces to return to battle, along with civilian casualties. They too operated with limited resources and inadequate supplies. Ill prepared, they had to practice emergency medicine without certitude as to when they would benefit from resupply. Given an emergency situation of unknown duration, it was all-hands on deck for the foreseeable future, a sprint was required to keep pace in what turned out to be a marathon, enduring throughout the war years.

In areas under German occupation, Jews were immediate targets of persecution and placed in ghettos. In retrospect, the ghettos were a place to contain the Jews until the Final Solution to the Jewish Problem became the operative priority of the German government and the infrastructure was built for their annihilation- death camps complete with gas chambers and crematoria. As a general principle under German occupation, there was no interest on the part of the occupiers in the general health of the Jewish population. There was only self-interest in preventing epidemics that could endanger German personnel or reach beyond the ghetto walls and afflict the Aryan population, which would in turn jeopardize the health of German troops and civilians.

German assistance to the hospitals of the ghettos was motivated solely by a desire to contain epidemics, specifically typhus, and not by a desire to care for the well-being of the captive Jewish population. Health care providers were thus working under conditions of deliberate depravation where the very act of obtaining medical supplies was contrary to the basic interest of the occupiers. During the COVID-19 pandemic, the entire world was faced with an unprecedented demand for medical necessities (e.g. personal protective equipment, ventilators, hospital space) that far outweighed the available supply. This is vastly different than the situation in the ghettos under German occupation, where the ability to provide medical care was present, but a deliberate choice was made not to do so.

Clearly, there are differences between the medical crises of the German occupied ghettos and our current experience with COVID-19. The Nazis manufactured a medical crisis to suit their own political and racial ideology, using science and medicine as a justification. The death and destruction caused by this medical crisis was linked to the second World War. COVID-19 is a global pandemic that has ravaged the world population, (mostly) independent of politics or international hostilities. Yet, there is still much to learn from medicine in the Holocaust, and the behavior of physicians in extreme circumstances in particular that can impact our response to the challenges we currently face. Stories of physicians who remained dedicated to healing and saving lives in any way possible prove that ethics, virtues, values and hope can prevail. These tales of Jewish physicians and righteous Gentiles who risked their lives to save others inspire a positive view of medicine and bioethics in which the power of the profession is harnessed for good, even in increasingly desperate circumstances. The lessons of the Holocaust- how the power and privilege of medicine can be used in both positive and negative ways- have informed our current situation as we have struggled to meet the challenge of COVID-19 in the most ethical manner possible.

1.5 Heroism and Self-sacrifice

Courage took many forms in the ghetto, not just armed resistance. On August 6, 1942, the Germans struck against the children's institution in the ghetto. Dr. Janus Korczak, an extraordinarily well-regraded pediatrician and a radio personality in Poland, ran an orphanage in the ghetto. Well-respected and well connected with significant admirers among non-Jews in Poland, he knew that deportation meant death. He was offered an opportunity to escape, but when his contacts were unable or unwilling to rescue his children, he lined the boys and girls of his orphanage up in rows of four. The orphans were clutching flasks of water and their favorite books and toys. 192 children and 10 adults were counted off by the Germans. Korczak stood at the head of his wards, a child holding each hand. One child carried a double-sided flag. One side was a green children's flag, like the one created by King Matt in the book *King Matt the First*. The other was white with a Star of David set in the center.

They marched through the ghetto to the *Umschlagplatz* (the deportation point), where they joined thousands of people waiting in the broiling August sun. There was no shade, shelter, water, or sanitary facilities. There were none of the cries and screams usually heard when people were forced to board the trains. The orphans walked quietly in their rows of four. One eyewitness recalls: "This was no march to the train cars, but rather a mute protest against the murderous regime…a process the likes of which no human eye had ever witnessed."

Korczak was the teacher who would not abandon his students, the physician who accompanied his patients. He was with his children to the end. All were gassed at Treblinka.

Less dramatic but no less valiant were the acts of Dr. Halina Szencier-Rotstein, near the end of the Great Deportation in 1942:

> On September 12 [one of the last days before the Deportation], all patients and remaining hospital personnel boarded the boxcars. Even those who had "tickets" and stayed in the hospital on Stawki Street to tend to their patients to the very end were also deported. Among them was Dr. Alina Szenicer-Rotstein who, despite being permitted to leave the *Umschlagplatz*, chose to accompany her patients. Dr. Adolf Polisiuk remembered that "she went to a wagon voluntarily, to be with those needing her help; this is how she understood her duty. To many such a gesture seemed abnormal, for the will to survive was so strong. Her behavior was very poignant in its heroism" (Ciesielska 2022, 227).

The cruel and corrupt Commander of the Jewish police was approached by a young nurse who timidly asked whether personnel had to accompany the children. "Korczak showed you the way," he answered.

Noble doctors do not abandon their patients, clergy their congregants, teachers their students. Of course, not all doctors are noble, not all clergy brave, not all teachers self-sacrificing, but there are models to be emulated, brave upstanders giving all they had, all acting with integrity.

There are other reports from the Great Deportation of physicians who injected their patients to ease their pain, to facilitate their deaths, of doctors boarding the train voluntarily, knowing that they were taking leave of this world. Not every doctor or nurse can be a hero but when they are, we must remember their names, revere their deeds. They can—and should—serve as role models for future generations of the importance of promoting the ethical virtues of the profession.

There are reports from virtually every ghetto where records were available of doctors and nurses who committed suicide, some out of despair and some because they simply could not take it anymore. No stranger to death, with easier access to drugs and painkillers, suicide is a choice that doctors and nurses make when they can no longer cope with the unique pressures of their profession. Other medical personnel succumbed to the diseases of their patients. Lacking protecting equipment, engaging too closely, not taking sufficient precautions or simply because they were doing their jobs with dedication and commitment, they themselves became patients. And we have witnessed this again and again during the current pandemic: medical personnel committing suicide, medical personnel dying of the disease they were trying to cure.

1.6 Maintaining Dignity and Professionalism

Physicians and other medical personnel used quarantine signs, most especially from typhus, to protect individuals including themselves from being rounded up. German and Ukrainian forces and the Jewish police were reticent to enter an apartment if the sign on the door indicated a quarantine. Typhus did not obey Nazi racial laws, much like COVID-19 does not discriminate based on class or socioeconomic status. The Prime Minister of Great Britain, the Prince of Wales and even the President of the United States have all battled COVID-19 at various points during the pandemic.

A major example of self-help occurred in Warsaw with too few medical personnel to provide for the needs of the ghetto. As a form of resistance, the Jewish doctors of the Warsaw ghetto created courses for medical students, nursing students, pharmacy students and anyone who cared to attend the classes. It was how they partially alleviated the personnel shortage. It was also how they strengthened their sense of professional commitment and maintained their dignity under oppressive conditions. They modeled their curriculum on how they were taught and did it so well that Warsaw University honored their credits after the war. It seems incredible, but some physicians began their training in the ghetto and completed it at the University. Their ghetto professors were able to maintain their honor, professionalism and productivity even inside the confines of the ghetto walls. It shielded them from dehumanization.

I know that we will find parallels in the contrasting circumstances of the COVID-19 pandemic.

While Nazi doctors conducted research on prisoner victims without their consent or consideration of their well-being, Jewish doctors in the ghetto conducted research on the impact of starvation- research which they took care to include in the *Oyneg Shabbes* archives assembled by Emanuel Ringelblum so that, once again, the story of how Jews lived and struggled to survive under condition of oppression could be documented. The commitment to scholarship and research was another assertion of dignity and professionalism amidst the quagmire that was their existence. These are important positive models for how physicians can behave *in extremis*, which can bring out the best in some but surely not all. Unlike Nazi medicine, these research studies have proved invaluable over time.

There is no doubt that physicians have learned how to treat COVID-19 over time both from experience and the research of colleagues. They have learned what works and what does not. Medical personnel have learned how to heal when they could not cure, at a time of great isolation when families could not visit, loved ones could not say goodbye. They have been aided by technology which allows remote visits. The best of them, the most dedicated, have found ways not only to treat their patients but also their patients' families who can no longer sit by the bedside of their loved ones. Those who do it well have diminished the anguish of the present moment. I know this first-hand having lost my beloved cousin to COVID during the first months of the pandemic, when a nightly call from a nurse was the only information we had and when a physician gave us important and most often dispiriting and disappointing information, accurately, intelligently, and kindly.

In extremis veritas, we learn much from the extreme. To return to my opening dilemma regarding the United States Holocaust Memorial Museum and how to create a transition between two worlds, i.e., that of the Holocaust and that of current society, maybe the answer to such a question can be found in what we can learn from our responses to the extreme.

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Chapter 2
Teaching Medical Ethics in Nazi Germany: Debunking the Myth that the Nazi Physicians Abandoned Their Ethics

Tessa Chelouche

Abstract In discussions on Nazi medicine, it is often presumed that the Nazi physicians abandoned or ignored all forms of medical ethics. This notion is far from the truth even though it is very difficult to come to terms with. It would be more comfortable to believe that Nazi physicians were a marginal group of madmen and what transpired in medicine during that period was unique and irrelevant to modern medicine. However, today we know that the Nazi physicians not only had a very detailed ethical code in place, but also that they were the first in the world to teach medical ethics at medical schools. These ethics courses were compulsory at every medical school in Nazi Germany and were based on the use of a specially published textbook, called *Medical Jurisprudence and Rules of the Medical Profession*. The textbook provides a unique insight into the values and beliefs systems of the Nazi physicians, many of which were greatly influenced by the political and social culture of the time, and some that resonate with the current practice of medicine. Discourse on medical ethics during the Nazi period, as demonstrated by this manual, serves to remind physicians that we are all vulnerable to ethical transgressions and could do well by learning the lessons from this past.

Keywords Nazi medicine · Medical ethics

2.1 Introduction

> Even though the physician's course is steep and difficult, if he is guided by a constantly urging conscience, and proceeds in faithful duty, he will be accompanied by a joy of responsibility and a sense of readiness to make sacrifices. Only the idealist has these qualities at this disposal (Ramm 2019).[1]

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[1] The exact citations from the English version of Ramm's book are presented in italics throughout the paper.

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This passage is from the preface to a medical textbook, *Medical Jurisprudence and Rules of the Medical Profession* (Ramm 2019). A medical professional can certainly identify with these words which, in essence, are what the practice of medicine is about. Medical students select their profession usually because they perceive medicine as a "faithful duty" to do good with inherent awareness, or "urging conscience" that the path will be "steep and difficult" requiring "sacrifices" to be made. Medicine is indeed an occupation that places huge demands on its members who are constantly obliged to question their actions, responsibilities, and their ethics, in other words to be somewhat "idealists." Reading this paragraph out of context one would accept it as words of guidance for regular medical students, but taken in context, the paragraph attains an entirely different significance. The words are in fact incredible, because they were written in a German medical ethics manual (*Arztliche Rechts–Und-Standeskunde*) in 1943, at the peak of the Nazi Regime, by a zealous Nazi family physician and educator, Dr. Rudolf Ramm (Bruns 2014a, b).

This is a period in history where all forms of accepted humanitarianism and dignity were convoluted and warped. The Holocaust, the murder of six million Jews and other minorities, was one of the darkest times in humanity, and certainly the darkest in medical history, during which physicians who had sworn to heal and to help, instead, killed and maimed. Yet during this very period, an ethics textbook was issued that medical students were obligated to use and study (Bruns and Chelouche 2017). Ramm, the author, has been deemed "the man in charge of supervising German medical education" (Proctor 1988, 174) and a course, with the same name as the book, was commissioned as required learning at every medical school in Nazi Germany (Bruns and Chelouche 2017).

This may be surprising, or disquieting, due to the widespread notion that the Nazi physicians abandoned or ignored all forms of accepted ethical behavior in their "pseudoscientific" medical research. We know now that this was not "pseudoscience" at all, but rather unrestrained science that intersected with racial policy (Weindling 2017). In the last decades much has been published on the criminal and barbaric actions of the Nazi doctors, especially in the domain of medical research (Annas George and Grodin Michael 1992; Weindling 2017; Roelcke et al. 2014) but little has been said of their motivations (Grodin 2010; Weiss 2005) or their ethics (Bruns 2014a, b). It has been very complex to address the Nazi physicians in the context of morality or ethics (Caplan 2010). For decades after the Holocaust it was easier, and less discomforting, for the medical world to distance itself from this past and dismiss Nazi doctors as having renounced or abandoned all forms of traditional medical ethics (Roelcke et al. 2014). It was comfortable to continue the belief that those Nazi physicians who had engaged in immoral and unethical acts could not have been motivated by any form of ethical stance (Miller and Gallin 2019; Caplan 2010). However, the historical truth is that medical ethics were not ignored, nor were they abandoned. The uncomfortable reality is that the physicians who executed these crimes were of the conviction that their actions were morally and scientifically right

(Caplan 2010). These were not incompetent, insane physicians from the fringes of the profession. Many were distinguished, experienced professionals from mainstream German medicine, which was considered to be the most progressive of the time (Aly et al. 1994; Weiss 2005). The German physicians were not coerced to join the Nazi Party, but did so on their own initiative and in greater numbers than any other free profession (Kater 1989). Among them were university professors and experienced physicians who, like Rudolf Ramm, took it upon themselves to inculcate future generations of physicians precisely due to the fact that they believed that what they were practicing and preaching was ethically and morally right (Bruns and Chelouche 2017). In Ramm's words: "*So this book should be a companion and a guide to the student of medicine and to the young physician for his established goal and an adviser to the young person in his choice of profession*" (Ramm 2019, x).

Ethical teaching does not take place in a vacuum; rather, it takes on its relevance to the culture and society of the time and has to be sustained by the values of the larger community (Weikhart 2009). Nazi Germany was no different. Ramm, well aware of this, expounds, "*Culture, race and spirit of the times affect a physician's values and manner of engaging with previous problems, according to the standards of the time*" (Ramm 2019, 75). In the "spirit of the times," Nazi ideologues, including Ramm, asked the German people to develop biological attitudes and feelings as part of their racial character in order to form an "ethnic conscience." The past racially indifferent, bourgeois-Christian morality, deemed responsible for the weakening of the national organism, was to be replaced by a racially appropriate biological humanism (Bialas 2013). This biological political thinking, permeated with ethical reasonings and underpinnings, was perceived by the Nazi leaders and the medical profession as "applied biology" (Proctor 1988; Weikhart 2009). For the very reason that the Nazi policies were so biological in their nature were they so appealing to the medical profession, creating a dangerous symbiotic relationship between Nazism and medicine that eventually served to radicalize them both (Weiss 2010).

It must be emphasized that the participation of the medical profession did not take on a "slippery slope" path as is commonly assumed (Hanauske-Abel 1996). Rather deliberate and careful steps, such as the publication and obligatory study of Ramm's ethics manual, were taken to ensure medicine's leading participation in the maleficent eugenic programs in the Nazi state. These physicians were not moral monsters to start out with, even if some of their subsequent actions were evil personified (Weiss 2010, 11). The reasons that they made their choices are varied, but it can be stated with certainty that they were certainly not "pawns" but rather "pioneers" in their contribution to racial hygiene. This contribution led to subsequent heinous consequences, for example transforming scientific orthodoxy in Germany to become supportive of totalitarian politics. Proctor (1988, 38). The challenging task ahead is to reflect and understand how and why this occurred, and not just to criticize and distance ourselves from this history by assuming that we in the present, and maybe the future, are morally enlightened or invulnerable to unethical behavior (Lerner and Caplan 2016). As evidenced by the widespread current international debates on whether to eliminate memorials to various historical figures, this is not a simple task. Studying Ramm's book enables embarking on this mission because it provides additional insight into the ethical motivations behind the actions of the Nazi physicians. The various medical crimes perpetrated under National Socialism have been well documented in the literature over the past decades, but in this chapter, I will approach these issues through the lens of the material that was published to teach ethics and professionalism to medical students in Nazi Germany. The textbook, considered to be an extremely influential document, and quoted as "Germany's leading textbook on legal and ethical aspects of the profession," Proctor (1988) demonstrates what value system they were expected to aspire to in their medical practice, and, in retrospection of the medical atrocities, enables us to somehow understand how and why they did what they did. The original manuscript has now been translated into English, and though the language used is the translation of the old-fashioned German style and is somewhat cumbersome, I have chosen to provide the exact text (cited in italics) to enlighten the readers since this adds a new dimension to the narrative. Many of the chosen passages are self-explanatory, but I have included historical context where needed. If the young students and physicians faced any dilemmas on the morality and ethics behind what was expected of them, Ramm's troubling text enlightened and guided them in providing the solutions.

2.2 The Development of the Course

At the start of the twentieth century, medical ethics did not exist as a formal teaching subject in medical schools. In many Western countries at that time, medical ethical philosophy was expressed primarily in medical literature and codes of conduct rather than didactic teaching (Jonsen 2000). In the wake of Germany's defeat in the First World War, fueled by the economic hardship and hyperinflation, crude utilitarian and eugenic thinking intensified in the medical community (Weikhart 2009). The central tenet in the Nazi system was eliminative Racial Hygiene, their view of eugenics, and these philosophies were to be transformed into pragmatic medicalized programs to which the commitment of the medical profession was essential (Proctor 1988; Weiss 2010). Medical students were seen as predestined for the future implementation of Nazi healthcare policy and race ideology because they, in contrast to the older doctors, had grown up and been socialized within the Nazi system (Bruns 2014a, b). A teaching program for medical students to substantiate and legitimize Nazi health policy was lacking. To realize these goals, the Nazis revised the medical curriculum and, in April 1939, introduced newly designed courses in racial hygiene, heredity, population policies, military medicine and the history of medicine (Bruns and Chelouche 2017). Another new subject and corresponding textbook, *Medical Jurisprudence and Rules of the Medical Profession*, became obligatory for students as well.[2] This was the first time that students would be required to formally study

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[2] The translation of the original title of Ramm's textbook in German, *Arztliche Rechts- und Standeskunde*, has been used differently by various authors in English.

physicians' moral and legal obligations to their patients, as well as to their profession and the state. Nazi medical officials established a lecturer for this new subject at all 28 medical schools in the German Reich. With the introduction of this new course, ironically Nazi Germany became the first country in the world to hold mandatory ethics classes in medical schools (Bruns and Chelouche 2017).

2.3 Hierarchy in the Medical Profession: Physicians as Health-Leaders

The revised curriculum provided the method of creating a new type of physician in Nazi Germany, where the whole medical profession was unified into a single political entity subordinated to the National Socialist Physicians' League, which was hierarchically organized according to the *Führer*, or leadership, principle (Proctor 1988, 72). This *Führer* principle emphasized that health care was now to be replaced by health leadership, and the physicians were to become these leaders. Germany was characterized by a ubiquitous sense of hierarchy and obedience, and it was these features, particularly inherent to the medical profession, that were to ensure the future of medicine in Nazi Germany. Ramm explains, "*The victory of the National Socialist revolution also meant for the medical community the breakthrough of a new attitude of mind… From this day forward, important regulations concerning the profession were no longer to be made by majority decision but rather by the leadership principle*" (Ramm 2019, 41).

As mentioned above, around fifty percent of the physicians in Germany joined the Nazi Party most of whom were young physicians (Kater 1989). Every lecturer in the ethics course was an "old fighter," i.e., a long-standing Nazi Party member (Bruns and Chelouche 2017), but belonging to a political party does not necessarily ensure immoral action. There was something very appealing for young students or physicians in the demonical blend of Nazi philosophy and medicine, both of which embodied hierarchal values and offered enormous power and prestige (Fernandes Ashley and Diann 2019). These young future physicians could easily identify with the promise of power and omnipotence that would enable them to take the lead, as the top echelons of the community, in solving the problems of post-World War One Germany. Ramm reiterates, "*Only the physician of our time who is a true National Socialist will be a pillar of Volk community and a cooperative creator of the German future, which means a Volk comrade, who not only outwardly, but also in his inner heart, makes the biological laws the unique principles guiding his life and behavior, and as a tireless pioneer and preacher, convinces his Volk of the correctness and real truth of these laws. Only with this attitude is he to be an intellectual and moral leader of his Volk*" (Ramm 2019, 76). This medicalized attraction to power typifies the Nazification of medicine during this period (Grodin 2010).

2.4 Obedience to Authority—The “Banality of Evil”

In our efforts to try to comprehend the motives for the actions of the Nazi physicians, we come across an expression coined by Hannah Arendt: “banality of evil,” which she used to describe the notion that Adolf Eichmann was not a monster, even though his deeds were indeed monstrous. Rather, the “banality”, or ordinariness, of his personality kept him from questioning Nazi orders (Arendt 1994).[3] Subsequent research has proven that under certain circumstances most individuals will conform to a majority and obey an authority even if this entails committing acts that are extraordinarily evil (Waller 2007). This has been used as one explanation for physician collaboration (Friedlander 1995), but we learn from Ramm that physicians were taught not just to thoughtlessly obey orders but were indeed expected to be held responsible for their own decisions: “*A Compulsion to treat does not exist for the physician*” (Ramm 2019, 101). He contextualizes this for the medical profession, and firmly displays his ethical stance that a physician cannot be expected to perform his duty under “impossible” circumstances, and that not every emergency needs to be treated as such. “*The physician, being the one responsible for his reputation and his place in the Volk community, is to be allowed to decide for himself to whom and when he allots his help.*” He continues, “*It is just natural that each physician should determine for himself his own professional obligations in certain respects out of his own drive*” (Ramm 2019, 103). He adamantly maintains that in the apparent conflict between the medical community and the legal system, the physician should always be the one to decide. It is thus only logical to conclude from Ramm’s text that physicians in Nazi Germany were taught that they would be expected to use their own personal judgement in exercising their professional duty and that there was no obligation to comply to a higher authority. This is just another example of the huge void between moral teaching and medical practice in Nazi Germany. Unfortunately, only a minute percentage of the Nazi physicians did indeed refuse to collaborate or to obey, and they suffered no dire consequences from this refusal (Friedlander 1995). Even in a culture like Nazi Germany, where obedience to authority was inherent, there was an option for conscientious refusal. They were not all idealists, although some like Ramm definitely were, but most were ordinary people (Browning 1998), who despite their medical training, abused their professional status in participation of murder. Obedience or “just following orders” was a subsequent defense mechanism and not a real motive for action. The Nazi medical students were taught that they their duty was to determine responsibly their choices of action in their practice of medicine. Nazi physicians knew that they had a choice.

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[3] There is legitimate debate over how applicable Arendt’s concept of the “banality of evil” is to Eichmann specifically, and therefore is open to many interpretations. However, this concept has been extremely useful in allowing for discussion on the potential that exists in every human being for committing heinous deeds.

2.5 The Physician as Caretaker of the Race

In addition to becoming health leaders, physicians were to take on the role of "genetic doctors" leading the country into a future where the genetic health of society was the central idea around which the community revolved. The transformation that was expected of them was to embrace and internalize the Nazi philosophical viewpoint "*which consists, not only as before, in the healing of physical and emotional wounds, consoling his fellow man during misfortune and in the administering of relief at the end of life, but additionally gives this mission priority over his duty to the individual*" (Ramm 2019, 76). This change in the direction of physicians' duty was rationalized: "*Even though the ultimate responsibility of the physician goes to the healing of the patients and the perpetuation of life, this responsibility has experienced an essential expansion through coming to grips with biological thinking in the National Socialist state. For our Volk there existed the same danger of decline that led to the present death of the older volkish cultures. Extensive mixing with other mostly minority races, shocking decline in the birthrate, above all among the high class of the Volk, and an unrestrained increase in the lower classes of our population were the alarming signs of the beginning of degeneration and, with that, racial collapse*" (Ramm 2019, 117). Race was to become a medical diagnosis, and physicians were the ones who were to administer this racial cure. Medical care was to be shifted away from the individual patient and geared toward the general welfare of the Aryan race, the Volk. Universally accepted medical ethics were to be replaced by a collective ethic of ensuring moral obligation only towards members of the Volk and excluding those of lesser genetic or racial value from the realms of morality (Bruns and Chelouche 2017). Ramm goes into minute detail on the role of doctors as medicalized political leaders and places a great deal of emphasis on the importance of becoming the "physician to the nation": "*As representative and reporter of the National Socialist idea he [the physician] should as a moral duty represent the elements of the party and state to Volk comrades, and should work for their fulfillment*" (Ramm 2019, 88).

Immediately after the Nazi takeover, in 1933, a new medical system emerged, whereby all existing medical associations were annihilated and a new Nazi Physicians' League, subordinated to the Nazi Party was created (Kater 1989; Proctor 1988). This step marks a crucial stepping stone in the "Faustian bargain" (Weiss 2010) between medicine and the Nazi government as the medical profession was not just overtaken by the Nazi political authorities, but rather played an active and premeditated role in the formation of subsequent highly coordinated, medicalized Nazi schemes of forced sterilization and murder. In 1936, the Reich Physicians' Chamber was established to control private and public medicine with the legal enforcement of the "Reich Physicians Ordinance," quoted to be the "Magna Carta" of the German Medical Association (Haedenkamp 1938a, b). This important document constituted a formal ethical guideline to medical practice in Nazi Germany, providing "German doctors at last with what they have badly wanted for a long time: a complete code of all those ethical conventions upon which their professional integrity is founded. Many of these closely concern everyday problems of their professional life" (Haedenkamp 1938a, b). Ramm emphasized the importance of the Ordinance by quoting the first paragraph: "*The physician is called to the service of the health of the individual person and the entire Volk. He fulfills a publicly regulated responsibility through this law*" (Ramm 2019, 86). In order to pursue this elevated status and revered calling he writes, "*The personality of the physician must be of a firmly National Socialist philosophical nature and reach a high degree of completeness which arise out of three roots: his nature as a human, his education, and his calling.*" According to Ramm "human" is defined as what the Nazis determined as healthy and Aryan: "*The physician must be fully adequate, well-formed and harmoniously proportioned in body, clear and sharp intellectually, and deep, strong and kind in his soul. He must combine healthy judgment with composed and stable behavior and must be resolute in his dealing with Volk comrades*" (Ramm 2019, 87). So we have here the juxtaposition of the physician as a healthy, honorable, moral human being who is responsible for his own wellbeing and also for the health and treatment of the deserving Aryan ill, but more importantly, whose foremost loyalty is now to the state and not to his individual patients.

2.6 Hippocrates in Nazi Medicine

It may seem indisputable that the words "Hippocrates" and "Nazi" are mutually exclusive, however this chapter proves how factually inaccurate this perception is. Medical historians have demonstrated that the Hippocratic Oath was not ignored in Nazi Germany, but was transformed into a nationalist, racial and collective ethic (Rutten 1996). Some Nazi physicians officially avoided disputing the validity of the Oath, others attributed no particular significance to the Oath, and another group saw their allegiance as belonging to the State in coherence with the Racial Hygiene paradigm of collective ethics (Bruns 2014a, b; Rutten 1996). Ramm imparted his rather progressive view of the "calling" of the medical profession as encompassing both art and science. He attributed the "art of healing" to Hippocratic philosophy, which he deemed eternally essential for the future physician. The Hippocratic Oath itself was an explicit, but not all inclusive, part of the medical students' education: "*It is clear to each person entrusted with the essence of the physician's profession that a professional Ordinance cannot deal exhaustively with all medical professional duties, and that there are certainly pure moral demands which can be taken to be striving for the medical ideal, which are perpetual, like those already laid down in the Hippocratic Oath, and which thereby have created estimable medical ethics up to the present time. The deeper this unwritten law becomes incorporated in to the soul of the physician, the more encompassing it comes to be expressed in his actions, the more pronounced becomes the bearer of such a professional conception, the more he will be an effectively good physician, as a representative of the ideal that we recognize in the concept of 'The Conception of Medicine'*" (Ramm 2019, 86). It is evident from this passage that the ethical principles of the Oath were considered meritorious and valid for the moral compass of the Nazi physician, and students were explicitly conditioned not to ignore it. There were, however, additional factors to consider: "*In addition to these [laws and regulations] there are even higher moral viewpoints completing the obligations of the physician, which arise in the concept 'Medical Ethics'*" (Ramm 2019, 86). According to the Nazi perspective, the new medical ethics encompassed the moral duties of the physician, not contradicting Hippocratic values but rather complementing them. Ramm explains what he means by the moral duties: "*Out of tradition, each profession and each occupation cultivate a special professional honor and demand from its members a definite moral attitude in its individual Volk-comrades in regards to the Volk community*" (Ramm 2019, 86). This Hippocratic ethic and art of caring was to be applied only to certain sectors of the community who were deserving of a good "trusting relationship" between them and their physicians. This trusting relationship demanded that the treating physician inform the patient if any danger was involved in the treatment, but this was enacted according to the coercive and paternalistic ethic: "*While the physician is also obligated to explain to the patient about the necessity and possible consequences of an operation and make its performance in general dependent on his agreement, there are often cases in which the patient is obligated to endure the intervention if he wants to run no danger of losing his social security to which he is otherwise entitled*" (Ramm 2019, 108). He does not specifically use the term "*primum non nocere*" but addresses the ethics of doing no harm and medical confidentiality in the liability context of negligence: "*In the relationship of the physician to his patients the liability of the physician plays no small role. Most legal proceedings against physicians are not because of a violation of the duty to explain or because of professional secrecy, but rather are carried out because of an unsatisfactory therapy brought about by presumably incorrect diagnosis which led to damages to the patient*" (Ramm 2019, 108). In accordance with the beneficence principle of the Oath, Ramm teaches physicians to treat the patient according to his best ability: "*A physician should not use any therapeutic technique that he himself has not mastered*" and that a physician should always use the "*best means of healing*" at his disposal (Ramm 2019, 109). He writes that the highest duty of the Nazi physician is to be vigilant with the use of "*highly potent medical modalities and poisons*" and to ensure that the doses of these medications are not too "*strong*" (Ramm 2019, 91). This is once again cruelly ironic because contemporaneous with the compilation of this manual, Nazi physicians involved in the "euthanasia" program, some of whom were lecturers in the ethics course, were at the peak of doing precisely this: poisoning their patients (Aly et al. 1994).

2.7 Bad Genes

By the third decade of the twentieth century, eugenics, the belief in science as a tool to reform and advance society, was widely accepted and became a popular international social and scientific movement (Weiss 2010). In Germany, the eugenic movement was led by physicians who enjoyed extraordinary prestige, which reinforced their view of themselves as the one professional group possessing the expertise to safeguard the health and the welfare of the nation (Weiss 2010). The meaning and uses of eugenics were not the same in every country and were interpreted differently in different cultures. Among the strongest intellectual and institutional ties within the international eugenics community were the ones between mainline American and German practitioners (Weiss 2010; Black 2003). In early twentieth-century Germany, eugenics was based largely on Darwinian inegalitarianism that contributed to the devaluing of the "inferior" in society. This emphasis on biological inequality and evolutionary ethics stimulated physicians to categorize people as "superior" or "inferior." In answer to the question of who were inferior, a German physician provided this crude reply: "The sick, the weak, the dumb, the stupid, the alcoholic, the bum, the criminal; all these are inferior compared to the healthy, the strong, the intelligent, the clever, the sober and the pure" (Weikhart 2009). After the tremendous defeat in the First World War, a huge shift occurred in the minds of the German eugenicists, the majority of whom were physicians who saw themselves as being responsible for restoring the devastated nation (Weiss 2010). During this period, the German government took a great interest in eugenics and human heredity, which were conceived of as scientific tools needed to construct a welfare state. It was understood that healthy people of good genetic stock, the "superior," were valuable resources to society, and much effort was put into various programs to promote eugenic ideas within the country (Weiss 2010). This development went hand in hand with a process of weakening humanist ethics centered on the individual, as physicians now propagated nationalist selective ethics defined on the basis of medical and racial criteria of inclusion and exclusion (Bruns and Chelouche 2017). It was argued that the sick, disabled or those with "bad genes" posed a huge burden to the state, and discussions began to take form on the value of human life from a medical and an economic point of view (Weikhart 2009). But most German eugenicists generally did not believe that their country was ripe for practical measures yet, even though the scientific literature was saturated with harsh terms such as "useless eaters" and "those unworthy of living" (Binding 2012, originally 1920). So, we see that eugenics, or the synonymous German term racial hygiene, was in fact not a Nazi conceived notion, but an accepted science that existed in the world long before the Nazis conceived of their murderous programs. It is important to understand, and not to underestimate, that the turning point came only with the Nazi takeover in 1933. Only after the Nazi's rise to power with the view that everything sick, alien and disturbing were to be cleansed from society (Aly et al. 1994, 15), was it possible to act on these egregious concepts, with Nazi Germany becoming the only country in which the eugenic medicalized programs were to play out to the extreme. With the Nazis in charge, the "useless individuals" and those with "bad genes" would pay the price for these policies with their lives (Muller-Hill 1998).

The Nazi medical conception of the morality behind this rhetoric of inclusion and exclusion can be better understood from Ramm's passages. He provides us with ample material on the importance of equitable care for patients, just not all patients: "*In the help of the sick, the physician is not allowed to make any distinction between high and low, poor and rich. Each genetically healthy person must possess the same* *value for him whether he takes advantage of his help for money or demands it as God's wages*" (Ramm 2019, 89). The significance of this was that only people belonging to a certain genetic group, or race, were considered as being worthy of receiving medical care and ethical consideration. It was morally right to treat only certain groups within society for the greater good, and equally morally right to exclude other groups as not deserving of the same attitude or treatment due to their perceived hereditary worth. "*As old as the science of healing itself is the responsibility of the physician to stand by the sick and weak person during his physical and psychological suffering and to help strengthen him. Equally as important from the standpoint of the Volk, is the pure preservation of blood through prevention of bastardization by bad qualities or foreign racial elements, as well as the responsibility for the protection of the genetic wealth, the preservation and improvement of the genetic predispositions and the complete eradication of the mass of bad genes*" (Ramm 2019, 89). This resonates as Nazi propaganda but is actually the basic principle that lies behind the ethical teaching of every medical student in Nazi Germany. The duty of the Nazi doctor was now expanded. In addition to his duty to care for his "genetically well" patients, he was ethically obliged to care for the "preservation of the blood" of his nation by dehumanizing those who were considered to be a danger to the genetic health of society, and as such were now deemed morally eligible for "eradication". This process of negative eugenics, validated by the internalization of the dehumanization of certain patients who were perceived of as being unworthy human beings, allowed for physicians to justify actions that would be otherwise considered as immoral.

2.8 Antisemitism in the Medical Profession

Antisemitism was an inherent feature of Nazi medical ideology. One of the first steps taken in the newly formed Nazi regime was the removal of Jews from medical practice, both academic and clinical. (Kater 1989; Proctor 1988). In reading the textbook we realize the extent to which the Nazi physicians internalized and embraced antisemitism as inherent to, and acceptable with, medical and ethical norms. Ramm praises the new antisemitic directives: "*One of the first measures of the National Socialist Physicians leadership was the cleansing of the profession of politically unreliable and racially foreign elements, so long as the medical benefit for the Volk population was not endangered*" (Ramm 2019, 42). "Cleansing the profession" refers to the expulsion of the Jewish physicians from medicine in 1938, whose licenses were revoked and who were no longer considered doctors, but rather healers permitted to treat only fellow Jews (Kater 1989). "*One can however today already grasp the blessings which are important to life and to our Volk in the offices of the states that have emerged after the forceful expulsion of the Jews from the profession*" (Ramm 2019, 42). He rationalizes the self-righteous persecution and marginalization of Jewish physicians: "*It was the Jew who forced some German doctors into a crass materialistic employment of professionally unworthy methods of competition; the Jew who endangered the German Volk, and the one who through extension of his* *souls-poisoning ideas, enabled the destruction of germinating life while generating the impression, through his methods of advertising in wide circles of the population, that he was indispensable as a medical researcher and medical practitioner…Today no full-blooded German would allow himself to be treated by a Jewish doctor*" (Ramm 2019, 42). Although these passages read as blatant racist propaganda, they are in essence what was deemed morally right to teach medical students in Nazi Germany.

Jewish medical students also were affected by the wave of overt brutal antisemitism. During the Weimar years a *numerus clausus* was established limiting the percentage of Jewish students, with the real objective of total exclusion of Jews from higher education and university life. Jewish medical students were excluded, provoked and discriminated against by the German professors (Weyers 1998). Many of the students in Ramm's, and his colleagues', classes would have been taught by these Jewish professors who now, under the Nazi regime, were expelled and forbidden not only to teach, but to practice as well.

Another facet of antisemitism in the medical profession, in line with the political discourse, was the perception of the Jews as contaminating the nation (Muller-Hill 1998). For professionals who deal with issues pertaining to contamination as a regular part of medical practice, this concept was particularly salient to the German doctors (Haque et al. 2012). In an attempt to give the Nazi race philosophy the appearance of true science, research was performed to prove that Jews, and other minorities, were more affected by certain diseases and had a genetic predisposition to criminality. (Weyers 1998; Weiss 2005). In accordance with the ethical notion of care for the genetic health of the nation, Jews and other minorities who were perceived as contaminating the genetic pool of the German citizens were not eligible or deserving of regular medical care. This perceived danger of "blood mixing" was realized by the passing of the 1935 Nuremberg Laws, thus putting policy into practice. These laws included the Reich Citizenship Law, determining that only "pure blooded Germans" would be given political rights; the Law for the Protection of German Blood and German Honor, prohibiting marriage or sexual relations between non-Jews and Jews; and the Law for the Protection of the Genetic Health of the German People, also known as the Marriage Health Law, requiring couples to submit to "genetic" medical examinations before marriage. These laws, conceived, compiled, and implemented by physicians were regarded as public health laws (Proctor 1988). Ramm elaborated on them with words of immense pride and praise: "[The Nuremberg Laws] *were energetically pursued and are the milestones on the way towards re-winning racial unity and the promoting of the genetic health of the German people. They serve to improve the health and the higher development of the genotype of our Volk through extermination and selection*" (Ramm 2019, 118).

2.9 Selection and Sterilization

Ramm continues his praise for the racial hygiene laws by including long passages on the 1933 Sterilization Law, or the Law for the Prevention of the Genetically Ill Offspring. A great deal has been published on this law (Muller-Hill 1998; Proctor 1988) but reading it from the textbook undoubtably sheds new light on how this was to be dealt with from an ethical perspective. The Nazis argued that existing principles of healthcare and social welfare encouraged the reproduction of people with little value who would soon out-number the nation's valuable citizens. To maintain the health of the nation, it was mandatory that the reproduction of certain citizens be restricted. In order to put this policy into practice, a compulsory sterilization program was legalized on eugenic grounds (Muller-Hill 1998; Proctor 1988). With unambiguous support of the Sterilization Law, Ramm proclaims: "*Sterilization can be forcefully carried out in some cases of refusal, but can be avoided through prolonged placement of the genetically ill person in a closed institution, if the family can bear the resulting cost. In so far as the house physician can bear the influence of the decision on the involved family, he should set the plans in place for the operation*" (Ramm 2019, 125). The Nazi physicians did indeed "set the plans in place," and this program of legal compulsory mass sterilization of the ill and the disabled was to transform the German medical profession (Muller-Hill 1998). This was not intended to be a racial law, and it was not geared specifically against the Jews. Rather, it aimed to eliminate an entire generation of what were considered to be genetic defectives. Eugenicists in Germany and other countries prior to the Second World War had viewed compulsory sterilization for certain categories of people as a means of improving the state of the nations, and indeed in many countries thousands of people were sterilized against their will or without their knowledge (Black 2003). Germany was largely influenced by these countries, especially the United States, but the rise of the Nazi dictatorial regime, which conferred race and heredity as a cornerstone of its ideology, partnered ideally with the eugenics movement, and the practical implementations of this sterilization program were far more extreme than in other counties (Weiss 2010; Proctor 1988). We read how the Nazi medical student was taught that this highly immoral program was in fact considered ethical, as Ramm praises the basics of this law to his students: "*The genetic health of the coming generation depends on his [*the physician's*] conscientious application of the law*" (Ramm 2019, 119). The "conscientious application" meant that in practice those deemed disabled or born with other conditions perceived of as hereditarily detrimental, were to be reported and forcibly sterilized by physicians, after special heredity court physician judges determined their suitability. These conditions included various forms of mental, physical and social impairments or disabilities such as mental illness, schizophrenia, manic depression, epilepsy, blindness and deafness and any form of physical deformity. Ramm expounds on this to his students: "*In order to prevent any discomfort in the population as a consequence of this law and to be sure of an understanding acceptance in all Volk circles, it is the superior responsibility of the physician to put himself in a position where he can clarify and advise the Volk regarding the goal of this law*"

(Ramm 2019, 122). Students are told one of their duties as “genetic doctors” is to recognize the genetic sickness in the community or the institution and to impart to the family that their relative’s reproductive right has to be sacrificed for the greater good of the Volk community. In recognizing that under certain circumstances this might have been a very difficult idea to accept, both on the part of the family and the physician, the paternalistic function of the doctor is emphasized. There is no discussion about the need to obtain a person’s consent (a concept that was universally foreign to medicine in those days), but in recognizing that this may pose a moral hurdle, Ramm explains that the duty of the physician is to persuade the family, despite possible refusal or objection, that this medical procedure needs to be performed: “*With the application of this law, we must, with great circumspection and special consideration to the feelings of the Volk, give clarification especially to the sense that the law is not demanding expiation for some guilt, but that the one affected has a tragic fate to thank for his genetic illness and that his elimination as a link in the chain of genetics represents a sacrifice in the interests of the Volk community*” (Ramm 2019, 122). In accordance with the Nazi notion that the citizens had a “collective and personal duty to be healthy,” (Bruns 2014a, b) Ramm explains that a person, or a family, with a genetic condition has a “tragic fate” whose destiny lies in the hands of his caring physician whose duty is to “*give psychological comfort to the genetically valued family and relieve them of their anxiety if they have a genetically ill member*” (Ramm 2019, 122). In continuance with the Nazi demand for every German to be healthy, opposition to the sterilization procedure was perceived of as being immoral, or as Ramm writes, to be “false humanity”: “*….the choices of cases must take place with great conscientiousness, with simultaneous consideration of the highest principles of all the physician’s activities so as not to cause injury, keeping in mind the many secret and public opponents of this law, who under cover of false humanity, seek to sabotage our racial hygiene measures*” (Ramm 2019, 124). Some medical students wrote their doctoral theses on sterilization cases, proclaiming the virtue of the law and even attempting to reconcile this practice with the Hippocratic Oath (Duello 2010). The number of German patients who were forcibly sterilized is estimated to be approximately 400,000 (Proctor 1988).

2.10 Positive Eugenics

Negative eugenics played out in the form of the Sterilization Law. Positive eugenics was also to be an integral part of Nazi medical practice. In studying the Marriage Law, students were instructed that their role was to oversee marriage by ensuring that only genetically fit couples were permitted to marry. The Law determined that prospective couples were required to receive certificates of genetic health from public health physicians (Proctor 1988). Ramm perceives this as one of the “most pleasant” duties and provides detailed discussion: “*The prohibition of marriage between a genetically ill person and one healthy is intended, on the one hand to prevent the generation of a genetically ill offspring, and on the other, not bind people with a* *healthy capacity for reproduction to a genetically ill partner.*" Ramm explains how the physician should approach this issue: "*For the physician, the completion of the clearance for marriage certificate does not exhaust his acts as caretaker of the Volk. Being knowledgeable on the genetic predispositions of the family entrusted to him, and given his knowledge and experience on the occasion of every consultation and each visit, during which questions of marriage and reproduction are brought up, he is to advise and clarify, and where he sees danger, effect limitation and hindrance. By the close contact with which he cultivates his charges, and by which he is in the position to practice great influence, there exists for him the high duty to recommend to one or the other Volk comrade, that they only go into a marriage in which there is to be expected no genetic damage to the offspring, but additionally and above all, there is also to be hoped an increase in the genetic value through the joining together of high valued marriage partners*" (Ramm 2019, 127). With this self-explanatory rhetoric, Ramm elucidates another way in which the trusting relationship, essential to medical practice, between physician and patient is to be exploited.

2.11 The Ethics of Medical Gender Policies

The Nazi conception of women, as reproductive rather than political beings, was enshrined in legal doctrine (Proctor 1988; Bock 2004). Many laws and regulations, some mentioned above, were passed to ensure that the biological reproductive function of fit Aryan women was preserved, and they were encouraged to have as many healthy offspring as possible, with contraception being forbidden (Proctor 1988). In his text, Ramm stresses the importance of maternal health, care for pregnant women, post-natal care and the essential role that physicians should play in "preventative medicine for mother and child" as integral to the care for the German nation. "*The female sex is the bearer of the coming generation of our Volk and has therefore a justified right to be acknowledged by everyone in respect to its high responsibilities and achievements, especially by the physician*" (Ramm 2019, 90). These passages, out of context, would be accepted in today's world, but when read in context, another light is shed on the sexist Nazi conception of reproductive health and women's rights, which was embraced fully by the medical profession. The students were taught that one of the physician's duties in the racial state was to "*induce the genetically healthy high valued family to have as many children as possible and tell the less valuable family, or family with endangering biology, that they, in the interests of the maintenance of the racial worth of our Volk, must remain child-poor or childless*" (Ramm 2019, 130). Medical advice was provided to fight infertility, and scientific research was carried out on fertility, including notoriously brutal human experiments (Weindling 2017). Ramm does not explicitly address human experimentation in his text.

2.11.1 Abortion

What he does address is abortion: "*There is a moral duty for every physician to strengthen the desire to have children and thereby guarantee the future of the Volk. As a logical consequence of this, it must be taken to be self-evident that he cannot carry out or recommend, without an extreme degree of justification, any means which leads to contraception, and further that he is permitted to perform an abortion and sterilization only in a legally determined capacity. Thus, it is one of the most noble responsibilities of the physician to protect a germinating life and to carefully guard over it to see that it is not destroyed*" (Ramm 2019, 94). This passage is included in the section on the Criminal Law Code because abortion was legally forbidden for a healthy German woman, and for the performing physician, unless the life of the mother was in danger (Proctor 1988; Bock 2004). "*There is an iron law of this code of honor that the German physician agrees to perform an abortion only if there is a danger to the life of the pregnant woman. Therefore, let this be a warning to each physician that anyone who does not keep to this prescribed way will have his license revoked by the Reich Physicians' Leader, even if there are mitigating circumstances for the perpetrator. Whoever weakens the Volk community through abortion of a fetus is to be placed on the same plane as a traitor to the country and Volk*" (Ramm 2019, 92). Surprisingly, he does not include the Nazi stance on permitting, or even demanding, abortion for eugenic and racial reasons, which was included as an amendment to the original Sterilization Law, allowing abortions for those already slated to be sterilized (Chelouche 2007).

2.12 Confidentiality

The Reich Chamber Ordinance underlined the importance of confidentiality (Haedenkamp 1938a, b), and Ramm echoes this in what he calls the "duty of silence" as a basic tenet to the trusting relationship between physicians and patients. "*The Professional Ordinance puts a very heavy emphasis of protecting the physicians' duty of silence, which is understood to be the protection of each secret that has been entrusted or accessible to him as a physician… This duty of silence is to be adhered to not only during the life of the patient, but even after his death*" (Ramm 2019, 91). However, there were exceptions to this rule, and in cases of certain "behaviors" or genetic illnesses endangering society, the physicians' higher duty was to report these cases (Proctor 1988). A physician in Nazi Germany could be punished for abusing the doctor-patient confidentiality in treating certain patients, but with regard to genetically-inferior patients the physician was obligated to report on their conditions and to ignore or disregard these patients' rights to confidentiality. This approach can be understood in the discussion on the Sterilization Law. "*If, however a sickness, behavior or genetic trait conceals the individual danger to the Volk community, then there is a higher viewpoint which transcends the duty of silence, leading to the duty to* *report and thereby serve to protect the community. We are thinking here of notifying the health authorities of overwhelming sicknesses and the reporting of genetic illness for the purpose of sterilization*" (Ramm 2019, 92). This is just another example of the disparity of the values and ethics that were integral to the Nazi medical profession.

2.13 "Euthanasia"—The Connection to the Final Solution

Ramm poses the question: "*Is the ethical duty of the physician to give, through some intervention or means, release from incurable suffering?*" (Ramm 2019, 94).

The term "euthanasia" literally means "good death," and is most commonly understood today as the bringing about of a merciful death for the terminally, irreversibly ill who are suffering and are in pain. There are two main reasons why it is imperative to include euthanasia in the discourse on Nazi medicine. The first reason is that in Nazi Germany "euthanasia" was demonically used as a euphemism for a devastating state-sponsored medicalized program of the murder of disabled patients by their physicians and nurses (Muller-Hill 1998). "Mercy killing" had been the subject of discussion in the medical ethics field for many years preceding the Nazi takeover. As early as 1920, two eminent German scholars, jurist Karl Binding and psychiatrist Alfred Hoche, proposed the most radical solution to the problem posed by the institutionalized disabled in Germany in their polemical work entitled "Authorization for the Destruction of Life Unworthy of Life" (Binding 2012, originally 1920). Drawing on eugenics, they introduced the idea of "life unworthy of life" and called for the legalization of "mercy killing" for the "mentally or intellectually dead", who were perceived as being a social and economic burden on society. Although implementation of this radical solution was not possible during the period of the democratic Weimar Republic, the book launched a lively debate in scientific circles. As war approached in 1939, the Nazi regime moved to adopt more radical methods of exclusion, and practices that would have been impossible in peacetime became possible during wartime. Coinciding with the outbreak of the war, a "euthanasia" program commenced with the murder of disabled children in around thirty specially established "children's wards" in various state hospitals throughout the country, where specifically selected physicians and nurses killed pediatric patients by starvation or overdoses of sedative drugs. These killings continued throughout the war, and it is estimated that at least 5000 children were victims of this malevolent medical program. Subsequently, the Nazi government broadened the killing process to include adults in what is known as Operation T4 (Robertson et al. 2019). Instead of protesting against this immoral medicalized murderous program, the physicians, who were well aware of the unethical aspect of this program and fearing possible prosecution, asked for a law to legalize it (Aly et al. 1994; Muller-Hill 1998). They never received the requested legislation, but instead relied on a document, personally signed by Hitler, authorizing physician compliance in murdering their patients under the guise of mercy killing (Muller-Hill 1998). As Hermann Pfannmüller, one of the "euthanasia" centers' head physicians, rationalized, "At this point, I for one, consider it appropriate to openly and expressly point out the necessity that, when treating the life unworthy of life, we physicians take the final appropriate action of eradication" (Hohendorf 2016).

Physicians determined and reported which patients would be killed; they aided in establishing six killing centers to implement this task; they experimented on the best method to kill patients, deciding on gas as the killing agent in specifically built gas chambers; they supervised the transports of patients from the various institutions in the Reich to these killing centers, where other physicians decided, on the basis of records alone whether the person would be killed; they operated the gassing process personally, and then determined and pronounced the deaths of these patients; they performed autopsies and other experiments on various body parts of the victims; and finally they sent fake death certificates and ashes to the victims' relatives. In August 1941, Hitler ordered these killings to be halted due to pressure mainly from the Church, but despite this, the medical staff continued to murder their patients with fatal doses of medication or starvation up until the end of the war (Hohendorf 2016; Robertson et al. 2019).

This "euthanasia" program was being implemented while Ramm wrote his manual. He elucidates his viewpoint for his students: "*One of the most noble responsibilities of the physician is to protect the life of the older and weaker people, even if they appear to have lost their mental capacity due to the severity of their illness, and to take them carefully into his protection so as to alleviate their pain and suffering according to his best ability up until the entry of releasing death.*" (Ramm 2019, 94). He proceeds to point out that according to the law, mercy killing is forbidden, even if it entails the relief of suffering. He then continues with the use of the term "euthanasia" to describe the position that physicians were expected to adopt in the cases involving the disabled or genetically inferior patients: "*The problem of Euthanasia extends however to people afflicted with intellectual and physical genetic illnesses, who can never develop normally and are always arrested at some low developmental level, especially in people in whom genetic traits produce later disintegration of their intellectual personality. This merely vegetative creature places a terrible burden on the Volk community to the extent that it drives down the living standards of the remaining family members, and requires a person to care for it during the remainder of its life*" (Ramm 2019, 95). We can, once again, understand that the Nazi medical ethical perception of the value of life had contrasting positions. For the genetically fit dying Germans, compassionate care was to be provided until their final days, but the genetically disabled and infirm, who in most cases clearly were not suffering from terminal illnesses but were posing an economic burden on society, were "vegetative creatures" not worthy of living. "*If a person is burdened by a terrible agony from an incurable suffering or if the intellect disintegrates from continuing derangement, then doubtless on the grounds of humanity, euthanasia would be appropriate to consider. It is the responsibility of the medical profession to be the forerunner in this consideration and the responsibility of the state to confer this on him as a force of law*" (Ramm 2019, 95). As mentioned above this never became a force of law, but this did not prevent physicians, together with other medical staff, from murdering an estimated 300,000 adult patients under the guise of mercy killing (Hohendorf 2016).

The second reason for the importance of discourse on the "euthanasia" program was that it was in effect the opening act of the Nazi genocide, the Holocaust. Jewish disabled patients were murdered in the T4 killing centers just because they were Jewish, forming the earliest link between "euthanasia" and the Final Solution. In 1940, German concentration camps were growing in number and size, but did not yet possess the facilities to kill the rapidly growing number of inmates. To reduce the population, the SS therefore turned to the T4 personnel to utilize their killing capabilities. Thereafter, a new killing operation commenced, designated as "Special Treatment 14f13", during which SS camp physicians selected disabled and Jewish inmates to be sent to T4 physicians who murdered them in the T4 centers' gas chambers, proving yet another link in the chain between "euthanasia" and genocide. Subsequently in June 1941, the German army invaded the Soviet Union, embarking on mass executions of Jewish civilians, among whom were disabled hospitalized patients. When the civilian mass murders proved to be too public, a better method was searched for and concentration camp staff turned, once again, to the T4 personnel, among them many physicians, for their expertise on how to construct gas chambers and which gas to use, based on the use of gas chambers in the T4 centers (Friedlander 1995; Robertson et al. 2019).

This was simple murder in disguise and could have been implemented without the actual participation of trained medical staff. Physicians realized what they were doing as they witnessed the agony of their victims but nevertheless, continued to inflict killing as part of their medical work. These physicians were not compelled to comply with the directives. Even when the "euthanasia" program was officially halted in 1941, they consciously decided to continue the killings (Friedlander 1995). The physicians who participated in murdering their patients were mostly young physicians (Friedlander 1995), who had graduated in the early years of the war when Ramm's textbook was used as an integral manual for their compulsory courses on medical ethics. Some of the lecturers in the ethics courses were actively involved in the "euthanasia" program while simultaneously delivering classes on medical ethics to their students (Bruns and Chelouche 2017). The entire medicalized killing enterprise that had started in January 1940, with the murder of the most helpless and vulnerable human beings, the institutionalized handicapped patients, had expanded in 1941 to include Jews and Roma (Gypsies), and had by 1945 cost the lives of at least 6 million men, women, and children (Friedlander 1995).

2.14 Conclusion

Reflecting on the ethic of medical practice in Nazi Germany through the lens of Ramm's book illuminates the fact that medicine under the Nazis cannot be conceived as arising from an absence of morality. Nazi physicians did not abandon, nor did they ignore ethics. As with every ethical system, including our present one, the Nazi medical ethic was greatly influenced by the political and social culture of the time, and a twisted, corrupt Nazi version of medical ethics was created to rationalize and substantiate their health policies. The Nazification of the medical profession was a long and deliberate process and was accomplished with the assistance of the whole German medical profession, including distinguished physicians who, like Ramm, provided ethical justification for the unethical practice of medicine. We cannot dismiss the Nazi physicians without contemplating how they functioned. We cannot distance ourselves from this history by claiming that it is irrelevant. Even though it is largely unknown and untaught, every aspect of modern medical ethics has been, and continues to be, profoundly affected by the acts of the Nazi physicians during the Holocaust (Wynia et al. 2015). The reading of this important instructive manuscript, with the aim of trying to understand under what circumstances it was published and how it was used, serve us well in reminding us that ethics instruction does not ensure future virtuous medical practice. In addition, the existence of codes and directives and in this case, ethical textbooks, does not assure moral integrity. In fact, Ramm's work shows us just how training and education can be used deleteriously. Medical professionals, and medical ethics teachers, would be wise to use this part of medical history to inform the modern medical ethics discussions, because internalizing this history can contribute to future physicians' realization that they are not invulnerable to unethical or immoral conduct. It can serve to remind us that in certain circumstances, physicians can be at risk of repeating these behaviors, in some form, if we do not recognize our own capacity for moral transgressions (Waller 2007). Using the platform of studying medicine during the Holocaust, including reflection on Ramm's textbook, can aid in educating students on their path to becoming future physicians where they will be called upon to reflect constantly on their ethical and moral views. This study can remind them to be vigilantly observant of external factors that may affect their decisions and can assist in emphasizing the importance of retaining their personal empathy (Horton 2019; Reis et al. 2019; Levine et al. 2019). Medical training is naturally hierarchal and tends to encourage a culture of subordination, especially in a culture like Nazi Germany, but our crucial role in education is to remind students that it is essential to realize their ability to differentiate right from wrong, even when they may be taught otherwise.

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Chapter 3

The Role of Professions in a State: The Effects of the Nazi Experience on Health Care Professionalism

Robert Baker and Matthew K. Wynia

Abstract This paper reviews three competing ways of organizing health care delivery—professionalism, consumerism and statism—and explores how Germany's exclusively statist model facilitated the ascendency of an alternative Nazi medical ethics predicated on eugenic conceptions of national "race hygiene." The primary obligation of health care personnel became using their skills and knowledge to achieve the aims of the Nazi state, which justified forcible eugenic sterilization programs, and then the killing of children and adults with mental or physical disabilities and, eventually, the medicalized mass murder of other groups seen to pose a genetic threat to the health of the state, such as homosexuals, Jews, and Roma. The evolving international response to these medical crimes would come to affect medical professional approaches to virtually every issue in contemporary Bioethics, from abortion to xenotransplantation. In the early post-war years, news of German health care professionals' participation in these actions shocked fellow health care professionals. Many denied these accounts, some defended German researchers, others dismissed the Germans' justifications of their actions as madness parading as medicine or medical ethics. Ultimately, however, reformers seeking to remedy or prevent actions reminiscent of Nazi medicine created the foundational documents of modern health care professional ethics and the new field of Bioethics. These are the Nuremberg Code, the Declaration of Geneva, and the Belmont Report. In firmly rejecting Nazi medical ethics, these documents emphasize the rights of autonomous individuals, with health professionals serving as their agents, thus cementing modern ideals of health care professionalism.

Sections of this chapter been adapted from Baker (2020a, b), Wynia (2008, 2012).

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3.1 Organizing Medical Work: Consumerism, Professionalism, or Statism

3.1.1 Introduction

Both the core values of health care professionals and the place of health care professionals in contemporary society are often taken for granted. For many people, the modern structures and ideals of professionalism in health care seem so obvious as to be unquestioned features of the landscape. They are the air we breathe, the water in which we swim—little noticed, at least until they are polluted. It may seem natural that one must be properly trained and licensed to practice medicine. It may be equally obvious that potentially dangerous medications must be tested by medical researchers and approved by medical regulators before they can be used, or that health professionals must establish and enforce educational, ethical and practice standards for themselves. Perhaps the only aspect of modern health care professionalism even more obvious than these structural features is its moral focus: health care professionals must be altruistically devoted to protecting the well-being of their patients. But it has not always been so. In fact, the Holocaus—coming as it did during the formative years of modern health care professionalism, and just before the birth of Bioethics as a field—was tremendously influential in the development of current professional structures and ideals.

3.1.2 Professionalism is a Choice

Medicine, and health care more broadly, along with the clerical and legal fields are classic "learned professions." The health care fields have been so successful in building and sustaining the core structures of professionalism over the last 150 years that one could be forgiven for thinking that health care work, by its very nature, is such that it *must* be organized as a profession, and it *must* have an internal morality of altruistic devotion to the sick at its heart. Indeed, some of the most influential founders of the field of Bioethics have argued as much (Pellegrino and Thomasma 1981), and many still believe in the existence of a natural internal morality of medicine today (Sulmasy Daniel 2019). Skeptics, however, argue that professionalism in medicine is simply a form of organization whose ethics amounts to whatever its members deem best suits their interests to proclaim (Applbaum 1999).

The view that professionalism in health care *must* be predicated on an internal morality focused on protecting patients as its core value is appealing, not least because such a belief is a direct rebuke to the Nazi doctors, who embraced a conception of medical science that explicitly rejected this view. Holding this belief allows medical professionals to say that what Nazi doctors and other German health care workers did during the 1930–40s was a betrayal of the essence of medical work. They were not really health professionals at all, having rejected the essential nature of the field.

Not coincidentally, however, this is a tautological way of separating us from them, since health care professionals, as we define the field today, by definition differ from the Nazi doctors, as they defined themselves.

Regardless of whether essentialist views about the internal morality of medicine hold, the existence of the Nazi doctors clearly proves two things about health care professionalism. First, professionalism is just one choice for how to organize and deliver health care services; other choices are possible. Second, the traditional health care ethics of altruistic devotion to individuals who are sick, wounded or vulnerable to disease is just one possible aim of health care services; other aims are possible.

3.1.3 Defining Professionalism

In considering these issues, it is helpful first to consider the origins of the term, *professionalism* (Wynia 2010). The root of the word is the Latin verb, *profere*, which means, to promise. To *profess* something is to publicly affirm or announce something, such as one's faith. A couple will *profess* their commitment to each other in a marriage ceremony, and *professors* affirm their beliefs in their teachings to students. These examples illustrate an important feature of the word, *profess*; to profess something is not a private act, it is an open, public declaration.

The noun "profession" designates a group of people who make such public declarations together. Hence the *professions* of medicine, teaching, law, engineering and more—all are groups who make public promises about the competencies, training and ethics the public can expect when interacting with members of their group. Professions also make declarations about why they should be trusted to uphold these promises, describing how they will regulate themselves. Importantly, many core structures of professions, such as codes of ethics, educational standards, and legal self-regulatory mechanisms, like licensure boards, are intended to reinforce public trust in the professed promises of the group.

Building further on this foundation, the word "professional," is either a noun, naming someone as a member of the group, or it can be an adjective describing knowledge, actions or attitudes that are in conformance with the declared standards of the group (these are *professional* behaviors or attitudes) or not (which would be *unprofessional* behaviors or attitudes).

What, then, is "professional-*ism*"? In short, it is an -ism. That is, *professionalism*, like other words that end in -ism—such as Catholicism, pragmatism, capitalism, consumerism, communism, racism, sexism and many others—are fundamentally systems of acting and believing. The -ism examples just listed reflect ways of acting towards and thinking about a deity, goods, services, or people with designated racial and/or and gender roles (Wynia et al. 2014). These examples also illustrate that each "-ism" is attached to a root word that is at the heart of its system of beliefs and behaviors. So, racism posits (incorrectly, we hasten to add) that differences between human 'races' should be organizing features of society. Capitalism posits the free movement of capital as a central organizing principle of a good society.

Libertarianism focuses on personal and organizational liberties in free markets as a means of producing optimal benefits across a society. Similarly, "professionalism" posits a critical role for professional groups (i.e., groups with specialized expertise that are granted the privilege of setting and enforcing their own practice standards) in creating and sustaining a good society.

To summarize, professionalism is the belief that the best way to organize and deliver a particular type of goods or services is to have a group of people dedicated to the task, and that this dedicated group should be charged with—and trusted to—establish, articulate (profess) and enforce standards of training and practice for the group, including its ethical standards. *Health care* professionalism more specifically (or medical professionalism, nursing professionalism, dental professionalism, and so on), is the belief that health care work is the type of work that *ought* to be organized, delivered and overseen as a profession.

3.1.4 Why Choose Professionalism in Health Care?

The primary reason to argue that health care work *ought* to be organized and delivered under a professionalism model is the combined moral and practical features of health care work. From a moral standpoint, people seeking health care services are often in a position of vulnerability, due to illness or their relative lack of knowledge about the technical aspects of health care treatments, and so may be vulnerable to exploitation—feeling they have no choice but to do as the health professional says and pay what the health professional charges. Thus, whereas "buyer beware" (*caveat emptor)* might work for many other consumer goods and services, it is an insufficient method for protecting people seeking assistance as they battle disease. Modern health care professionalism promises that due to codes of ethics and extensive socialization into the moral norms of the profession—which focus largely on protecting patients—patients today can and should regard health professionals as their trusted agents, rather than sales agents (so-called "snake oil" hucksters), corporate agents, or agents of the state.

As a practical matter, the rapidly evolving and often technical nature of health care work—requiring literally years of study and lifelong "practice"—makes it impractical for individual patients or even regulators external to the profession to fully understand the nuances of how best to establish and monitor practice standards. Consequently, the self-regulation promised by the profession is asserted to be more effective than regulation by the state or through the free market—assuming, of course, that the profession lives up to its promises.

These are strong theoretical moral and practical reasons for preferring to organize health care as a profession. But the existence of the Nazi doctors also offers tangible historical evidence of the potential risks in adopting alternative mechanisms for organizing health care and its ethics. We will have more to say on this below, but in brief, the history of health care's involvement in Nazi medical crimes provides perhaps the most compelling argument today supporting the notion that health care *should* be organized around a group of independent professionals (i.e., professionalism) and that this group should be primarily dedicated to the well-being of individual patients.

3.1.5 Options Other Than Professionalism

The two main alternatives to professionalism in health care we will call health care *consumerism* and health care *statism.*[1] In each of these alternatives, there is a central role for a different actor in establishing and enforcing standards, setting prices, and otherwise governing health care work. In health care *consumerism*, consumers of health care goods and services (who are called patients in the professionalism model) play central roles in deciding which practice standards matter most to them, and they are also responsible for determining for themselves whether a health care practitioner is living up to those standards. Tools supporting consumerism include those that promote transparency about costs and quality, to help informed consumers make better choices about which services they prefer to receive, which practitioners to hire, and at what price.

While consumerism is different from professionalism in its basic beliefs, and they sometimes directly conflict with each other, there are areas where consumerism and professionalism complement each other and can provide balancing forces more effective at producing high quality care at reasonable cost than either approach alone. In other words, it is possible, and probably desirable, that a health care system incorporate some features reflecting a belief in professionalism and some reflecting a belief in consumerism.

Statist systems place the state/government in a central role in organizing and monitoring the quality of health care services, which offers important opportunities for the coordination of health care personnel and services to achieve broad social aims that would be much more challenging, or even impossible, to achieve using a consumerism model. For example, statist systems are well-suited to implement public health initiatives, such as the Nazi public health programs banning tobacco to prevent cancer and encouraging consumption of whole grain breads (Proctor 1988, 1999), and to implementing cost controls, like setting prices for medical services (Haedenkamp 1938) and increasing the numbers of patients cared for in German "sickness funds" (Levine et al. 2020). Moreover, insofar as governments reflect the will of the people, there is ethical legitimacy to using the power of the state to regulate health care in ways that seek to ensure it is marshalled to achieve societal aims.

As with consumerism, there are times when professionalism and statism come into direct conflict, and others when they can be mutually reinforcing. The Nazis,

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[1] The sociologist Elliot Freidson called professionalism "The Third Logic" because it contrasted with these two alternative models, or "ideal types," for organizing and delivering goods and services in society, which he called free market and bureaucracy (Freidson 2001).

however, exerted strong state control over health care ethics, with a sole focus on the German people *(Volk)* as the primary "patient" for all doctors. This led German medical personnel to act in ways directly contrary to Hippocratic traditions. But to understand the path to statism that Nazi medicine followed, we must trace some international trends in medicine-state relations leading up to the 1930s.

3.1.6 Ancient Arguments About the Ethics of Health Care

For generations prior to the Holocaust, there had been disagreement among physicians and other health workers about their proper social roles and ethics. These disagreements were not always explicit, since it was not always obvious to those putting forth the arguments that people working in health care comprised a clear social group, and the language of "professionalism" in health care or any other field was not used until the 1800s. Still, for over 2000 years before the Holocaust, different visions for medical ethics had been proposed.

These differing visions, which remain important today, are illustrated in two brief historical vignettes about the actions of two ancient physicians, both of whom lived about 400 years after Hippocrates. First, is the story of Agrippina (AD15-59), the wife of the Emperor Claudius (AD41-54). When their marital relationship soured, she reportedly called on his doctor (Gaius Stertinius Xenophon, c. 10 BC–54 AD) for help in poisoning her husband. Apparently, he agreed to use his technical expertise on herbs and potions to help her, without particular concern for his reputation as a doctor (Tacitus, *The Annals* Book XIV, 1–16). His expertise was purely technical, with no necessary moral underpinning separate from serving his client, the Empress.

An alternative ideal of medical ethics was described by Scribonius Largus (fl. ca. 14–54), a military physician who served in the armies and at the court of the Emperor Claudius. As a follower of Hippocrates, Scribonius took seriously the Hippocratic injunction to "do no harm." When allegations arose from Cato the Elder (234–139 BCE) and Pliny the Elder (23–79) that "Greek doctors exploit[ed] the sick [prisoners]…[by] testing remedies at the expense of human lives," Scribonius defended his fellow Greek physicians by invoking the Hippocratic Oath, writing:

> No man bound by the medical profession [i.e., the Hippocratic Oath] will give dangerous drugs to anyone, even to enemies of the state, although when events demand, the same physician will fight against these men as a soldier and good citizen with every means at his disposal. This is because Medicine truly promises her assistance in equal measure to all who seek her aid, and she swears never to injure anyone deliberately, for she judges men neither by their fortune or their character…For medicine is a science of healing, not of harming. Unless Medicine fully devotes herself with all her resources to the aid of the suffering, she does not provide the mercy promised to all of mankind. (Tempkin 1991, 60; Hamilton 1986, 213–214)

These contrasting stories—one of a physician prioritizing his empress's request to kill her husband, the other of a physician prioritizing healing even over the interests of his state—suggest that, as the anthropologist Margaret Mead noted, Hippocratic physicians may have been the first to distinguish the social roles of physician as healer from that of a mere expert purveyor of benign or deadly drugs (Bulger and Barbato 2000).

3.1.7 *Early Development of Modern Professionalism*

Medical practitioners would wait through the Middle Ages (Geraghty and Wynia 2000a, b), until Thomas Percival (1740–1804), would first coin the terms "medical ethics" and "professional ethics" in the late 1700s (Baker et al. 1999, xix). Percival also articulated a practical rationale for establishing and enforcing shared ethical responsibilities for all doctors: the urgent need for better teamwork. His own hospital, the Manchester Infirmary, had been riven by public feuds between competing doctors (Baker et al. 1999; Pickstone 1993; Wynia and Kurlander 2007).

But Percival's notion of a profession was never widely adopted in nineteenth-century England. The British medical establishment saw a shared code of ethics as unnecessary because English doctors were gentlemen who already knew how to behave. Proposing the need for a code was insulting, and some thought a written code could be counterproductive, "useful only to persons who, lacking decent character, wish to pretend that they had one" (Baker 2013, 97).

American medicine, in contrast, was ripe for development and adoption of an explicit, shared code of medical ethics. Like their English counterparts, American doctors were suffering from medical chaos at the time, with multiple competing ideologies of medical practice (Thomsonianism, Eclecticism, and more), no medical training standards, and widely disparate values among practitioners, many of whom were blatantly commercial.[2] Internecine conflict among these competing practitioners led to pamphlet wars and sometimes duels but, unlike in England, Americans were not steeped in presumptions of class-based virtue and were more inclined toward social mobility, free contracts between equals, and French enlightenment ideals of social contracts as governing relations within communities. Following local efforts especially in Baltimore and New York, an explicit social contract for the entire US medical profession was first published as the *Code of Medical Ethics of the American Medical Association*, at the organization's founding meeting in 1847 (Baker et al. 1999, Appendices A, B, C).

As the first code of ethics adopted nationally by any professional medical society anywhere, the AMA's code was widely hailed as revolutionary. One commentator at

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[2] Thomsonian practitioners, for example, modeled themselves as alternatives to pharmacists and like pharmacists advertised freely and sold the rights to prescribe their medications only to those pledged to follow the teaching of their founder, Samuel Thomson. In contrast the AMA's 1847 Code of Ethics and its successors forbade advertising, prohibited patenting medicines, and required members to consult with and share treatment information with each other (American Medical Association (1847, 1999; Berman 1951).

the time called it "the most important public document since the Declaration of Independence" (Baker et al.1999), because it made an explicit, combined and integrated set of promises from doctors—as a group—to their patients, their colleagues and their communities regarding their scientific, ethical and service orientation. For example, it promised that all physicians would undergo training in "scientific medicine" and be "conservators of the public health." Through it, doctors also promised to protect patient confidences, treat the poor free of charge, and during epidemics "face the danger, and continue their labors for the alleviation of the suffering even at the jeopardy of their own lives" (Baker et al. 1999, 333).

Philosophically, the 1847 AMA Code was based on moral notions of *reciprocity*, with society, physicians and individual patients all receiving explicit benefits and having explicit reciprocal obligations. The Code thus followed in the tradition of Hippocrates, Gregory and Percival—but it succeeded where the others had not in making the profession's social promises as a collective, that is, *as a profession*, rather than as individual commitments. And, presciently, the Code emphasized a careful balance of obligations for physicians to patients, the community and each other.

How best to achieve this balance has remained a matter for debate to the current day (Wynia and Kurlander 2007; Geraghty and Wynia 2000b), but by the eighteenth century in Europe the concepts of "social medicine" and "medical police" of Johann Peter Frank (1745–1821) had been adopted across the German speaking countries and Italy (Lindemann 1996). Moreover, across Europe medicine was increasingly seen as valuable for achieving civic aims, with medical personnel acting as agents of an enlightened state. This became apparent during the French Revolution (1789–1799), which included a bloody experiment with a completely "free market" in health care. Disabused of the virtues of free enterprise in medicine the French government created a national system of physician training and licensure by 1803 (Geraghty and Wynia 2000b). Meanwhile radicalized European physicians came to view medicine as not just affected by, but as integral with, public policy. For example, the 1848 famine and typhus outbreak in Upper Silesia (modern-day Poland) was famously investigated by Rudolph Virchow (1821–1902), and the experience led him to conclude that:

> Medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time. Let it be well understood, it is no longer a question of treating one typhus patient or another by drugs or by the regulation of food, housing and clothing. Our task now consists in [improving] the culture of 1½ millions of our fellow citizens who are at the lowest level of moral and physical degradation. (Virchow 1848, reprinted in 2006)

In brief, for Virchow and an increasing number of physicians of his age, free enterprise medicine had to be supplanted by social medicine, and health care should be strongly influential in and strongly supported by state policies.

3.2 Nazi Statist Professionalism and Race-Based Medical Ethics

3.2.1 German Medicine's Embrace of a Pure Statist Approach

When the National Socialist German Workers party (*Nationalsozialistische Deutsche Arbeiterpartei*—the NSDAP or NAZI party) assumed control of the German state in early 1933–1934 they inherited a statist model of national health insurance, which had been initiated in 1884 by Prince Otto von Bismarck, Chancellor of Germany, as one of many ways to unify the young German State (created from various German states and principalities in 1871). Thus, the Nazi government was in command of a statist system of health care financing, and like many European and American doctors of the time, many German doctors already believed in combining state powers and "social medicine" to improve public health. There was also, in the wake of Germany's defeat in World War I, an oversupply of physicians—11% of whom were Jewish (US Holocaust Museum)—rising physician unemployment, and physician financial distress. These were often blamed on Jews and communists, who were accused of "stabbing Germany in the back" at the end of the war (Levine et al. 2020), a factor that amplified the number of German physicians supporting the Nazi's call to "synchronize" the profession (Kater 1989) around a "radical nationalist consensus on national rebirth" (Jarausch 2001, 8).

Still, when the Nazis came to power independent medical professional associations published medical journals and set professional standards. By October 1933, however, all prior independent associations were disbanded and replaced by a single German *Federal Chamber of Physicians* (Seidelman 1996a, b), from which Jewish physicians were excluded and with a single medical journal that would be strongly supportive of Nazi health policies (Image 3.1). By 1938, the German medical practice law was re-issued. According to an approving commentary by Karl Haedenkamp the new law would achieve the "reform and unification of medical practice throughout Germany" (Haedenkamp 1938, 1749). Doctors were required to "actively support all State measures for increasing the numbers and racial purity of the population…(1749)" and "the doctor must not charge a fee higher than that permitted by the statutory scale of charges, (1750)" and use of contraceptives and abortions were prohibited without state approval, though for eugenic purposes "sterilization can be performed without the subject's consent" (Haedenkamp 1938, 1750). Overall, the new law had three explicit aims: first, to unify the profession around their duties toward the state (e.g., it's preamble said, "the duty of the medical profession as a group [is] to preserve and promote the nation's health, sound heredity, and racial purity" (Seidelman, 1996a, 1695); second, to turn away from consumerism (i.e., to "protect the medical calling from becoming commercialized;" (Haedenkamp 1938, 1751)) and third, to reduce the independence of physicians (e.g., it "abolishes or

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Image 3.1 German Medical Journal, "*Deutsches Ärtzeblatt*", July 1, 1933

limits many of the liberties which the medical practitioner previously enjoyed." (Haedenkamp 1938, 1751).

By 1938 the Nazi's had amplified and expanded the statist health care financing system they inherited and introduced statist ways of organizing, delivering, and thinking about health, including standards of practice and ethics. They also took multiple steps to explicitly diminish any role for consumerism or professionalism (Ramm 1943). These steps were designed to achieve the "Nazification" of German medicine, with health care professionals working in concert to achieve the aims of the Nazi state, which Nazi leaders saw as fundamentally medical in nature. As such, they believed success for the Nazi project would require not just medical participation but medical leadership. Hitler's deputy, Rudolph Hess, called Nazism "applied biology," (Kakel 2011) and Joseph Goebbels, the Nazi Minister of Propaganda, said, "Our starting point is not the individual, and we do not subscribe to the view that one should feed the hungry, give drink to the thirsty, or clothe the naked… Our objectives are entirely different: we must have a healthy people in order to prevail in the world" (US Holocaust Memorial Museum, *Deadly Medicine: Creating* *a Master Race*, available at: https://encyclopedia.ushmm.org/content/en/article/deadly-medicine-creating-the-master-race). In 1933, Dr. Ernst Rudin (1874–1952), the prominent Swiss psychiatrist and fervent eugenicist (who would receive awards from Hitler for his work on the Nazi forcible sterilization program) said that doctors should be primarily responsible for "preservation of the healthy hereditary elements and eradication of the pathologic elements" in society (Seidelman 1996a,1694). Hitler himself, who was portrayed in propaganda images as the "Doctor of the German People" (Image 3.2) argued in an early speech before the National Socialist Physicians' League, that he could, if need be, do without lawyers, engineers, and builders, but that "you, you National Socialist doctors, I cannot do without you for a single day, not a single hour. If not for you, if you fail me, then all is lost" (Proctor 1988, 64).

In the end, the Nazis rewrote the German medical profession's basic ethical promises to society along statist lines. In doing so, they replaced traditional medical ethics with a eugenic ethics whose primary focus was promotion of "racial hygeine,“ *Rassenhygiene*, a concept that was initially proposed by Alfred Ploetz (1860–1940) in his 1895 book, *The Foundations of Racial Hygiene*, and later revised by Nazi intelligentsia, like Ernst Rüdin, who brought his eugenic beliefs to a series of psychiatric inheritance studies and eventually became the director of the Max Planck Institute

Image 3.2 "Adolf Hitler: Doctor of the German People" *Die Volksgesundheitswacht* Ostermond 1935, p. 3—from USHMM

of Psychiatry in Munich and an infamous Nazi leader. The German medical profession's new ethical promise placed the genetic purity and health of the German *Volk*, i.e., a people connected to each other genetically and culturally, above the needs of individual people; in effect, prioritizing the nation's genetic future above the welfare of anyone living in the present. (Proctor 1988). These linguistic distinctions might be dismissed as mere ideological semantics, political correctness, so to speak, had they not laid the foundations for a moral revolution affecting medical practice as the Nazi government officially proclaimed the state and its medical professions "Guardian of the Health of the *Volk*" (Baker 2019). As Rudolf Ramm (1887–1945) explained in his textbook on medical jurisprudence—the only medical ethics textbook used in German medical schools from 1942 through 1945—this meant that the traditional focus on curing the sick and ameliorating their suffering was secondary to a new primary objective of German health care, "the maintenance and promotion of a healthy genetic makeup and racial purity of the German *Volk.*" (Ramm (1943) 2019) By virtue of *Bevolkerungpolitiks*, i.e., a politics for the *Volk*, the medical and political were intertwined as one (Bruns and Chelouche 2017; Ramm (1943) 2019). As guardians of the health of the *Volk*, public health authorities promoted healthy eating (whole grain rather than white bread, for example), and prohibited acts that "weaken the *Volk* community through the abortion of a fetus" (Ramm (1943) 2019, 92) and forbade euthanasia, although both acts were permissible or even ethically required for non-*Volk* or for so-called "useless eaters," i.e., people with mental or physical disability (Ramm (1943) 2019).

Notoriously, such non-*Volk* as Jews and Roma, as well as dysgenic *Volk* with physical or mental disabilities, including, in the view of the Nazis, homosexuals, came to be viewed as threats to the genetic purity of the *Volk*. The 1933 law "For the Prevention of Progeny of Sufferers from Hereditary Diseases," became the rationale for the 1939 genetic health care initiative, for the eugenic *euthanasie* (euthanasia) of dysgenic children: a systematic program for protecting the German *Volk*'s gene pool by culling, i.e., killing, children with disabilities. To implement this initiative physicians, nurses, and midwives were required to report infants and children who showed signs of mental or physical disability to public health authorities (Ramm (1943) 2019). They were also to encourage parents of such children to admit them to "special children's wards," where the children were covertly "euthanized," i.e., killed by health care practitioners. In 1939 the child "euthanasia" program was expanded to include *euthanasie*[3] for institutionalized adults with disabilities, in the *Aktion T4* program, which later served as a model for the wholesale extermination of Jews and Roma in the Holocaust. And, of course, medical personnel led the most infamous of Nazi medical crimes, the heinous experiments carried out on unwilling victims.

International revulsion over these medical crimes would come to permeate thinking around medical professionalism in subsequent decades. Sometimes, the

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[3] The word 'euthanasie' was introduced to the German lexicon in Adolf Jost's 1895 book (*Das Recht auf Den Tod*), (T*he Right to Die).* Although *euthanasie* was a translation of the English word 'euthanasia,' in the sense of mercy killing, Jost's translation broadened the meaning to include the right to kill those who placed an undue burden on society.

links to contemporary ethical issues would be more explicit (such as in debates about assisted dying or abortion, or around genetic ethics), in others it would be more implicit (such as in debates about appropriate roles for physicians in cost-control, or in public health ethics). But more important than a link to any specific issue is the fact that international responses to this history would come to frame the medical profession's way of thinking about its social role.

3.3 Medicine's Response to the Nazi Challenges to Professional Ethics

3.3.1 Western Medical Professions' Reaction to the Holocaust

"We read the world wrong and say that it deceives us" (Tagore 1972). Physician Elisabeth Kübler-Ross (1926–2004) quotes this line from Indian poet Rabindranath Tagore (1861–1941) to explain the phenomenon of denial: peoples' initial impulse to reject bad news as, somehow, false (Kübler-Ross 1972, 50). Tagore's line also encapsulates Western health care professionals' initial reaction to information about their German colleagues' complicity in the so-called "child euthanasia" program, *Aktion T4* and the Holocaust, and the use of people as involuntary human guinea pigs. They were incredulous! In 1946, for example, the eminent British scientist Sir Kenneth Mellanby, OBE (1908–1993) confessed "a great deal of sympathy for some of those [German medical professionals] who were responsible for carrying out [controversial medical] experiments…. especially serious research workers….Given the chance of using prisoners for experiments, which one believed to be of great importance and value to mankind… if…the victims were dangerous criminals who were anyhow condemned to death and likely to die in some particularly abominable manner?" Mellanby was "not sure what [he] should have done" (Mellanby 1946, 850).

Dr. Klaus Karl Schilling (1871–1946) was one of the German researchers that Mellanby defended. He described Schilling as an

> eminent malariologist, [who] was hanged for his part in experiments in which some 1200 prisoners were infected with malaria.… He was over 70 when these experiments were carried out. Believing that the experiments would provide an unequalled opportunity for the advancement of malariology he used a mild strain of benign tertian malaria which would be unlikely to prove fatal in healthy individuals, and he himself appears always to have administered drugs carefully and scientifically. He is said usually to have obtained the consent of the prisoners before he infected them. (Mellanby 1947, 148–150)

As late as 1973 Mellanby was defending Schilling as "a scientist of international reputation, for some years a leading member of the League of Nations Malaria Commission… [who] infected over a thousand prisoners with malaria, and, according to the indictment, several hundred died of the disease. I simply do not believe this."

Citing a reason for his disbelief, Mellanby remarked that, “Those who knew and worked with [Schilling] did not think that he would be a party to serious and inhumane crimes.” (Mellanby 1973, 106–107). For Mellanby, his profession was an old boys’ club whose rules, written and unwritten, protected and advanced the interests of fellow gentlemen like himself, i.e., men who had gone to the right schools, who talked the right way, and who instinctively knew what was and was not, “the done thing.” It was simply unthinkable to Mellanby that Schilling, “a scientist of international reputation, for some years a leading member of the League of Nations Malaria Commission,” could have done the deeds attributed to him. After all, other club members “who knew and worked with him did not think that he would be a party to serious and inhumane crimes.” (Baker 2020a, b; Wilson 2014).

“When the first stage of denial cannot be maintained any longer,” Kübler-Ross observes, “it is replaced by feelings of anger, rage…and resentment…. This anger is displaced in all directions and projected onto the environment at times almost at random” (Kübler-Ross 1972, 50). As if following Kübler-Ross’s script, Mellanby and others of his generation projected their anger onto the Nuremberg War Crimes Tribunal. They failed to appreciate that, by focusing attention on a few bad actors, like Schilling, the Tribunal shielded the bulk of German health care professionals, such as the midwives, nurses and physicians who, acting in response to the law “For the Prevention of Progeny of Sufferers from Hereditary Diseases,” reported children with disabilities to authorities, who, in turn, covertly, “euthanized” them. In effect, an implicit bargain was struck between the allied groups occupying Germany and the German health care professions: prosecute and punish a few notorious malefactors but allow the great majority of health care professionals who were complicit in less nefarious deeds to go unpunished so that they could serve the needs of the public—provided that these professionals promised to behave themselves in the future. This implicit bargain was formalized in two promissory notes, both issued in 1947: the Nuremberg Code and the Declaration of Geneva.

3.3.2 The 1947 Nuremberg Code and the Declaration of Geneva as Promissory Notes

The first of the foundational documents of modern professional medical ethics, now known as “the Nuremberg Code,” was initially an addendum to the verdict in the case of *US vs. Karl Brandt, et al.* (the “Nuremberg Doctors’ Trial”) (Nuremberg Tribunal 1949). It stipulated ten sets of presumptively universally accepted do’s and don’ts for ethical research on humans. By spelling out this code the Tribunal camouflaged the embarrassing truth that, in fact, there was no such universal code: not in America, not in Britain, not in continental Europe—except, perhaps, for a 1931 German Health Council (*Reichgesundheitsrat*) regulation addressing research on *patients*, and a Prussian precursor. Neither of these addressed experiments on prisoners, and both had been purged in the 1930*s*, because they were inconsistent with the Nazi ethics of *Rassenhygiene* (Grodin 1992).

To cope with the embarrassing absence of professional ethics standards governing research on humans, prosecutors and their witnesses turned to the oldest and best-known formulation of medical ethics in the Western canon, the Hippocratic Oath. Appealing to this purportedly universal statement of the internal morality of the health care professions, the lead prosecutor, Brigadier General Telford Taylor (1908–1998), opened the trial by proclaiming that this was "'no mere murder trial" because the defendants were physicians who had sworn to "do no harm" and to "abide by the Hippocratic Oath" (Shuster 1997, 1437). Taylor's claim was historically inaccurate. Although Hippocratic matriculation, graduation, and induction oaths were once common in Europe, they were abandoned during the interwar period and were often supplanted in communist and fascist regimes by pledges of loyalty to a class, a leader, a party, a people, or a race (Lifton 1986; Weindling 2004) Yet, since necessity is, as always, mother of invention, fictions can and often do displace irritating facts, and the German researchers' violations of the oath became a recurring theme throughout the trial. Thus, Andrew Conway Ivy (1893–1978), the AMA's observer at the trial, testified that "the Hippocratic Oath represents the Golden Rule of the medical profession…throughout the world," consequently researchers should "have respect for life and the human Rights of his experimental patient" (Ivy 1946; Schuster 1997, 1439).

Prosecutors focused on two very different types of experiments at the Nuremberg trials: experiments on therapeutics, like Schillings' malaria experiments, and so-called "thanatological" experiments like those at Auschwitz and Ravensbrueck concentration camps designed to perfect methods of mass sterilization or mass killing in furtherance of *Rassenhygiene* initiatives. The Nuremberg Tribunal had no difficulty condemning health care practitioners and administrators involved in thanatological experiments or in *Aktion T4* mass killing of people with disabilities, since these comprised murder, as well as war crimes and experiments on human subjects directed at biomedical issues related to the war itself, however, were not as easily condemned. Armies confronting each other on the same battlefields encountered many of the same biomedical issues and their scientists conducted seemingly similar experiments: experiments to improve treatments for wounded soldiers, for pilots downed in freezing waters, to find cures for diseases like malaria, and so forth. Thus, to condemn presumptively "immoral" experiments conducted by German researchers like Schilling, prosecutors had to distinguish his experiments from seemingly similar experiments conducted by American or British scientists.

At issue, for example, were experiments on anti-malarial drugs conducted by the University of Chicago's Malaria Research Unit at Jolliet-Stateville prison from 1944 to 1946. In these experiments researchers infected 500 healthy white male inmates with malaria to test the efficacy of various anti-malaria drugs (Alving et al. 1948; Miller 2013). Although these experiments were superficially similar to Schilling's, prosecutors pointed out that no deaths were associated with the Jolliet-Stateville experiments; in contrast, as Schilling's assistant, Czech prisoner Dr. Franz Blaha

(1890–1980) testified, hundreds of deaths were associated with Schilling's Dachau experiments. Blaha also testified that none of Schilling subjects were volunteers (Blaha 1946); whereas, prosecutors emphasized, all of the subjects involved in the Jolliet-Stateville experiment had signed a written informed consent form (Green 1948, 457).

Based on the contrasting mortality outcomes and the presence of signed consent forms in the one case and their absence in the other, the Nuremberg Tribunal dismissed claims of similarity between the Dachau and Jolliet-Stateville experiments. Thus, written voluntary informed consent of the research subject became a primary differentiator to distinguish the unethical experiments by Nazi scientists from the ethical experiments by American scientists. Not coincidentally, the first principle of the Nuremberg Code stipulates that "The voluntary consent of the human subject is absolutely essential" (Annas and Grodin 1992, 2). Later in the post-World War II era, the informed voluntary consent of autonomous agents or their surrogates became foundational to Bioethics reforms in research ethics and the ethics of clinical practice.

3.3.3 The 1947 Declaration of Geneva

In 1947, the World Medical Association (WMA) was founded by physicians who served in the allied armies during WWII. Its initial objectives were to provide health care for war-ravaged Europe and to rebuild European medical education. As news of German physicians' participation in the Holocaust surfaced, however, the newly founded WMA embraced a third commitment. They "endorse[ed] the judicial action taken [at Nuremberg] to punish those members of the medical profession who share in the crimes and…solemnly condemn[ed] the crimes and inhumanity committed by doctors in Germany and elsewhere against human beings, both during the Second World War and in the years preceding the war"(WMA 1949, 6), and took note of "evidence…offered of crimes against humanity committed by medical men…[that] shocked the whole profession." In so doing, they also undertook to restore the integrity of medicine (WMA 1949, 6). Noting that the tradition of swearing the Hippocratic Oath had "fallen into disuse in many countries" during the interwar period, the WMA issued an updated Hippocratic Oath to ensure that never again would physicians abandon medicine's traditional ethics of "the care of the individual patient." (WMA 1949, 8). They were also aware that Nazi doctors, like Karl Brandt (1904-executed in 1948 by judgment of the Nuremberg Court), justified their role in the *Aktion T4* eugenic *euthanasie* initiative by appealing to the medical ethics of *Rassenhygiene*. "We German physicians" Brandt had proclaimed, "look upon the state as an individual to whom we owe prime obedience, and we therefore do not hesitate to destroy an aggregate of, for instance, a trillion cells in the form of a number of individual human beings if we believe they are harmful to the total organism—the state." Asked about the traditional medical ethics of the Hippocratic Oath, Brandt, a good statist physician, replied, that had Hippocrates been a German physician in the 1930s he would revise his oath (Schmidt 2007, 376).

Reacting to these phenomena, the WMA created another foundational document for professional medical ethics. Taking as its goal "impress[ing] on newly qualified doctors the fundamental ethics of medicine" in a way applicable to "every age and every country," and mindful that "In view of the recent war crimes and continued troubled state of the world," they drafted a new version of the Hippocratic Oath to serve as a "common promise, given by every newly qualified doctor…[to] afford a world-wide bond uniting them in a common service to humanity" (WMA 1949, 12). As in the original, the new version of the Oath required neophyte physicians to pledge, "The health of my patient will be my first consideration"—note, not the health of the *Volk*, but the health of individual patients—and it also required those entering a health care profession to pledge that they "will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient… even under threat, I will not use my medical knowledge contrary to the laws of humanity (WMA 1948, 1(1),13).[4]

The WMA also offered to admit fellow German medical professionals (represented by the *Arbeitsgemeinschaft Westdeutscher Artzekammern*, (AWA)) into their organization. They were, however, "Astonish[ed] … that no sign whatever had come from Germany that the doctors were ashamed of their share of the crimes, or even that they were fully aware of the enormity of their conduct" (WMA 1949, Vol. 1, 7). So the WMA pressured the AWA into distributing copies of the Nuremberg Trial's findings and the Nuremberg Code to every German physician and to apologize formally for crimes against humanity by stating that it "deeply regret[s] that men of their own rank committed such horrifying crimes," and "mourn[ed] for the victims sacrificed by a despotic régime which availed itself of science as one of its instruments, and was assisted in so doing by doctors" (WMA 1949, Vol. 1, 9). As a further condition of admission into the international medical arena, AWA was also to require German physicians to swear to the Declaration of Geneva as a condition of receiving a license to practice (Lederer 2004, 202).[5] On the basis of the AWA's acceptance of these and other conditions,[6] and despite ongoing AWA leadership by active supporters of the

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[4] This preliminary version appeared in the *World Medical Association Bulletin*, 1948 Vol. 1 (1) 13. The official *Serment de Geneve, Declaration of Geneva, Declaracion en Gemebra*, (WMA 1949, 1(2), 35–37), was published the following year in three languages with slight variations. Thus, "classe sociale" is rendered as "social standing" in the English version, and the "absolute" respect for human life demanded in the French version became "utmost" respect for human life in the English version.

[5] The Declaration of Geneva had special resonance for some in the AWA, because German medical opposition to Nazi policies of *Rassenhygiene*, like *AktionT4*, rare though it was, often cited the Hippocratic Oath to invoke the internal morality of the medical profession, as in Freiberg pathologist Franz Büchner's (1895–1991) 1941 public lecture on "The Oath of Hippocrates" (Büchner 1941).

[6] On October 18, 1947 the AWA condemned all German physicians who committed crimes against humanity and war crimes; on November 29, 1947, it petitioned the German government to "reinstate full medical rights" to physicians stripped of the right to practice by the Nazis for "reasons of race, religion, or politics." (WMA 1949, Vol. 1, 9).

Nazi regime, like Karl Heidenkamp (Seidelman 1996a, b), the WMA admitted the AWA to membership by a nearly unanimous vote.

Health care professionals varied reactions to their German colleagues' involvement in the Holocaust were shaped by three somewhat different notions that are compounded in our modern concept of a profession (Baker and McCullough 2009). Some envisioned professions as occupations in which members assume [1] a role governed by an internal morality of service to others stated in public promises, often in the form of oaths, codes or declarations; whereas others held the statist view [2] that their social and legal privileges were conferred on them in exchange for social obligations to serve society [e.g., the *Volk*] or the state; and still others [3] viewed professions as merely social clubs bound by self-imposed rules that serve members' collective interests. Mellanby, for example, seemed to subscribe to the notion of health care professions as a fraternal society, a self-serving old boys club. Thus, since Shilling and other eminent Nazi researchers had been vouched for by eminent members of the club, he could not, and did not, view their conduct as either unprofessional or unethical. In contrast, Alexander, Ivy, Taylor and the WMA invoked the Hippocratic Oath as a universally accepted internal morality of health care, thereby appealing to the notion of health care professionals as inhabiting a role governed by its own internal morality, formalized, in this example, by the Hippocratic Oath. Thus, they could and did contend that it was unprofessional and unethical for anyone in health care to have accepted the Nazi's medical ethics of *Rassenhygiene*. Brandt, in contrast, asserted a contractarian conception of medicine, viewing medical ethics as a social construct negotiated between medical professionals and the state. For him "the content of the role of doctoring [was] largely conventional, not natural…. Thus…those with medical training [could] question whether they are bound by [traditional] rules of doctoring which they did not shape and did not chose." (Baker et al. 1999, 155). Hence his remark that, had Hippocrates been alive in the 1930s, he would have revised his oath.

3.3.4 Broken Promises, Scandals, and Reform

"Promises associated with quiet guilt" are seldom kept (Kübler-Ross 1972, 84). Not surprisingly therefore, as the Cold War between the West and the Soviet Block heated up (1945–1990), retrograde amnesia about Nazi doctors became widespread in the West; and "The Nuremberg Code…was routinely ignored by researchers in Britain…who believed the guidelines… did not apply to them" (Wilson 2014, 44), and in America, "Neither the horrors described at the Nuremberg Trial nor the ethical principles that emerged from it had a significant impact on the American research establishment" (Rothman 1991, 61). Yet, even as the Western health care professions found it convenient to consign memories of the Holocaust and Nuremberg Code to the dustbin of history, it remained seared into the memories of Jews, and was meaningful for some World War II military physicians. One of them, Harvard medical researcher Henry Beecher (1904–1976), a Cold War warrior, had hoped to glean useful information from the Nazi experiments. As he did so, however, it dawned on him that some of his own Cold War experiments were morally suspect and, in what might be construed as an act of contrition, he publicly condemned research published in leading medical journals for violating the Nuremberg Code's informed consent standards (Beecher 1966; Harkness et al. 2001; McCoy 2007; Moreno 2016).

Beecher soon found a kindred spirit in fellow physician and World War II veteran, Maurice Pappworth (1910–1994), and the two whistle-blowing physicians supported each other in a transatlantic correspondence (Gaw 2012). Pappworth had once been denied appointments at teaching hospitals because, as he was informed, such positions were reserved for gentlemen and "no Jew could ever be a gentleman" (Booth 1994, 1577–1578). Thus unburdened of the club morality of so-called "gentlemanly" practitioners, Pappworth alerted the British medical community and the public to unethical experiments conducted on patients in the British National Health Service and elsewhere that violated the Nuremberg Code's informed consent standard (Pappworth 1962, 1967). When the gentlemen of the British medical establishment expressed outrage, Pappworth responded, "those who dirty the linen and not those who wash it should be criticized" (Pappworth 1990, 1456–1460).

Although the Nuremberg-inspired whistleblowing activities of Beecher and Pappworth initiated the first stages of research ethics reform in America and Britain, the American inflection point was catalyzed by Peter Buxtun, a former army medic who served as a United States Public Health Service (USPHS) contact tracer for sexually transmitted diseases. Several people had previously raised questions about the ethics of USPHS's Tuskegee Syphilis Study of untreated syphilis in 400 African American men (1932–1972): most notably, William C. Jenkins (1946–2019) an African American statistician employed by the USPHS, and Irwin J. Schatz (1932–2015), a Jewish cardiologist. What differentiated Buxton's complaints from theirs, however, was that Buxton, the son of Holocaust refugees who had done graduate work on German history, buttressed his complaints with a report to the USPHS comparing the Tuskegee study to the Nazi experiments condemned at Nuremberg. After formal consideration of Buxton's report, the USPHS discounted his objections and decided to continue the study. Frustrated, Buxton took his concerns to the Associated Press (Government Accountability Project 2014; Heller 1972). The resulting scandal led to congressional investigations that culminated in the current research ethics review system and the 1976 Belmont Report articulating three ethical principles to guide researchers and IRBs in assessing the ethics of experiments on human subjects (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). First among these principles was the precept that was highlighted in the first article in the Nuremberg Code; respect for persons' autonomy; however, this was now to be balanced by principles of beneficence (and later, nonmaleficence) and justice. These principles were foundational to a transition from traditional paternalistic medical ethics of "doctor/researcher knows best" to an anti-paternalistic Bioethics paradigm based on respect for patients' and subjects' rights (Office for Human Research Protections 2016).

3.4 Concluding Reflections

In this chapter we reviewed different ways of organizing health care delivery—commercialism, professionalism, and statism—as well as various conceptions of how professionalism works and to whose benefit. We also sketched the tragic convergence of statism and Nazism during the 1930s that led to mass sterilizations, child murders, the *Aktion T4* program, the abuse of humans as experimental subjects and ultimately, the Holocaust. We then tracked the evolution of Western medicine's reactions to these activities, from incredulity to denial, anger, and then acceptance of the fact that German health care practitioners had committed acts that violated the traditional ethical core of Western medicine. As a practical matter, most Nazi health care personnel were excused and just a few of the most notorious were punished. This reflected a tacit and sometimes explicit compromise with German doctors, which was conditional on promissory commitments to future good conduct spelled out in the Nuremberg Code and the Declaration of Geneva. However, having written these documents for Nazi monsters, the international medical community soon entered a stage of retrograde amnesia about medicine's integral involvement in the heinous crimes of the Nazi regime. Memories of these events were kept alive only by a handful of reformers who had been personally touched by this history. They eventually forced fellow professionals to recollect past misdeeds and recognize their resemblance to then-current practices. These reformers would catalyze a Bioethics revolution predicated upon recognizing patients and research subjects' as autonomous agents whose informed voluntary consent was a prerequisite to treatment and to ethical research on humans.

Today the relationship between consumerism, professionalism, and statism remains in flux, as do various conceptions of the health care professions. Some still invoke the Hippocratic Oath as a formulation of the internal (or essential) morality of medicine to critique such actions as physicians' complicity in torture (Miles 2004, 2009); others regard the structures of professionalism, including the contents of codes of ethics, as entirely flexible and potentially self-serving (Applbaum 1999); still others pronounce "The Hippocratic ethic, or similar [one-sided proclamations of professional ethics] ethics… dead" (Veatch 2012, 159), believing that professional ethics should be agreed upon in more explicit negotiations between practitioners, their patients and the public (Veatch 2012). The future of health care professionalism remains open. As this brief overview suggests, however, modern professional ethics—as laid out in the Nuremberg Code, the Declaration of Geneva, and the Belmont Report—with its emphasis on the informed voluntary consent of autonomous individuals and with health professionals cast as protectors of individual patients against both commercial and state forces, began in reaction to, and rejection of, Nazi medical ethics. Virtually every aspect of contemporary professionalism is, in the end, predicated on the vow that never again would health care professionals treat people, or research subjects, as German health care professionals did during the Nazi era.

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Chapter 4
The Physician's Role: Patient v. Population

David K. Urion

Abstract There is always a tension between Public health and individual medical care. The former seeks, by one ethical optic, a fundamentally consequentialist goal: the greatest good for the greatest number of individuals. The latter has, at its moral base, an encounter between a medical provider and a patient, and its ethical goal is to optimize the outcome that the patient desires. While this dichotomy of intent and effort must be nuanced, setting it out in these terms helps us understand the tensions that we see between Public health initiatives and individual medical care. This chapter will suggest that by examining two movements that attempted to insert larger community concerns into the individual patient encounter, we might gain insight into what happens in the moral space of the patient encounter when the provider is compelled to consider these larger concerns. The Eugenics movement of the late nineteenth and early twentieth centuries, and the population health movement of the late twentieth and early twenty-first centuries will be considered as two examples of attempts to alter the individual patient encounter through the lens of larger societal concerns.

4.1 Introduction

During the past eighteen months, as medical systems have navigated the COVID-19 pandemic, we have seen the conflict between Public health and individual medical care arise time and again. For sound Public health reasons, hospital visitations were severely curtailed, even forbidden in some settings. Hospital systems that utilized these restrictions saw the transmission of COVID-19 drop significantly between patients and personnel. For equally compelling ethical reasons, providers in these settings who had to enforce these measures experienced substantial moral injury (Anderson-Shaw and Zar 2020). This moral distress arose, one may submit, because of the profound conflict of interests experienced by the practitioner who was devoted

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to the care of the individual patient while simultaneously enforcing a Public health measure.

We can make a good case that the four basic principles of biomedical ethics often cited in Western settings, namely autonomy, beneficence, non-maleficence, and justice, can also be considered along similar lines (Beauchamp and Childress 2019). The first three principles lean heavily in the direction of individual provider-patient encounters, while justice is a principle which is inherently communitarian in outlook and context.

The response to a crisis, such as COVID-19, may reveal the underlying (mal)functioning of a medical care system and disclose many aspects we often prefer to ignore or deny: structural racism, classism, genderism, and a host of other elements embedded in the social structures in which a medical care system exists. It is often difficult to understand a historical moment as one lives through it. It may be helpful, therefore, to consider other examples of the conflict between larger social considerations and individual practice and examine their impact upon individual providers in their care of individual patients. The Eugenics movement of the late nineteenth and early twentieth century and the Population health movement of the late twentieth and early twenty first centuries serve as two such examples.

I should state from the outset that I am not equating Eugenics with Population health . There are significant and fundamental differences between these movements. There are, however, equally significant and fundamental similarities, and this chapter suggests that by examining these we may gain insight into how larger societal concerns can both illuminate and disrupt the individual patient encounter. Furthermore, we will examine these two movements through a consideration of two phenomena common to them both: their appeal to science over sentiment in the individual encounter, and their alteration of the concept of Informed Consent.

4.2 The Rise of the Eugenics Movement

It would be useful to begin with some definitions. Eugenics was a movement that arose in the Anglo-American context, and by the late nineteenth and early twentieth centuries became a very American medical movement. It had, at its core, the assertion that human genetics was central to human disease, and that by controlling human mating one could eliminate much human disease and human misery. On the face of it, this appeared to be a wise and noble scheme. Early English eugenicists emphasized "positive eugenics"—the encouragement of people with desirable characteristics to marry one another and produce children that were healthier, hardier, and showed even more desirable characteristics (Roberts 1964). Its enthusiasts viewed humans in much the same way gardeners viewed plants, developing cultivars that were more productive, more beautiful, more disease-resistant.

What we might consider "negative" Eugenics was far more rooted in the American experience. This movement sought to remove undesirable traits from the population by either forbidding the marriage and thus potential for procreation from segments of the population deemed to have undesirable traits, or in even more stringent settings, by involuntarily sterilizing those with medical conditions felt to be hereditary. Persons with epilepsy, for example, were refused marriage licenses in many states (Lindsay 1998). "Feeble-mindedness," an elastic term favored by the American Eugenics movement to represent people with a variety of characteristics and traits deemed undesirable by "proper" parts of society, was grounds for involuntary sterilization in many jurisdictions. In the landmark Supreme Court decision Buck v Bell, which upheld the state's right to involuntarily sterilize someone diagnosed with "feeble-mindedness," Justice Oliver Wendell Holmes wrote the majority opinion, observing "three generations of imbeciles is enough" (Cohen 2016). It is worth noting that Buck v Bell has never been overturned.

German scientists and physicians of the early twentieth century embraced Eugenics and its methods as a functional, scientific, forward-thinking way of dealing with the problem posed by Karl Binding and Alfred Hoche, a German academic psychiatrist and jurist, in their essay *Die Freigabe der Vernichtung lebensunwerten Lebens* (Allowing the Destruction of Life Unworthy of Life) (Hafner and Winau 1974). Germany, the last of the Western European nations to industrialize and urbanize, had a tradition of universities and academic hospitals that made it the most advanced medical system of its time, a position similar to that held by the United States in the late twentieth and early twenty-first centuries. The disruption produced by the urbanization and industrialization of late Wilhemine Germany, however, produced strains in the healthcare and social service systems that generated a sense of consternation about the future of the German Reich. Large numbers of poorly housed workers who lived in unsanitary conditions and had inadequate food sources led to a general concern that the nation would be swamped by a large number of debilitated and unhealthy people. Coupled with the belief that much of this human misery had a genetic, hereditary basis, an ongoing discussion emerged about what directions to take. While conservative forces argued for better schooling, an immersion in an urbanized form of traditional German values, and improved housing (Sweeney 2006), other forces argued for a forward-thinking, scientific, rational approach to this perceived crisis. Into that conversation, Binding and Hoche asserted that it was legally and ethically permissible to terminate the life of persons with certain degenerative, hereditary, or function-limiting disorders; lives, they argued, that were not worth living. This, in turn, would reduce the stresses on systems that were weakening under burdens difficult to carry.

While their monograph created a large stir, including positive responses in many quarters of public and academic life, it did not contain a methodology to achieve their goal. It was into that space that Eugenics was inserted. The approaches, techniques, and systems developed across the United States were studied, reflected upon, and embraced by increasing numbers of medical academics in Weimar Germany. While we tend to think of the embrace of Eugenics and its derivative, racial hygiene, as products of National Socialism, this would be inaccurate. Large numbers of German and Austrian academics had embraced Eugenics before the seizure of power by the National Socialist Workers Party (NSDAP). Indeed, it can be argued that the rise of the NSDAP was legitimized in German society by the support academics provided when it embraced their principles of Eugenics and grafted those onto the cruder antisemitism that had characterized older NSDAP writing (Aly 2011).

How is it, then, that the most technologically advanced medical system of its era, a place where the world came to study, learn and train, first embraced Eugenics so whole-heartedly, and then became so complicit in the racial hygiene policies of the NSDAP? It would be convenient to think of the so-called Nazi Doctors as exceptional villains who went rogue from the system of medicine. It would also be profoundly wrong. Compared to other classic liberal professions of the nineteenth century (law, clergy, military), or the rising class of merchants and industrialists, or state functionaries such as teachers, postal workers, and civil servants, physicians joined the NSDAP in greater numbers, and represented a greater percentage of their profession, than any other group in Weimar Germany. More ominously, they also joined the *Schutzstaffel* (SS) in higher numbers and percentages than any other group as well (Aly et al. 1994).

4.3 Eugenic Medicine: From Theory to Practice

How, then, did this happen? While individual choices have been examined by several generations of cultural and psycho-historical investigators (Leonard 2016; Lifton 1988), and have proffered various theories, it might be helpful to look at the climate that the intellectual discussion had created to see what features were present as people considered the crisis they perceived to exist—rising numbers of persons with neurodevelopmental and neuropsychiatric disorders produced by generations of “disadvantageous breeding” (Cohen 2016). We may consider three key elements in the arguments made by eugenicists: a justification for the need to address the problem, an ethical basis for the Eugenics agenda, and the policy implications of that agenda.

The justification for the engagement of Eugenics practices and policies was based upon what we might term a “looming disaster” argument. It was argued that the individuals of “poor stock” would produce ever-increasing numbers of “feeble-minded” offspring, that these individuals would out-reproduce those of “better stock,” and the dwindling numbers of the capable would be left to fund the care of those of insufficient intelligence and skills to fend for themselves (Hafner and Winau 1974). Arguments such as: “The future looks grim; we will see increasing numbers of needy persons and have inadequate resources to care for them” (Binding and Hoche 1920, 7–8) and “We will be overwhelmed by ever-increasing numbers of people dependent upon others to care for them” (Binding and Hoche 1920, 15) became commonplace.

The ethical argument made was that a move away from the ethics of individual encounters and patient care and towards a concern for the whole of society by the provider in the context of their daily work, was required at that moment in order to save society from being overrun by individuals unable to care for themselves. The metaphors used were medical, identifying the society, the body politic, and not the individual in the examining room, as the patient to which the provider now owed the most significant moral allegiance. Examples of these arguments include: “Radical surgery on a diseased patient may seem harsh but it is in his best interest; similar radical surgery must be undertaken as the most ethical approach for the society as a whole" (Ramm 1942, 35–40) and "We must stop thinking about each individual patient and think about the good of the whole" (Ramm 1942, 74). This ethical shift towards thinking about the entirety of society as opposed to the individual patient in the context of medical care was a profound departure from traditional medical ethics and practice.

The policy implications of these ideological changes allowed providers to shift their focus from the individual patient to the good of society as a whole and were represented as the replacement of a sentimental sensibility to a forward-looking, rational, scientific medical care. This can be seen in statements such as: "Individuals always exist in a larger context and must be willing to have their needs placed in the context of the people's needs as expressed by national policy" (Murray et al. 1999, 981–992) and "We must make decisions at a national level based upon the principles identified here, rather than stumbling along making sentimental decisions we can no longer afford as a people" (Bornstein and Emrich 2001, 97–107).

The transition to these eugenic foundations of medical practice resulted in three distinct changes: (1) providers were inculcated into a mindset that a vast crisis was looming; (2) a justification to move from an ethics of individual encounters to one based on the good of society arose; and (3) prioritizing the health of society was considered forward-thinking, rational, and scientific. The older approach of individualized patient ethics was deemed ill-conceived, naïve, sentimental, and unscientific.

We know where this shift in ethical context of the patient encounter eventually led in the context of NSDAP German medicine. Beginning with the euthanasia of individuals with significant neuropsychiatric disorders and children with progressive degenerative disorders (*Aktion* T4 and the *Kindereuthanasie* programs), the goal of medical care shifted from the care of an individual to regarding whole classes of individuals as defective based upon their racial characteristics, their sexual orientation, or their "anti-social tendencies" (Ramm 1942). Rather than striving to give the best life possible for an individual with a neurodevelopmental disability, this new paradigm asserted that such individuals were a defective or disease part of the body politic which must be excised.

4.4 Population health : Examples in Modern Medicine

We may now examine the contemporary movement towards Population health within the context of the moral space of the individual patent encounter. Population health may be considered as the measurement of the health, variously defined, in the entirety of a given group, demarcated by various demographic means. In the current setting, it is most often used to measure the efficacy of a given health care intervention across a group, or to measure the overall effectiveness of a health care system of care provision for a defined group of patients.

Take, for example, stroke and arterial hypertension. We know that these two events are related; uncontrolled arterial hypertension demonstrably increases the risk of stroke, which is a large factor in morbidity and mortality in the US. We also know that certain populations have high incidences of both these events. We can therefore measure the effectiveness of an intervention to improve blood pressure control across a group of people—that is, how many people have blood pressures which come into a desired range after a population-wide initiative has been instituted. We can then track the efficiency of the intervention's system of delivery if we track rates of stroke after the initiative. Thus, since we know people in lower socioeconomic strata in certain parts of the United States have high rates of stroke and arterial hypertension, we could see if an intervention reduced the incidence of hypertension and thus reduced stroke in those high incidence areas. This, one could argue, is the classic domain of Public health, rather than individual patient care, utilizing the techniques of Population health to measure the efficacy of a group-wide or system-wide initiative aimed to reduce the incidence and prevalence of a significant medical issue.

What happens, however, when Population health metrics enter the individual encounter? This can arise when medical reimbursement schemes are based on Population health outcomes. Various insurance carriers in the US now write contracts for groups of patients that are called "shared risk" contracts. A sum of money is given to a health care system or entity to take care of a group of patients (for example, a hospital and a group of its affiliated primary care providers are given a contract to care for a defined population on Medicaid). This is referred to as an Accountable Care Organization. The contract is written as a fixed amount of money given to the system each year to care for all the healthcare needs of that population, determined as a fixed reimbursement per patient. The ACO does not have access to additional money over the year of the contract—that is, if the ACO spends the entirety of its allotment by the middle of the year, it must perform the rest of the year's work without further reimbursement. The following year, the contract is re-written based upon how much money was actually spent (the ACO gets more per patient if it stayed below the total fiscal allotment) and by "quality" outcomes across groups (the ACO gets more money per patient if it achieves certain quality metrics). Quality metrics are chosen based upon the most significant morbid or mortal illnesses afflicting the population covered. Population health metrics are thus a way to determine "quality" of healthcare delivered—outcomes not in each individual patient's instance, but across the entirety of the population.

This has been viewed as both a progressive and scientifically-driven way to improve the health of populations, by creating monetized incentives for improved outcomes. However, there has been an emerging critique of this melding of market incentives and Population health metrics as a force that would lead to the exclusion of the very people it purports to help. Certain populations have been viewed as having healthcare issues that have been recalcitrant to intervention. If we examine that literature, we can see certain ideas reminiscent of those themes we identified previously in the context of Eugenics and racial hygiene: justification, ethical underpinnings, and policy implications.

The epidemic of obesity, with increased incidences of metabolic syndrome, type 2 diabetes, and associated cardiovascular health issues, has been cited as a looming disaster. The following arguments have been set forth with regards to obesity: "We cannot afford to care for this population and achieve other goals as a society" (Bornstein and Emrich 2001, 97–107) and "Without dealing with this looming crisis, our children will be forced to make even more painful choices than what is proposed here" (Murray et al. 1999, 981–992). This language bears more than a passing resemblance to the citations noted above about rising tides of "feeble-mindedness" and invokes the same ethos of impending disaster that will overwhelm our medical care system.

The ethical underpinning of moving towards populations and away from individual patient care has been stated along lines that again sound familiar: "We must stop thinking about each individual encounter, but instead focus on the group as whole, if we are to establish a system that functions" (Ibrahim et al. 2001, 75–81) and "We can no longer afford to consider individual families at the expense of the well-being of the larger society"(Minkler 1999, 121–140). While the move towards a population-facing ethics invokes the traditional Western bioethical principle of justice, in practice it runs the risk of further marginalizing the very groups it suggests it can help. As noted above, the economic uses of Population health in the setting of ACO's creates powerful incentives for systems to remove populations with difficult to treat healthcare issues from the panel of patients covered; these ethical arguments provide a sort of cover, or justification, for that neglect and removal.

Finally, the policy proposals regarding equity and access to care for all people echo some of the same themes noted in Eugenics and racial hygiene. Examples of these claims include statements such as: "Our current system is leading to disaster, by its widespread access for people who make no organized approach to their own health and well-being. This must be dealt with at a governmental level as policy" (Resnik 2007, 444–445) and "We must take bold action as a society to re-orient our system towards accountability as a prerequisite of access" (Resnik 2007, 444–445). This language takes individuals whose healthcare issues, as difficult as they are, have deep roots in social determinants of health and structural racism, classism and genderism, and finesses them into issues of "accountability". The critique of the Crisis Standards of Care that were developed in many state jurisdictions in response to the COVID-19 pandemic and a feared shortage of Intensive Care beds and ventilators used similar regressive thinking. Sequential Organ Failure Assessment (SOFA) scores were used in allocation schemes for determining ventilator access when in short supply. Criticism of these methods of allocation point out that people often have disadvantageous SOFA scores due to lack of access to equitable healthcare, and thus are being victimized twice by the same unjust system (Webb Hooper et al. 2020). Thus, we need to distinguish between social forces which underpin a system that relegates groups of persons to poor health outcomes from the assumption that those groups' exercise of free choice led them to these outcomes. Correlation is not necessarily causation. Eugenics and racial hygiene argued for this flawed comparison. Population health advocates need to avoid it.

4.5 The Role of Informed Consent in Eugenics and Population health

This is not to equate Population health and its many advocates with the Eugenics movement, racial hygiene arguments, and the doctors and academics who engaged so fully with the NSDAP government. It is to say, however, that when we have historical examples of where such arguments can lead, and we can find similarities between those arguments and the current moment, we would be well advised to consider these with care. We can now examine the erosion of Informed Consent in the setting of Eugenics and racial hygiene efforts in NSDAP as well as in the context of Population health . The modern understanding of Informed Consent can be argued to begin with the Nuremberg Code of Ethics, often-cited and nearly as often forgotten. This code was written by the American jurists who presided over the Doctors' Trial after the Second World War. While other trials in the collective war crimes tribunals in occupied and defeated Germany had jurists from a variety of the Allied nations, the Doctors' trial was presided over solely by American jurists, and the prosecution was also entirely American. Thus, while international in its scope, we can argue that the results were American jurisprudence at their core. The Code had as its first point that all human medical experimentation had an absolute requirement for Informed Consent: "The voluntary consent of the human subject is absolutely essential" (Shuster 1997, 1436–1440).

From 1932 through 1972, the United States government funded the now well-known and infamous "Tuskegee Study of Untreated Syphilis", which, built upon the premise of non-treatment, followed the natural course of syphilis in infected black men. The ethical justification for this was the importance of knowing the natural history of an infection in a population that was thought to have a different response to infection than the white population of the US. The study had a complete absence of Informed Consent, not even disclosing to the men that they were being recruited as part of an experiment. There was also a complete absence of adequate treatment for the disease even after penicillin became a proven, identified treatment (Kaplan 2015). When the study was reported in the Journal of the American Medical Association in the 1960s while still in its early years, a physician wrote to the editors to decry the violation of ethics the study constituted. The editors failed to respond to the writer, feeling this was an isolated view of the work (Kaplan 2015). The project investigators of this trial utilized a tactic of deceit, enrolling subjects into the study by providing false promises of effective treatment and requesting that Black medical providers help collect information from subjects without complete knowledge that such information was being used as part of an experiment (Kaplan 2015). This complete negation of the principles of Informed Consent elucidated by the Nuremberg Code was justified on the basis of the importance of the information being obtained, and upon a doctrine of "implicit consent" constituted by agreeing to participate in a trial that required ongoing sample collection. The act of presenting for sample collection was argued to be evidence of this notion of "implicit consent" (Kaplan 2015).

Harriet Washington has pointed out that in a climate of Population health initiatives, concepts such as "presumed consent", "implied consent", and "waiver of consent" have eroded the notion of autonomous, informed, and revocable consent that the Nuremberg Code, and the jurists who wrote it, argued was a fundamental, foundational ethical principle (Washington 2021). She notes that this process begins with the issue of tissues taken from a given person and used for purposes of research without their express consent. The example of Henrietta Lacks and her immortalized cells is the most infamous example in the American experience of a waiver of consent. It was argued that the tissues, once removed, could be put to any purpose and did not need her subsequent consent, nor that of her heirs. The removal had been done with consent typical of the day; after that further consent was viewed as waived. This led to any of a number of scientific discoveries, many of which were commercialized, without any consideration of compensation or collaboration with her heirs.

Biobanks, an increasingly widespread phenomenon on the medical landscape, represent a form of implied consent. The individual in question is asked to consent for the original sample, often blood or tissue "left over" from a clinical sampling, that is then banked. Researchers may then use their access to the biobank to use samples without further consent of the subject who offered them. The justifications used for such biobanks are extending the understanding of genetics or other biomarkers of human disease, increasing or improving the efficacy and fundamental mechanisms of various treatments, or slowing or containing the spread of infections during epidemic or pandemic events. The risk noted by many ethicists is the progressive erosion of the autonomy of medical consent by the individual in favor of the development of population-based understanding of disease mechanisms, with significant limitations to the consent of the individual to participate in such research (Washington 2021).

The increasing use of Big Data, pooling the healthcare data of large groups of patients to identify trends, risks, or the evolution of a disease across populations, represents a form of presumed consent. When an individual becomes part of a healthcare system, their data is amassed in an electronic medical record, as required by US Federal law and regulations. Programs in Big Data analytics now access those individual healthcare data and include an individual's medical information into investigation. These analytic systems presume consent to access and use these individual's patient data—including personal, medical and demographic information—since the individual presented themselves for treatment. In essence, the choice offered an individual is this dichotomy: to be treated means to give up one's data and be on the grid; to refuse to be on the grid requires one to refuse treatment. Thus, seeking care means giving up any control over the privacy of one's healthcare data. The erosion of the autonomous individual offering consent for their participation in a research enterprise is both complete and nearly invisible.

This erosion becomes singularly important in the current move towards a geneticized medicine, with important figures in the biomedical world arguing for universal whole exome sequencing (WES) at birth in order to facilitate the ready development of individualized therapies (such as antisense oligonucleotides) for certain rare genetic diseases (Crooke 2021). It is argued that only with universal WES at birth can we quickly identify individuals with diseases that might be amenable to newer technologies. However, since many of these disorders have no good animal model, the patient in such n of 1 “trials” has a simultaneous phase I, II, and III medication trial practiced on her. Informed Consent, for both the acquisition of data as well as drug development, becomes problematic since the minor child is being committed to a lifetime treatment by the substituted judgment of her parents in consort with biomedicine. The stockpiling of an entire population’s genetic data also leads to significant concerns about who might have access to those data, and for what purpose. The development of an individualized treatment for children suffering from fatal disorders can be argued to be a good. However, a profession of whom the public has reason to be skeptical in terms of its trustworthiness in using and possessing deep and detailed information about members of the public needs to offer clear safeguards and watchdogs over its possession of this data.

We can think of the evolution of the Curative Education Department at the Vienna Children’s Hospital from its origins as a highly patient-centered treatment unit for marginalized children in the early 1930’s under the leadership of Erwin Lazar to its co-optation after the Anschluss by Hans Asperger and his colleagues as part of the machinery of the Child Euthanasia program of NSDAP Germany (Sheffer 2018). Data and information gathered there was put very different uses than its idealistic founders intended.

4.6 Conclusion

We can therefore see that the development of population-based approaches to health care and medical research have placed both the provider and the patient at a sort of crossroads. One direction, invoked in the name of justice and historical exigency for support of the health and well-being of populations, leads to the slow and steady erosion of individual patient autonomy, provider beneficence toward the patient he or she encounters, and the non-maleficence of a system that would enhance individual choice and freedom. An examination of Eugenics is instructive in showing us where such endeavors can lead. The other direction, whose strongest advocates arose from facing the horrors of the racial hygiene medicine of NSDAP Germany, that is, the Third Reich and rejecting them, supports autonomy, but demands much more of individuals, systems, and providers if scientific advancement is to be continued.

The question before us now, as it was a century ago to our medical and ethical forebears, is which path to follow? Will we continue on a path of convenience and less rigor that promises faster results if we are willing to sacrifice some protections and rights for some of our fellow citizens for the benefit of society, or will we insist that human rights cannot be compromised for anyone lest they be compromised for everyone?

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Chapter 5
The Transformation of Physicians from Healers to Killers: The Role of Psychiatry

Susan M. Miller and Stacy Gallin

Abstract This chapter will examine the direct and systematic involvement of psychiatry in the labeling, persecution and eventual mass murder of millions of those deemed "unfit." While the entire medical profession can and should be held accountable for the abrogation of ethics that took place during the Holocaust, the role of psychiatrists, specifically, must be explored because of their ability to conflate clinical diagnoses with the worth of an individual. The theory of eugenics allowed psychiatry to provide the scientific justification and the practical mechanisms for the "mercy killing" of "life unworthy of life." The leadership and expertise of psychiatrists paved the way for a powerful merger of medicine and politics that ultimately led to the mass murder of millions under the guise of scientific and societal progress.

5.1 Introduction

Johann Weyer was the first physician to specialize in mental illness, redefining melancholics as mentally ill, not demonically possessed (Cavanaugh 2015). In 1808, Johann Christian Reil coined the term "psychiatry," based on the Greek words *psukhē* (soul, mind) and *iatreia* (healing) (Lomax 2019; Gaebel et al. 2007). Starting in the late 1800s and early 1900s, large psychiatric institutions were founded, typically outside of metropolitan areas (Gaebel et al. 2007) as a mechanism to provide humane and

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holistic care (Strous 2007) to these patients. The next advancement in psychiatric care began with the work of multiple psychiatrists, Emil Kraepelin, Alois Alzheimer, and Carl Wernicke, who developed the foundational basis of the psychiatric diagnosis system (Gaebel et al. 2007), which was used to label those individuals medically considered inferior (Strous 2007). By the 1920s and until the end of World War II, governmental institutions, private financiers, and wealthy patrons, funded what was then contemporary psychiatric research (Roder et al. 1994). Psychiatrists became instrumental in differentiating what medicine and society defined as normal versus abnormal. Moreover, psychiatrists helped enact laws which defined psychiatric diagnoses and therapies as they subsequently became the agents who enforced these legislative mandates. Through their camouflage of social policies as medical science, and by broadening (what in retrospect is considered arbitrary) definition(s) of mental illness, they maintained and expanded their burgeoning influence on the medical profession (Roder et al. 1994).

The contemporary psychiatrist Dr. Rael Strous further describes how, during the Nazi era, this political influence allowed psychiatrists to systematically exterminate their patients. Although members of other medical specialties were also involved in this medical genocide, psychiatrists were among the worst transgressors (Strous 2007). Their professional participation in "identifying, notifying, transporting and killing…racially and cognitively compromised individuals…was *central* and *critical* to the success of Nazi policy, plans and principles" (Strous 2007, 1). This genocide "did not take place in a vacuum" (Friedlander 1995, 1). The concept of medicalization allowed psychiatry to attain an unprecedented professional status during the Nazi era and provided a framework for the classification, labeling and persecution of millions of individuals deemed unfit by this newly powerful group of professionals. Instead of actively or even passively resisting the ideology of medicalization, psychiatrists played a central role in what became known as "crimes against humanity" (Strous 2007, 2). In spite of parallel advancements in science (e.g., cancer research, biochemistry, and quantum mechanisms), ethical protections went awry (Strous 2007).

In addition, very few physicians had the ability to identify, circumvent or ameliorate their multiple conflicting obligations as members of the medical profession, the court system, the *Volk* and the political regime for the well-being of their patients. They even disregarded Germany's sophisticated 1931 codes of medical ethics (Strous 2007). Instead, they provided leadership roles in bureaucratic genocide, such as the mass killings occurring in psychiatric facilities (e.g., Hadamar) and within industrial killing centers (e.g., Auschwitz). This is in contrast to their fallacious, post-war justifications that opposition to the State would result in the threat of their own execution (Roder et al. 1994).

5.2 The Paradigm Shifts

Historically there existed two traditions of medical care in Germany: individual-based and public health care. Economic pressures after World War I had a negative impact on earlier health care benefits and priorities which had emphasized the early detection of illness, relief of suffering, preventive care and occupational health. Post-war financial stressors and subsequent eugenical categorizations of patients created a system identifying those individuals deemed “unworthy” to receive governmental-supported health services. The ensuing reversal of moral priorities from those which emphasized Aesculapian, patient-centered interests to those which gave precedence to the health of *society* redefined the medical profession’s obligations to their patients (Reich 2001). This represented a critical paradigm shift away from the traditional Hippocratic methods focusing on the relationship between patient and doctor towards one in which the doctor’s foremost responsibility was to care for society. The repercussions of this crucial change in perspective would have disastrous outcomes for millions whose existence was not considered beneficial to the health of the nation. This transformation was felt not only in the field of medicine, but also in the political realm. In 1934, Rudolf Hess, the Deputy Führer to Hitler, went so far as to describe “National Socialism as nothing but applied biology” (Lifton 2000, 31).

The protection of the health of the “transcendental” *Volk* (albeit limited to a homogenous Aryan population) became the new, primary obligation of the physician (Lifton 2000). Specifically, in 1926, the professional code of German medicine asserted: “The profession of a doctor lies in health service for the German nation” (Pross and Aly 1991, 10). This misguided emphasis on the idiosyncratic primacy of the *Volk* (which was considered an “organism” in itself), professional empowerment and the corresponding belief the state was justified in determining which members of society were judged as productive, served as a perceived legitimate basis for the subsequent, selective exclusion and involuntary sterilization and the “eliminative genocide of the Holocaust” (Robertson et al. 2017, 66; Pross and Aly 1991; Lifton 2000; Strous 2007). This disruption of the prior relationship between physicians and patients was predicated on an opposition to the equality of men (Friedlander 1995). What began as a humanitarian, post-World War I effort to provide universal, state-funded health care, became politically tied to a biomedical vision based on ultra-nationalistic and militaristic goals as a mechanism to create a healthy German population (Bachrach 2004; Friedlander 1995). The Aryan population was unambiguously considered to be superior (Haque et al. 2012; Hofstadter 1992; Friedlander 1995). The developing, eugenic-based, definitional proof of inequality and “hostility toward the handicapped” (Friedlander 1995, 196), led to this misguided and unsound social policy. By creating the pretext of a eugenic biological “crisis,” the government could assume sovereign power over the lives of its citizens (Robertson et al. 2017).

Psychiatrists, many of whom represented senior members of academia, provided the theoretical foundation based on biology and heredity (Strous 2007). It was psychiatry that was the most involved in determining the hierarchy of human worth (Dudley and Gale 2002). As the “Nazi movement both absorbed and advanced this ideology”

(Friedlander 1995, 1), psychiatrists, as part of the new scientific elite, provided the necessary legitimacy and ideological commitment to the Nazi regime (Friedlander 1995). Their involvement not only led to new career opportunities but placed those within the profession “close to the center of power” (Friedlander 1995, 196). Psychiatrists provided the necessary leadership, backing and oversight in the respective planning committees, which resulted in the successful implementation of political policies based on race (Strous 2007; Friedlander 1995). These committees created the medical and bureaucratic processes that would identify the targeted individuals. The harms associated with this ideology were further exacerbated when the interests of science (i.e., racial-hygiene) assumed priority over the autonomy of an individual patient. Over time, the psychiatric template for the *Endlösung* (Final Solution) became itself a “medical procedure” (Robertson et al. 2017, 70) that was used to legitimize the application of medical techniques as weapons against the most vulnerable members of humankind, and to support societally-sanctioned genocide.

5.3 Dehumanization and Degradation

Why did so many physicians willingly participate in the murder of their patients? How could those dedicated to healing abandon the Hippocratic Oath (Proctor 1992, 17) and transform into killers? Why were they complicit with the ingrained societal ideology? These questions become especially hard to answer as scholars remind us that ethics training was a required component of their medical curriculum (Bruns and Chelouche 2017).

In retrospect, it was not sufficient for German academics to teach the concept of eugenics to colleagues or students. Silencing dissenting voices was also not enough. Physicians needed to embrace this indoctrination as truth, so that the ideas and methodologies could be practically applied. The systematic implementation of racial hygiene theory required intentional cooperation and collaboration as a basis of consultation, politicization and enactment of “early national Socialist legislation” (Miller and Gallin 2019, 260). Psychiatric and neurologic communities were heavily influenced by Erwin Bauer, Eugen Fischer and Fritz Lenz’s 1921 textbook *Human Heredity and Racial Hygiene*. In their seminal writing, these three prominent geneticists not only described, but promoted the “scientific rationale for medically-sanctioned, eugenic sterilization programs” intended to protect the racial hygiene of society and the *Volk* (Miller and Gallin 2019, 267). For example, Lenz estimated ten to fifteen percent of the population was defective and could be candidates for sterilization (Proctor 1992, 21). This book became the foundational training for many psychiatrists and neurologists as they established eugenic practices advocating for the extermination of the unfit and reflected academia’s pioneering role in Hitler’s rise to power (Roder et al. 1994). Separately, the racial hygiene institutes within German universities and the “journals of racial hygiene…were established long before the rise of National Socialism” (Proctor 1992, 20–21).

The consequences of the mandatory racial-hygiene curriculum established in medical schools created the antecedent mechanism to academically justify dehumanizing members of society based on their defined social status. Historically, demonizing members of a society leads to dehumanization. This does not occur with a single event. Rather, it is a gradual process that includes the labeling, classification, debasement and persecution of individuals on the basis of their being defined as less than human. During the Nazi era, physicians had the moral imperative and required medical authority to protect the *Volk* via sterilization and ultimately the eugenic genocide of those considered to be unfit, or subhuman. These decisions were asserted to be immutable and based on empirical data. Dr. Robert Jay Lifton, a post—war psychiatrist, describes the process of Nazi physicians' professional development. The German physician's desired identity was based on the Renaissance physician, Paracelsus, who was noted for using his knowledge of chemistry in the field of medicine. Hippocrates was also considered a medical ideal from an earlier generation. Professionalism was further amplified to now include a primary, political obligation to the *Volk*, which would result in the larger healing of society (Lifton 2000). For example, Gerhard Wagner, a Nazi medical authority, claimed the life of the nation takes precedence over "dogma and conflicts of conscience" (Lifton 2000, 29). This politization is reflected by multiple German physicians who told Lifton, "the oath of loyalty to Hitler they took as SS military officers was much more real… than a vague ritual performed at medical school graduation" (Lifton 2000, 207).

As the medical system became politicized, the political system itself became more medicalized. Hence, the confluence of medicine and politics that proved deadly for so many. This transformed professional identity and allegiance replaced the Hippocratic Oath as the principal driving force behind Nazi medicine, creating a unique scenario that paved the way for healers to become killers (Miller and Gallin 2019).

5.4 Psychiatry Timeline—Kraepelin to Rüdin

Eugenics, which arose in the late nineteenth century was "considered to be the leading, cutting-edge science of the time" (Grodin et al. 2018, 54). Scientists and politicians, including those within the United States, worked together to implement mechanisms to decrease the prevalence of those defined as hereditarily weak (Grodin et al. 2018). Lifton quotes an anonymous physician who asserted, "physicians alone possess the necessary combination of theoretical knowledge and direct human experience to serve as authentic biological evangelists" (Lifton 2000, 31).

Emil Kraepelin, founder of the German Institute for Psychiatric Research, specialized in the study of hereditary factors in illness (Roder et al. 1994). Geneticists were concerned that society's compassion would prevent natural selection, thus allowing pathological traits to flourish (Lifton 2000; JAMA 1933a). One of Kraepelin's specific research interests was schizophrenia, and his work on this is still referenced in the Diagnostic and Statistical Manual (DSM) (Roder et al. 1994). Using this handbook, psychiatrists were instrumental in identifying individuals who displayed schizophrenic characteristics, which became one of the criteria for coercive sterilization (Strous 2007).

These ideas were further developed by Kraepelin's student Ernst Rüdin (Roder et al. 1994). Rüdin was considered one of the major leaders and pioneers in German psychiatry and was, notably, financially supported by the Rockefeller Foundation (Torrey and Yolken 2010). He was an influential, first generation, racial hygienist, and the famed originator of psychiatric genetics (Bachrach 2004; Roder et al. 1994). He was also the co-founder of the German Society for Racial Hygiene, the Director of the Department of Heredity of the Kaiser-Wilhelm-Institute of Psychiatry, and the President of the Association of German Neurologists and Psychiatrists from 1933 to 1945 (Lifton 2000; Breggin 1993; Seidelman 1988; Lindert et al. 2012). In addition, Rüdin taught psychiatry at the University of Munich, where Mengele studied medicine (Seidelman 1988).

As early as 1911, Rüdin proposed eugenic legislation based on his population study exploring "*Fortpflanzung, Vererbung, Rassenhygiene*" (Procreation, Transmission, Racial Hygiene) (Roder et al. 1994, 43). These eugenic ideas were based on an interpretation of Darwin's survival of the fittest within animal populations and Mendel's laws of genetic transmission (Roder et al. 1994). Eugenics presumed that genetic purity and homogeneity were a definitional basis of this fitness (Ernst 2001). For instance, in 1935, Rüdin stated "the bases of all race hygiene were the preservation of the healthy hereditary elements and the eradication of the pathologic elements" (Seidelman 1988, 222). Rüdin's colleagues Alfred Ploetz, (creator of the term 'race hygiene' (*Rassenhygiene*)) and his pupil, the geneticist Fritz Lenz, further influenced the medicalization of eugenic precepts by using genetics to justify racial inequality (Ernst 2001). In contrast to the political heterogeneity of the United States which encouraged diversity, German society and its political systems became more homogeneous and consolidated. Until the German defeat in World War I, the eugenicists initially focused on positive eugenics which encouraged increasing desirable traits in society through reproduction (Friedlander 1995). This history reveals it was the early German psychiatric-racial hygienists, not the Nazis, who were at the forefront of the movement to improve the racial health and hygiene of society (Roder et al. 1994).

Despite the fact that German medicine and Nazi ideology complemented each other, Rüdin had to wait for the eventual political empowerment of National Socialism for eugenic-based legislation to be passed by the *Reichstag*. The use of academic studies in human genetics provided the practical justifications for population policy (Pross and Aly 1991). Because physicians provided "the science and claim to authority of the medical field," they could then be "mobilized to turn this vision into a reality" (Kelly et al. 2017, 99). It only took four months for the escalation to occur.

Although Germany approved legislation after WWI to permit voluntary sterilization, this initial legislation did not mandate involuntary sterilization (Grodin et al. 2018). It was not until 1933 that Rüdin was able to merge health and social policy by co-authoring the compulsory, surgical-sterilization "Law for the Prevention of

Genetically Diseased Offspring" (*Gesetz zur Verhütung erbkranken Nachwuchses (GVeN, July 14, 1933*) (Torrey and Yolken 2010; Bachrach 2004; Grodin et al. 2018; Ernst 2001; Roder et al. 1994). This policy was inspired by American sterilization legislation created by Harry Laughlin (Truman State University 2021; Breggin 1993; Proctor 1992, 21). Although German law initially targeted individuals diagnosed with feeble-mindedness (e.g., mental retardation), schizophrenia, genetic epilepsy, manic-depressive disorders, hereditary blindness, hereditary deafness, chronic alcoholism, severe physical malformations, and Huntington's chorea (Bachrach 2004; Grodin et al. 2018; Lindert et al. 2012; Lifton 2000), the "Law Against Dangerous Career Criminals," passed in November 1934, was expanded to include "habitual criminals" and the "Law for the Alteration of the Law for the Prevention of Hereditarily Diseased Offspring," passed in June 1935, allowed for involuntary abortion. These abortions could occur anytime during the first six months of pregnancy if the mother had a hereditary illness (Lindert et al. 2012). Physicians, as "advocates of the state," could now "*prosecute* those…charged with being 'genetically ill'" by regulating their reproduction (Pross and Aly 1991). Between 1934–1935, 388,400 individuals were identified as hereditarily *suspect* and referred to the Hereditary Health Courts in Berlin. The overwhelming number of individuals denounced by the referring health care personnel underwent involuntary sterilization (Friedlander 1995). These examples reveal how mandated sterilization was used as a medical weapon.

Furthermore, the psychiatrist Karl Bonhoeffer offered a course in 1934 describing a psychiatrist's responsibilities in upholding this law. The impact of this legislation resulted in approximately 300,000 to 400,000 individuals undergoing involuntary sterilization, with 62,000 incidents in the first year alone. (Pross and Aly 1991; Kelly et al. 2017; Roder et al. 1994). Age was not a factor in implementing sterilization procedures: "The youngest reported victim of involuntary sterilization was two years old" (Meyer-Lindenberg 1991, 8). It wasn't until after 1945 that this law was finally annulled in Germany (Pross and Aly 1991).

Not all eugenic sterilizations were based on traditional psychiatric diagnoses. For example, the September 1935 "Nuremberg Laws for the Protection of German Blood," defined *race* as a category of eugenic control (Seidelman 1988, 223; Friedlander 1995, 11, 23–24). This legislation placed race in the purview of psychiatry, thus allowing psychiatrists to enforce eugenic sterilization using racial inferiority as a diagnosis. Moreover, conscientious objectors were targeted by eugenicists, with those who did not support war activities classified as schizophrenic. This "hereditary" condition became an independent criterion for sterilization (Seidelman 1988). Rüdin, during his 1935 address to the Society of German Neurologists and Psychiatrists, gave "credit to psychiatry for its role in improving racial hygiene," (Seidelman 1988, 223) through its essential enforcement of eugenic sterilization.

Other essential roles of psychiatrists included adjudicating who was sterilized and educating the next generation of physicians. For example, two of Rüdin's colleagues, Eugen Fischer and Otmar von Verschuer subsequently served as medical judges/racial experts for the newly convened Hereditary Health Courts (Seidelman 1988; Bachrach 2004; Pross and Aly 1991). In addition, Fischer and von Verschuer created the racial-science curriculum for SS physicians. In these legal and educational processes, theory became practice (Pross and Aly 1991). Further evidence of von Verschuer's entanglement includes mentoring his first assistant in Frankfurt, Josef Mengele (Seidelman, pp. 224–225).

The concomitant sterilization efforts became part of a comprehensive racial hygiene program which also informed antimiscegenation laws (e.g., "Law for the Protection of German Blood and Marriages") and led to the creation of hereditary data banks (Ernst 2001; Bachrach 2004). Once involuntary sterilization became normalized, physicians' participation was no longer viewed as anomalous or wrong. This is an important point when trying to understand the psychological justifications given by Nazi doctors for their behaviors.

5.5 Sterilization Was not Enough

Once Hitler assumed power in 1933, any prior political opposition to eugenics was swept aside (Bachrach 2004). All professions were subject to a process of *Gleichshaltun*, whereby professional values were made to align with the authoritarian ideology of the Nazi regime (Robertson et al. 2017). Hitler advocated (Aryan) social unity even if this resulted in the dehumanization of German citizens. The contemporary theologian Professor Warren T. Reich notes:

> "*Gemeinnutz geht vor Eigennutz*" (What is useful for the community has priority over what is useful for the individual) and "*Du bist nichts, dein Volk ist alles*" (You are nothing; your people [nation] is everything) (Haque et al. 2012, 477; Reich 2001, 64).

The primary theoretical underpinning of *Gleichschaltung* for German psychiatry was eugenics. The faulty genetic inheritance theories of Rüdin and his colleagues coincided with the international popularity of eugenics and the growing interest in *Rassenhygiene* (Racial Hygiene) within Germany (Robertson et al. 2017).

In 1913, there were an estimated 238,583 psychiatric inpatients in German psychiatric facilities (Torrey and Yolken 2010). By 1924–1929, the number of psychiatric hospital patients increased to over 300,000. These overcrowded asylums (e.g., sanatoria, nursing homes or care institutions) were *the* focal point of psychiatric clinical practice (Robertson et al. 2017). Psychiatrists, as part of their daily clinical routines, were exposed to the distressing extremes of aberrant human behavior(s). Correspondingly, there were minimal effective therapies which they could utilize as part of their treatment armamentarium. By the 1930s, psychiatric interventions appeared more promising, leading to the reform movement in psychiatry which prompted the optimistic exploration of research therapies including open care (*Erlangen* model), malaria therapy, aversion therapy and insulin coma therapy (Robertson et al. 2017; Lindert et al. 2012). In spite of these new therapeutic interventions, psychiatric illnesses and their associated disabilities remained irremediable and intractable (Robertson, 72), resulting in increased social norms of stigmatization, isolation and condemnation (Robertson et al. 2017; Strous 2010). Ineffective, non-curative medical therapies and lifelong institutionalization, combined with the perception of psychiatric illness as a biological threat to society, reinforced negative public views about the financial burdens associated with this patient population (Robertson et al. 2017; Torrey and Yolken 2010). The ultimate danger to the patient, however, was the immense power psychiatry wielded, compared to other medical specialties, to forcibly and involuntarily remove "undesirables from society and plac[ing] them in asylums" (Strous 2007, 7). Thus, a connection was forged between psychiatry and public health which allowed the medical profession to identify, denounce and remove those individuals whom society deemed unsuitable from the general public.

Prior to Hitler's rise to power, Karl Binding, a renowned Professor of Law, and Alfred Hoche, the Freiburg Chair in Psychiatry, wrote the controversial 1920 academic treatise, *Permission for the Destruction of Life Unworthy of Life*, which promoted the idea of killing individuals labeled as *lebensunwertes leben* (life unworthy of life) (Lindert et al. 2012; Lifton 2000). The biological concept and designation of genetic inferiority provided the foundation for proposing the legalization of "mercy killing," while the traditional concept of the sanctity of human life was ignored. Mercy killing, rationalized as a compassionate and "allowable, useful act," became re-defined as a therapeutic, "healing" medical procedure (Lifton 2000, 46–47).

Although these were not initially mainstream views, Binding and Hoche imparted separate economic arguments, partially based on war reparations, to justify these proposed premature deaths (Gardella 1999; Strous 2010; Torrey and Yolken 2010; Lifton, 2000), stating "the burden on society by having to care for these individuals was too high and their human status too low" (Grodin et al. 2018, 54). Or, as Binding states: "Reflect…on a battlefield strewn with thousands of dead youths…-Compare this with our mental hospitals, with their caring for the living inmates…the meticulous care shown to existences which are not just absolutely worthless but even of negative value" (Gardella 1999; Binding and Hoche 1920, 246). The idea that human beings were entitled to be treated with dignity and respect simply by virtue of being human instead was replaced by the notion that a person should be measured by his or her worth to society—a chilling economic argument that continues to have repercussions to this day.

If a mercy killing program was to be objectively implemented, Binding suggested the use of a team comprised of a general physician, a psychiatrist and a lawyer. The rationale for this proposal was that medical care of those without economic value to the *Volk* unjustifiably drained social resources, and any limited financial resources should instead be directed toward healthy men and women. This medical hubris was further validated by the untimely deaths of otherwise healthy German citizens, with their "best available genes," during the previous war (Lifton 2000, 47).

Binding, a German jurist, described the physician's legal responsibilities in "killing….consenting participants," or in killing "incurable idiots" unable to consent as legally and moral permissible (Lifton 2000, 47). Binding and Hoche further described the need for a "carefully controlled judicial process" (Lifton 2000, 47) when applying for permission to perform euthanasia. Fidelity to the process would provide legal protection for physicians (Lifton 2000, 47). They argued that consent could not be a relevant factor because an “incurable idiot [is] unable to consent” (Lifton 2000, 47). More practically, consent would undermine the intentional secrecy of the program (Friedlander 1995). Hoche further noted “physicians must be protected against prosecution for euthanasia” (Friedlander 1995, 16).

Robert Jay Lifton recounts Hoche’s purported role as a “biological visionary” when Hoche stated: “A new age will come which, from the standpoint of a higher morality, will no longer heed the demands of an inflated concept of humanity and an overestimation of the value of life as such” (Lifton 2000, 47). Hitler and other Nazi officials ardently agreed with this concept. By 1931, Fritz Lenz noted “Hitler is the first politician…who has recognized that racial hygiene is a crucial political task and is prepared actively to support it” (Longerich 2019, 140). Immense power was thus given to doctors based on their ability to determine an individual’s worth to society. The trajectory of healers to killers began with this accumulation and consolidation of power.

Before 1939, “the majority of eugenicists and race hygienists did not support the systematic killing of the mentally handicapped…They believed that there were more effective means of preventing their reproduction” (Kuhl 2001, 185–186). Even after the First World War, the “majority of leading right-wing eugenicists and race hygienists drew a clear line between eugenic measures like sterilization and marriage prohibition, and the killing of the handicapped” (Kuhl 2001, 186). This was in contrast to Karl Binding’s and Alfred Hoche’s campaign to kill those not worthy of living. Initially, the eugenicists argued against incorporating euthanasia as a component of social reform programs. They argued sterilization would be a sufficient mechanism to reduce the production of inferior offspring and should not be used to terminate “already living people” (Kuhl 2001, 199).

The leaders of the eugenics movement, again, well before the Third Reich, were principal directors of the psychiatric institutes of the Kaiser Wilhelm Society. As noted by Thomas Roder, “the architects of the Holocaust … gathered in the psychiatric societies” (Roder et al. 1994, 159). Henry Friedlander further describes the publications of a German journalist, Ernst Klee, who provided a “detailed account of the so-called euthanasia program. Friedlander then recounts how the analyses by Benno Muller-Hill revealed how “euthanasia was not simply a prologue but the first chapter of Nazi genocide” (Friedlander 1995, XII). As the relative value of an individual life diminished, psychiatrists put eugenic principles into action, assuming their central role in the Nazi regimen’s euthanasia program. This abrogation of their primary responsibilities toward recognizing the ethical concept of human dignity diminished the moral stature not only of psychiatrists, but of all physicians.

5.6 The Importance of Eugenics for the War Machine

Between 1918 and 1924, Paul Weindling describes the progressive development of eugenic thought and practice, which began to advance the concept of “euthanasia” (Weindling 1989). In addition, Stefan Kuhl describes how the eugenicists argued that wars were dysgenic, based on the indiscriminate killing of "superior" individuals in the battlefields or by disease (Kuhl 2001). After World War I, eugenicists "saw their countries invaded by an 'army of the unfit'… [which] included beggars, alcoholics, criminals, prostitutes, psychopaths, epileptics, mental invalids, feebleminded, and cripples" (Kuhl 2001, 198). This perspective further changed society's compassion towards it most vulnerable members.

During a 1934 eugenics conference in Zurich, Rüdin argued that the "will for peace" was an important "common tie" between eugenicists. His colleague, Alfred Ploetz initiated a resolution against the "menace of war… (which) would again kill the most capable men" (Kuhl 2001, 200). In this international arena, this resolution politically linked Nazi race policies with the condemnation of contra-selective or dysgenic wars. The Nazi government hoped to commend and reward Ploetz's "eugenic peace" efforts by nominating him for the Nobel peace prize in 1936 (Kuhl 2001).

Rüdin and his colleagues hoped that the biological mission of creating hereditarily healthy offspring would result in the utopian vision of "true peace" among the most capable. This vision was further echoed by Hitler. Eugen Stähle, a German internist and politician, further justified the Nazi killing program by stating: "If during the war we ask thousands of young and healthy people to sacrifice their lives for the community, we can ask the same sacrifice from the incurably ill" (Kuhl 2001, 202). This propaganda of "race policy as peace policy" became the ideological matrix and verbiage within which the Nazis justified the killing of its handicapped citizens (Kuhl 2001, 202).

World War II required a dissociative shift from eugenics as a "form of peace" to an escalation and intensification of eugenics as a form of race policy. Otmar von Verschuer, Eugen Fischer, Fritz Lenz, and Ernst Rüdin "saw the necessity not only for an economic and military mobilization, but especially for a biological one" (Kuhl 2001, 204–205). This resulted in a further radicalization of their race hygiene policy.

5.6.1 Euthanasia Decree: From Eugenics to Euthanasia

Beginning in February 1939, Hitler began his next phase of euthanasia in consultation with professors of neuropsychiatry and pharmacology to determine which method(s) should be used for killing (Meyer-Lindenberg 1991). In July 1939, as he was planning to invade Poland, Hitler asked his private physician and other officials to draft a law that *permitted* the heretofore, illegal killing of mental patients with mental disorders (Torrey and Yolken 2010; Strous 2007). In August 1939, approximately ten to fifteen expert psychiatrists, asylum directors and other key organizers met to discuss and advise the logistics of a euthanasia program (Schmidt 2007). On August 18, 1939, the German Ministry of the Interior created a "highly confidential" circular that ordered physicians and midwifes to report newborn babies with deformities (Longerich 2019; Pross and Aly 1991). These required documents were then sent to a centrally located post-office box in Berlin for review by the "National Committee for the Scientific

Registration of Serious Hereditary and Congenital Diseases." Three experts would then determine the subsequent actions regarding these children.

The physician-perpetrators needed legal protections if this policy was to be implemented. Hitler pivoted, and forbade the creation of explicit legislation as an "unrealistic solution during war" (Friedlander 1995, 188). Instead, Professor Max de Crinis, a senior academic T4 psychiatrist and SS member, was thought to have provided wording to Hitler for what became the written authorization known as the "euthanasia" decree (Lindert et al. 2012; Schmidt 2007). Professor de Crinis was considered "the most outspoken and influential Nazi within the German psychiatric establishment" (Lifton 2000, 120). He knew a verbal order to psychiatrists authorizing killing was insufficient for this task (Friedlander 1995). Soon after Warsaw's capitulation on September 17, 1939, Hitler dictated a memo to Karl Brandt and Reichsleiter Philipp Bouhler on his personal letterhead and backdated it to September 1, 1939, to correspond with the beginning of the war (Schmidt 2007). This letter, by disregarding existing law, enabled and empowered physicians to administer "a merciful death" (Lindert et al. 2012). The correspondence not only provided legal immunity to physicians and nurses, it served as the legal basis for the subsequent Nazi euthanasia program, *Aktion T4*. Of note, this letter is the only surviving document which clearly links Hitler to the killing program (Schmidt 2007).

5.6.2 *Aktion T4*

It is important to understand that no one was ordered to carry out these murders (Strous 2007). As Robert Proctor states, "In times of war or economic crisis things can happen that otherwise—in times of peace or economic stability—would never be tolerated" (Proctor 1999, 289). Hitler's document not only provided legal protection, it also facilitated logistical collaboration between the medical profession and the government (Friedlander 1995). Even more importantly, it provided a mechanism to diffuse individual responsibility as Karl Brandt let his physician-colleagues know that in "Hitler's name" they could carry out euthanasia (Schmidt 2007).

Hitler's misdated correspondence disguised his intentions and shielded perpetrators during the initial phases of the invasion of Poland (i.e., formal beginning of World War II), when he believed citizens would otherwise be distracted and would have diminished concerns about the value of human life. This was "consciously thought" (Proctor 1992, 24) to be the "best time for the elimination of the incurably ill" (Lifton 2000, 50). War also allowed the implementation of more radical measures. Historians estimate 2000 Polish psychiatric patients were killed on September 22, 1939, at the Kocborowo (Conradstein) mental institution (Meyer-Lindenberg 1991; Lindert et al. 2012). By October 1939, the heads of all German psychiatric hospitals submitted forms identifying and "nominating" individuals with "hereditary" mental illness to an oversight committee of selected psychiatrists, eventually targeting an additional 70,000 patients for death (Torrey and Yolken 2010; Haque et al. 2012).

Between 1940–1945, a separate medical department within the Ministry of the Interior, located at *Tiergartenstraße 4* (T4), supervised the registration of institutionalized patients as part of an economic planning registration. In a similar manner, the T4 consultants would determine whether transfers to specialized facilities were required.

What began earlier as the sporadic, incremental murder of disabled children, soon become the pilot program for *Aktion* T4, a centralized process of mass murder whereby selected victims were supposedly transported for "improved" treatment, but instead, were murdered at six dedicated killing centers based on geographical proximity: Brandenburg, Grafeneck, Hartheim, Pirna-Sonnenstein, Bernburg, and Hadamar (Strous 2007; Friedlander 1995; Grodin et al. 2018). Family members were not initially suspicious of these transfers because these facilities represented some of Germany's most prestigious hospitals. Those who did try to intervene were considered "totally unreasonable" and admonished by the physician(s) (Friedlander 1995).

These euthanasia sites, however, were not chosen because of excellent specialty care, but because of their relatively isolated locations (Lifton 2000; Grodin et al. 2018). Brandenburg, for example, became the training ground for those who would implement the Reich's child euthanasia program (Roder et al. 1994). These deaths generally occurred within the first twenty-four hours of the patient's arrival (Lifton 2000). In many cases, the killing was done solely for the purpose of research. It wasn't until 1990 that the stored brains of many of these victims were comprehensively identified when located in the "basement of the Max Planck Institute for Brain Research in Frankfurt" (Roder et al. 1994, 156). By 1945, there were around 5,000 "euthanasia" victims of this program (Longerich 2019).

Attempts to maintain the secrecy of this program failed, resulting in Hitler's "official" discontinuation of the T-4 program on August 24, 1941, following increasing community protests from both the general population, the clergy and the legal profession (Ernst 2001; Lindert et al. 2012; Friedlander 1995). These protests notably included dissent from Catholic Bishop Clemens Graf von Galen in his famous August 4, 1941 sermon, and Brandenburg judge, Dr. Lothar Kreyssig (Longerich 2019; Friedlander 1995; Strous 2010). Kreyssig, a lower court judge in charge of guardianships, reported to the Reich Minister of Justice the disappearances and sudden deaths of his wards (Friedlander 1995).

After August 1941, the original killing centers on German soil were closed (Friedlander 1995). However, although the killing centers were shuttered, the killing did not stop. Medical personnel continued to carry out murders through an unofficial, decentralized process known as "wild euthanasia" (Lindert et al. 2012; Von Cranach 2003). In this "wild euthanasia" program, children and adults in the psychiatric hospitals and sanatoriums were killed with overdoses of sedatives or starvation, albeit more haphazardly (Lifton 2000). Further murders occurred in the concentration camps within occupied territories as part of the new program code-named, 14f13, which was initially intended to kill all handicapped and insane prisoners (Friedlander 1995; Lifton 2000; Grodin et al. 2018; Ernst 2001). If the SS camp physicians did not include a medical diagnosis within their documentation, the T4 physicians, now assisting in the camps, would. Operation 14f13 resulted in approximately 20,000 additional deaths. The T4 killings revealed that otherwise ordinary men and women were willing to participate in these murders. (Friedlander 1995). Without a firm ethical foundation, individuals felt that "they were doing (what) was correct from a moral and scientific standpoint; therefore, they were not the demons and 'paradigms of evil' that we perceive them to be" (Strous 2007, 4).

The German institutional physicians continued killing their patients until the target number of 70,000 was reached (Breggin 1993; Meyer 1988) thus providing a "rehearsal" (Proctor 1992, 24) for the subsequent genocide.

5.6.3 Mechanisms of Death

Again, it was the psychiatrists who were leading every step of these programs. Once the psychiatrists identified and certified which patients were to be transported to which destination, the psychiatrist used carbon monoxide, injections and starvation to facilitate their patient's deaths (Bachrach 2004; Burleigh 1994; Strous 2007). Reprieve could only occur if the patient was a war veteran, a foreigner, or if the medical records were incomplete. Although medications could be used to kill handicapped children, different mechanisms were required to kill adults. Deception and subterfuge were essential in adult killing. Patients thought they were undergoing normal medical routines as they removed their clothing and entered the rooms disguised as showers (Friedlander 1995). Relatives and guardians were not notified until after transfer, "actually only after the patients were killed" (Friedlander 1995, 85). For those with unusual underlying illnesses, "(t)heir brains were immediately removed and dissected, many on the same day" (Roder et al. 1994, 156). Psychiatrists were also instrumental in certifying fraudulent death certificates purporting credible, natural deaths, which were sent to the next of kin by the "Condolence Letter Department" (Strous 2007; Friedlander 1995; Grodin et al. 2018; Lifton 2000). The police and local governments were no longer involved in the vital statistics record keeping of these facilities because the number of deaths would raise suspicions. Even the site of death was altered (Friedlander 1995).

By 1942, Ernst Rüdin "collaborated with leading figures of the euthanasia action to redefine the role of psychiatry in Germany. He declared his agreement, in principle, with the killing of the mentally handicapped" (Kuhl 2001, 186). Other psychiatrists, such as Kurt Pohlisch and Werner Villinger, served as medical experts in the handicapped and adult euthanasia programs. As Stefan Kuhl articulates, "killing was a neutral issue subordinated to the higher goal of race improvement" (Kuhl 2001, 204). As early as 1943, Hitler authorized the emergency transfer of psychiatric patients to other decentralized sites so that hospital beds could be made available near the war zones for those wounded in bombing raids (Longerich 2019; Pross and Aly 1991). The use of asylum beds for the hierarchical care and rehabilitation of war heroes camouflaged the murder of extant psychiatric patients.

Although there was now no formal approval from Hitler or the T4 administration, psychiatrists justified their continued participation in "euthanasia" activities based on eugenic principles. The decentralized nature of the killings redirected the program's profile away from Hitler, while serving as a precursor to the Final Solution (Roder et al. 1994). With increasing experience in the murder of those deemed eugenically unfit, physicians abandoned their traditional ethical principles and expanded their killing net (Lifton 2000).

Lifton describe the perversion of the "healing-killing paradox" and how physicians rationalized these eugenic killings as a form of healing (Lifton 2000, 430–433). Omar Haque reiterates how physicians believed they were "saving the ones that most mattered amid the entire society" (Haque et al. 2012, 478). One observer noted "how rapidly gas caused death" (Friedlander 1995, 97), as if this made the process of killing humane. Karl Brandt confirmed the effectiveness of carbon monoxide as a "major leap …in medical history" (Schmidt 2007, 138). Another psychiatrist, Hermann Pfannmüller, the head of the Eglfing-Haar mental institution, remained deeply committed to a "Nazi worldview that demanded the elimination of…the pitiful patient who exhibited only the semblance of human existence" (Lifton 2000, 120). Pfannmüller, in his role as the director of this Reich Committee institution, developed policies of starvation instead of "wasting medications" on their deaths (Lifton 2000, 62). In contrast, the protests against this killing did not arise from within the medical profession, but rather from parents who protested against their "disappeared" children and from the churches, who believed in the sanctity of all human life (Lindert et al. 2012). Note, these stages of the genocide occurred prior to the Wannsee Conference held on January 20, 1942, which ratified "The Final Solution of the European Jewish Question" (*Endlösung der europäischen Judenfrage*) (Lindert et al. 2012).

At the camps, the "diagnosticians…according to Himmler's wish, [were] experienced psychiatrists" (Ernst 2001, 4). The only physician to command an extermination camp who could be considered young (age 32), and "minimally trained", was the psychiatrist Dr. Imfried Eberl (Strous 2010). His promotion was based on his acquired technical experience from Brandenburg and Bernburg, where he had previously coordinated the murder of "tens of thousands of mentally ill patients" (Strous 2010, 208; Strous 2007, 3) prior to becoming the commandant of Treblinka (Kaelber 2013, 22). It soon becomes apparent to the modern reader these expanded genocidal processes "would have been much harder to accomplish without the willing participation of physicians" (Grodin et al. 2018, 53).

5.6.4 Continued Psychiatric Leadership

On June 26, 1943, psychiatry's "elite" (e.g., Rüdin, de Crinis, Carl Schneider, and Hans Heinze) wrote a memorandum about the future development of the field. This document described insulin, electro-convulsion and dietetic therapies and nominally characterized psychiatry as a healing discipline. However, the memorandum also emphasized that only the "economically valuable … (have) the right to live" (Roder et al. 1994, 183–184). In writing this paper, Rüdin complained about how psychiatry was getting a bad name because of the "completely wrong demands of the hereditarily sick" (Roder et al. 1994, 184). The psychiatrists neglected to mention, however, their role in genocide, or how, until Mengele, they were unable to "test psychiatric twin theories by comparing the side-by-side autopsies of twins" (Roder et al. 1994, 161). Even after the war, twin research continued at the German Research Institute for Psychiatry. Rudin's daughter Edith performed schizophrenia research at the Max Planck Institute for Psychiatry and also minimized the "perceptions of her father's role in the Third Reich" (Roder et al. 1994, 197).

In 1943, Rüdin further published: "It is the unfailing historical merit of Adolf Hitler and his true followers that they dared to take the first decisive step past the purely scientific discoveries to open the way for the ingenious racial hygienic work in and on the German people… [to] prevent the propagation of the hereditarily ill and inferior" (Roder et al. 1994, pp. 235–236).

The medicalized "euthanasia" program ultimately resulted in the deaths of an estimated eighty percent of the psychiatric patient population, "(a)pproximately 400,000 psychiatric and /or patients with disabilities" (Lindert et al. 2012, 7). After the war, the psychiatrist Fredric Wertham further described these activities: "The tragedy is that the psychiatrists *did not have to have an order*. They acted on their own" (Wertham 1966, 161; italics added). Contrary to what many people continue to believe, there was no coercion. There were no mandates. There were only choices made to kill those deemed unfit by those entrusted to heal and care.

5.7 Resistance

Although psychiatrists were not the only physicians involved in genocide, their willing participation justified by the premise of eugenics facilitated the planning and implementation of involuntary sterilization and euthanasia (Strous 2007). "Young doctors, who were the most innovative and enthusiastic…may have been easily convinced to accept and participate or excuse the killing of the non-curable ill…as an inevitable professional part of healing the curable" (Lindert et al. 2012, 9–10). Psychiatrists could no longer claim the professional mantle and privilege of a moral agent. When their patients became re-defined as "useless eaters," they took a critical step along the slippery slope of criminal genocide. According to Rael Strous and Johannes Meyer-Lindenberg, very few psychiatrists publicly protested against these injustices. There were some notable examples, however, including: Martin Hohl, Hans Cruetzfeldt, Gottfried Ewald and Karsten Jasperson (Meyer-Lindenberg 1991). Dr. Jasperson, although a member of the National Socialist party (1933), was the head of the Department of Psychiatry at Bethel and wrote a memorandum to Hitler protesting the institutional registration forms in 1940 which identified patients for transfer (Ernst 2001). Jasperson also alerted Cardinal von Galen, who openly condemned these murders during his famous sermon in Lambert church (Meyer-Lindenberg 1991). Another opponent of National Socialism, Dr. John Karl Friedrich Rittmeister, was ultimately arrested and tortured by the Gestapo prior to his death by guillotine on May 13, 1944, in the Berlin-Plötzensee prison (Ernst 2001). In 1942, Professor Jurg Zutt, the editor-psychiatrist for the journal *Zentralblatt für die gesamte Neurologie und Psychiatrie* opposed the “great injustices” associated with psychiatric advocacy surrounding determinations of inferiority and genetic/mental illness (Roder et al. 1994). None of the protesting psychiatrists were able to prevail against the power psychiatry wielded in the Third Reich. Dr. Cruetzfeldt, who managed to save the majority of his patients, was only able to bring Werner Hyde, the Wurzburg Chair in Psychiatry and T4 Medical Director, to justice after the war (Lifton 2000; Lindert et al. 2012; Meyer-Lindenberg 1991).

Another example of resistance within the medical community was the White Rose (*Die Weibe Rose*), a non-violent, opposition group founded by five medical students from the University of Munich in 1942 (Lindert et al. 2012). Two members, brother and sister Hans and Sophie Scholl, were caught distributing leaflets denouncing the Nazi regimen on February 18, 1943, along with Christoph Probst. All three were tried on February 22, 1943 and executed by guillotine that same day (Ernst 2001). They were not given an opportunity to speak in their defense. Although most Germans accepted some level of Nazi ideology, the swift and immediate actions taken by the Nazis to silence any type of opposition or resistance demonstrates the “depth of their commitment and the degree of their radicalism” (Friedlander, 197).

5.8 Summary

Alexander Mitscherlich (1908–1982), a neurologist/psychoanalyst, and his co-author, Fred Mielke, were chosen as the delegates of German medicine to attend the Nuremberg Medical Trial (Hirsh 1949). Their seminal 1947 book *Doctors of Infamy* describes how eugenics, eugenicists, psychiatrists and the psychiatric euthanasia programs were instrumental in the eventual development of the Holocaust:

> This became the starting point for a line of development that inexorably led to enforced ‘mercy death’ for the incurably insane on the one hand, and, during the war, on the other, to plans for exterminating races declared to be inferior (Mitscherlich and Mielke 1949, 90).

Their book describes how doctors could become licensed killers. Physicians’ belief in the truth of eugenics in combination with the ideology of National Socialism led to the degradation of the medical profession. As racial hygiene became ingrained within medicine and politics and as more people were classified as “unfit,” the progressive, systematic processes of dehumanization and medicalization became routine, and served as a mechanism to reinforce already existing prejudices and biases. As the evidence of war crimes became apparent to the Allied forces, criminal trials were the mechanism to illuminate and immortalize the evidence. The legal system (vis-à-vis the Doctors’ Trial) became one such mechanism to correct the misconduct. Even though the victims did not receive complete justice, the Doctors' Trial resulted in the creation of the Nuremberg Code, a set of ten principles of ethical conduct that were intended to guide international human subject research and ensure that this misconduct of this magnitude was never repeated. The rate of suicides among Nazi physicians after the German defeat escalated and included Max de Crinis (May 2, 1945), and several other senior SS officials within custody who had access to cyanide (Schmidt 2007). Even the Führer's personal bunker surgeon, Ludwig Stumpfegger, provided the cyanide used in the deaths of Hitler, Eva Braun, Hitler's dog Max, and Magda Goebbels' six children (History Collection). Dr. Eberl committed suicide in 1948 while awaiting trial (Kaelber 2013).

As Jutta Lindert describes: "…the leading psychiatrists of the time…voluntarily and often enthusiastically took part in all stages of the operation to kill their defenseless victims. But…when confronted after the war with their deeds, denied any knowledge or responsibility" (Lindert et al. 2012, 16). Otherwise, they would have had to acknowledge that their participation was amoral and not permissible. Their loyalty to the *Volk* replaced the normative values and moral compass which were central to the physician–patient relationship.

Peter Breggin further chronicles the range of psychiatric involvement which began with the development of eugenic philosophy, followed by Binding and Hoche's (1920) book justifying "mercy killing," through physicians' integration of extermination programs within state mental hospitals, their subsequent technological education and staffing of the extermination camps, and their direct involvement in the murder of millions (Breggin 1993).

In closing, the field of psychiatry provided the scientific justifications and the mechanisms for practically implementing the eugenically-based sterilizations, child euthanasia, *Aktion* T4 and the later Operation 14f13 programs. Psychiatrists exterminated an estimated 220,000 and 269,500 German individuals with schizophrenia (Torrey and Yolken 2010). Other estimates by Fredric Wertham suggest the total number of killed psychiatric patients may have been as high as 275,000. It is important to understand that Nazi genocide was based on erroneous Mendelian genetic theories and "was the greatest criminal act in the history of psychiatry" (Torrey and Yolken 2010, 26).

By becoming an instrument of genocide on behalf of the state, psychiatrists were no longer constrained by their personal or professional moral codes. Their methods for treating and preventing mental illness and protecting the public's health were eugenic sterilization and genocide. Their willingness to place a value on human life determining who would live and who would die is contrary to the foundational principles of medicine. While psychiatrists stand out among medical professionals due to their ability to conflate clinical diagnoses with the worth of an individual, the direct and systematic involvement of the entire medical community in the labeling, persecution, sterilization and mass murder of millions of people deemed "unfit" based on the very criteria they defined, stands as the most egregious abuse of the power of science and medicine in modern history. Contemporaneous understanding of the process by which healers became killers and our moral responsibility to all members of society, will help ensure that this never occurs again.

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Chapter 6
The Physician at War

Sheena M. Eagan and Zohar Lederman

Abstract When examining bioethics and the Holocaust, the role of physicians is often shocking. As a society, we expect more of physicians. Learning about physician participation in the atrocities of the Holocaust prompts many questions: How did caregivers and healers become killers? How did physicians end up so intimately involved in war time atrocities? But the involvement of physicians in war atrocities is not unique to the Holocaust. Throughout history, medical professionals operating together with and in the name of the governing power and particularly the military, have played key roles in genocides, wars, and human rights violations. This chapter will explore the ethics of physician participation in war. We focus on the foundational and recurring issue known as "the problem of dual- loyalty"—the ethical tension of a single moral agent with two competing interests or sets of moral obligations. The underlying assumptions of this debate will be explored to examine how both the professions of medicine and the military involve a set of professional moral obligations that sometimes conflicts.

6.1 Introduction

Physicians joined the Nazi party in greater numbers than any other professional group. By the end of the war, over 38,000 physicians were members of the Nazi Party—representing almost half of all German physicians (Proctor 1988). Physicians were also overrepresented in the Nazi Schutzstaffel (SS). Compared to <0.5% of the general population, 7% of all physicians were members of SS with significant responsibilities at the concentration camps (Proctor 1988). The ideas of National Socialism and later Nazi ideology were both informed by and enthusiastically embraced by the medical profession. Framed as "applied biology," National Socialism became

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the political mechanism through which eugenic science was implemented as social policy (Proctor 1988). In accordance with the work of the international eugenics conference, National Socialism advocated that commitment to race betterment was an obligation held by those in government to their citizens (Kevles 2007). It was a government intent on improving the so-called health of the German people by excising those populations that were deemed as inferior. Physicians were instrumental to the policies and practices of World War II Germany. They were involved in many of the atrocities committed during the Holocaust including: forced sterilization, institutionalized killing (Child Euthanasia, *Aktion* T4 Program, Wild Euthanasia, Operation 14f13, The Final Solution), and Medical Experimentation (Lifton 1986).

When examining bioethics and the Holocaust, the role of physicians is often surprising to students of history. As a society, we expect more of physicians. How did caregivers and healers become killers? How did physicians end up so intimately involved in war time atrocities? But the involvement of physicians in war atrocities is not unique to the Holocaust. Throughout history, medical professionals operating together with and in the name of the governing power and particularly the military, have played key roles in the most horrible human-made calamities: genocides, wars, and human rights violations.[1] Since the specifics of physician involvement in the Holocaust are explored in detail other chapters, this chapter will explore the ethics of physician participation in war more generally. We will focus on the foundational and recurring issue known as "the problem of dual loyalty," which is when a single moral agent has loyalty to two competing interests or sets of moral obligations. The underlying assumptions of this examination is that, first, both the professions of medicine and the military involve a set of professional moral obligations, and, second, that these obligations sometimes conflict. We will further describe the concept of "dual loyalty" through historical examples, which will provide breadth and depth of understanding to the moral tensions that undergird it.

6.2 The Military Physician

> When physicians were clearly non-combatants in a civilian culture, tending to the sick and wounded of belligerent, armed combatants, regardless of country of origin, protecting and preserving the integrity of the healing arts was less complicated. Today physicians wear the uniforms of their countries, travel imbedded with the fighting forces to intervene and to provide care and treatment to the sick or wounded soldier as quickly as possible with the best expectation of survival (Allhoff 2008, 39).

Physicians and other caregivers have long played an important role in armed conflict and other military operations. Their involvement is critical to ensure both

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[1] From here on, we will use the term 'conflicts' to include all of these different kinds. We do not use this term to minimize atrocities but rather to be inclusive of all conflicts where atrocities do and have occurred. These are in no way limited to "war" itself.

that the war wounded receive proper care and that the able-bodied stay that way—healthy and able to fight. Medical treatment is also essential to military morale. Soldiers will run towards battle when they know that military physicians are ready to treat them if they are injured. However, the existence of caregivers on the battlefield has always been complicated. Their role is highly valued and specialized granting the profession unique status and warranting specific protections—but sometimes these protections and status fall away, and they act in service of the state, rather than in service of the patient.

The physicians who provide care to war's wounded have not always been part of the military itself. Throughout history, civilian doctors have been mobilized in times of war to provide medical care (Gillett 1981). However, using a civilian medical force without battlefield training often led to a steep learning curve, lost lives, and compromised missions (Cowdrey 1987). Civilian physicians also lacked the cultural knowledge and rank to influence military operations (Gillett 1981). In response to these limitations, military physicians have become increasingly embedded within professional militaries. Now physicians hold high ranks and serve in command roles. They can also be attached to specific units to serve a limited and specialized patient pool (such as flight surgeons). They are trained to use weapons and deploy to combat zones; they wear the same patch as the soldiers around them to symbolize their belonging. Despite their special status, they are now fully integrated in the military, and are in many ways separated from civilian medicine. However, embedding medical professionals within the military not only ensures the necessary training to provide adequate medical care, but it also confers two sets of obligations on a single moral agent and ushers in a foundational ethical tension: are these moral agents doctors? Soldiers? Both? And if both, which role is primary?

6.3 The Problem of Dual Loyalty

The dual loyalty problem refers to dilemmas that challenge military physicians to prioritize the obligations of one of their professional roles over those of the other (Chamberlin 2013; Howe 2003) These physicians find themselves confronted with situations where military protocol, orders, or strategy requires them to behave in a way that is contrary to norms of medical ethics in civilian and peacetime medical practice.

Of course, military medicine has always differed greatly from civilian medicine. Generally, these differences were manifested in scale and scope: military physicians, unlike their civilian counterparts, were responsible for the health of large numbers of soldiers in crowded environments such as camps and transports (Gillett 1981). By contrast, private practice physicians were largely unfamiliar with the unique medical issues of large populations in crowded environments or in the battlespace (Gillett 1981). However, scope and scale are not the only differences between these two groups of medical doctors. Beginning in the First World War, military physicians and outside critics began to discuss a perceived ethical dilemma inherent in physician participation in the military and in war (Byerly 2005). Private-practice, or civilian, physicians were obligated to serve the individual patient, having sworn the Hippocratic Oath and made a public promise to uphold the fiduciary relationship between them and their patients. However military physicians had also sworn another oath—making the public promise to serve their country. During times of war, this meant preparing men to be deployed into war zones that could result in mass deaths (Byerly 2005). Military physicians were also subject to military hierarchy, where they were often outranked by men with no medical training and had to adopt an almost utilitarian framework in order to "maintain the fighting force."[2] Although this language was not yet used, the issue of focus was the problem of dual loyalty.

According to the normative conception of modern western medicine, physicians have intrinsic moral obligations that engender responsibility first and foremost towards their individual patients. Many scholars have argued that the medical profession carries its own set of natural ethical maxims (Troug 2011). Edmund Pellegrino, Howard Brody and Franklin G. Miller, for example, have argued that the moral obligation of physicians is grounded in an *internal morality of medicine* (Pellegrino 2001; Miller and Brody 2001). These authors argue that the internal morality of medicine is internal because it is derived from the nature of medical practice (Pellegrino 2001; Miller and Brody 2001). Edmund Pellegrino and David Thomasma specifically argue that the individual patient encounter is the central defining moral phenomenon of medicine (Pellegrino and Thomasma 1998). They contend that it is this relationship that shapes the foundation for the moral obligations assumed by the physician when she offers to "heal, help, care for, or comfort a sick person" (Pellegrino and Thomasma 1998, 115).

Even those who are not swayed by the argument of an internal morality of the profession of medicine generally agree that there are additional moral obligations that arise due to the special status of the medical professional. This special status confers obligations that, in turn, warrant the public trust and cultural authority granted to members of the medical profession. Longstanding conceptions of medical ethics obligate physicians to prioritize the good of the patient and avoid doing harm. Further, the concept of an internal morality of medicine grounds the physician-soldier's obligation to her patient in the relationship, locating, at the very least, a prima facie priority where a physician is obligated to care for an often vulnerable, ill patient who requires help. However, in some situations, military health professionals face circumstances and scenarios in which this prima facie priority towards their patients seemingly breaks down. Within the military context, occasions may arise that present ethical tensions between the responsibilities felt towards the individual patient and those felt (and enforced) towards the military mission (Lederman 2013; Gross 2006; Chamberlin 2013).

This ethical conflict is the problem of dual loyalty. This issue arises throughout military medicine, with dilemmas ranging from the common and mundane to the extreme. As a practical matter, the unique issues of military medicine are rarely experienced in garrison. When soldiers receive care in military hospitals at home, it

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[2] The official mission of the United Stated Army Medical Department (AMEDD).

is seldom different from civilian medical care. However, the battlespace is unique. Military hierarchy and the exigencies of war change everything from the experiences of the patient and the provider to the foundational patient-provider relationship. The military itself, usually as represented by the mission or command, enters into this relationship. Beyond that, the physicians' focus is reoriented away from patient-centred beneficence to the military's objectives and the mission's success. In the deployed setting, the military mission is paramount and aggregate concerns are prioritized, this is especially true of combat deployments. Thus, the physician-soldier's participation in war extends beyond patient care to include other activities perceived as critical to mission success. These activities may even limit or obfuscate patient care completely.

In the following section, the philosophical concept of dual loyalty will be examined through historical examples that offer illustrative case studies arising from physician participation in war.

6.3.1 Historical Examples

Human Experimentation in Concentration Camps

The full extent of physician complicity and participation in the Holocaust is examined throughout this book, so we will not delve into significant detail here. Simply put, the medical community's involvement was instrumental to everything from early sterilization laws to the Final Solution. While these practices were not limited to military physicians, those working in the concentration camps were uniformed military officers (generally members of the SS). In concentration camps, physicians had many responsibilities and roles, including the development and implementation of inhumane medical experiments. Many of these experiments were military in nature, with the aim of addressing real-life issues facing the German military. This type of wartime research typifies the rationale that national security and military necessity permit normally unethical practices. In prioritizing the mission of the Nazis, these physicians not only failed to protect the vulnerable, but they actively abused and harmed them. Further, their use of prisoners of war highlights the problematic othering that can occur when enemies are not seen as patients, research subjects, or even people. We will briefly describe three experiments with clear military application: High-altitude decompression, wound care/infection, and hypothermia/re-warming.

High-altitude decompression: WWII was the first time that a significant portion of warfare happened in the sky. As a result, prior to the Second World War, aviation medicine did not exist and our comprehension of flight's effect on the human body was nascent. Militaries were anxious to understand the effects of high altitude and the limits of their pilots. To address this, SS physicians developed and conducted high-altitude experiments on prisoners at the Dachau concentration camp. A pressure chamber was constructed to simulate altitudes as high as 68,000 ft (Caplan 1992).

Prisoners were then placed in low-pressure chambers where physicians monitored their physiological response as they lost consciousness and died. These victims were then either dissected of vivisected. Of the reported 200 people subjected to these experiments, 80 died during the experiment and the remainder were either executed or dissected alive (Caplan 1992).

Wound care/infection: In a similar vein, the Nazi doctors conducted many experiments on the treatment of wounds with the hopes that their findings would benefit the German Army. As in prior wars, battle wound infection continued to have significant impact on the health and readiness of troops. For example, German soldiers suffered greatly from gas gangrene in both WWI and WWII. To explore best practices, doctors performed studies to test the effectiveness of sulphanilamide and other drugs in curbing such infections. These experiments involved the intentional infliction of wounds on victims to mimic those of combat. These non-consenting prisoners were first either shot, stabbed, or otherwise mutilated; the wound was then infiltrated with bacteria such as streptococcus, tetanus, and gas gangrene and aggravated by rubbing ground glass and wood shavings into the wound. On occasion, healthcare professionals even tied off blood vessels on either side of the injury to simulate what would happen to an actual war wound. A variety of ointments, salves, and sulfa drugs were then applied to the festering wound. Victims suffered intense agony and serious injury, and some of them died as a result.

Hypothermia/re-warming: Among the most infamous experiments were the hypothermia experiments conducted at Dachau. Again, these experiments were designed to address a pressing issue facing the German military. German pilots were becoming hypothermic after ejecting into the cold ocean and facing extreme exposure on the Russian front. Without any best practices in treatment, experiments were designed to determine the most effective means of treating hypothermia in German soldiers. Dr. Sigmund Rascher and others conducted freezing experiments at Dachau. For up to five hours at a time, victims were placed into vats of icy water, or strapped down outside (Caplan 1992). Victims were either dressed in aviator suits or naked. Physicians were involved in all aspects of the study. They measured changes in the patients' heart rate, body temperature, muscle reflexes, and other factors. When a prisoner's internal body temperature fell to 79.7 °F, the doctors tried re-warming him using hot sleeping bags, scalding baths, and they even forced naked women to copulate with the victim (Caplan 1992). Victims of these experiments were said to have writhed in pain, foamed at the mouth, and lost consciousness, with many dying in the chamber itself. According to records, roughly 80–100 patients perished during these experiments (Caplan 1992).

These experiments are unethical on every level: the participants had no choice and did not consent, the experiments themselves were torturous, and often the desired outcome was death and dissection. The integral role of doctors highlights the danger of unreflectively applying medical knowledge to military goals. While this research was intended to serve a military mission—albeit a clearly immoral one aimed at genocide and domination—it accomplished these goals by harming patients. This abuse was made possible through a reorientation of medical ethics to serve the *Volk* and to support the Nazi war effort. Physicians used their medical knowledge and expert skill to design and implement research that was not in keeping with any conception of professional medical morality.

Physician Complicity in Torture: CIA

Half a century later, clinicians once again used their expertise for purposes that ran counter to their professional ethos. Physicians, psychologists, physician assistants, and medics were intimately involved with the "enhanced interrogation" techniques used as part of the Global War on Terror, which in many cases constituted torture[3] (Senate Select Committe on Intelligence 2014). In fact, medicine was built into the torture system by way of institutional policy. Steven Miles has argued that tactics constituting torture depended on the participation of medical professionals. According to Miles, "In 2002, Defense Department attorney Diane Beaver crafted Guantanamo's request for harsh interrogation, arguing that such techniques were legally permissible 'with appropriate medical monitoring" (Miles, Oath Betrayed: Torture, Medical Complicity and the War on Terror 2009: xiii). Thus, non-clinician commanders and policymakers saw the use of medical professionals as being a *more humane* approach to the issue of enhanced interrogation. Similarly, Secretary of Defense Donald Rumsfeld included physicians in his harsh interrogation plans for Abu Ghraib and Afghanistan (Miles, Oath Betrayed: Torture, Medical Complicity and the War on Terror 2009).

According to Miles, military medical officers and psychologists played three important roles in the enhanced interrogation system: (1) vetting patients to ensure that they could withstand torture, (2) monitoring patients during interrogations, (3) personalizing enhanced interrogation plans according to medical indicators (S. H. Miles, Oath Betrayed: Torture, Medical Complicity and the War on Terror 2009). The third role, which involved the personalization of the plan, was performed by a group of psychologists and psychiatrists known as Behavioral Science Consultation Teams (BSCTs). These teams were responsible for creating harsh interrogation plans that exploited medical weakness and were informed by psychological knowledge and theory.[4]

According to the Senate report on the CIA detention and interrogation program, detainees underwent inhumane and cruel abuses that included: slaps, "walling" (slamming against a wall), sleep deprivation, loud music, extreme temperatures, prolonged stress positions, waterboarding, and "rectal rehydration" or rectal feeding (Senate

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[3] According to the World Medical Association, torture is defined in the Declaration of Tokyo (2016) as "the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason."

[4] Now it is well known that two psychologists, whose pseudonyms are Hammond Dunbar and Grayson Swigert, (real names are Jim Mitchell and Bruce Jessen) have been the masterminds behind the protocols for the CIA interrogation program, and even conducted the interrogations themselves. (Senate Select Committe on Intelligence 2014, 72).

Select Committe on Intelligence 2014, 3–4). Physicians for Human Rights (PHR) issued a report summarizing the more lengthy CIA document. Their report elaborates on the roles of medical officers mentioned by Miles (Physicians for Human Rights 2014).

According to their report, medical professionals:

1. Designed, directed and profited from the torture program.
2. Intentionally inflicted harm on detainees.
3. Enabled the legitimization of interrogation practices.
4. Engaged in human subject research to provide legal cover for torture.
5. Monitored interrogations.
6. Evaluated and approved detainees for torture.
7. Conditioned medical care on cooperation.
8. Failed to document physical or psychological evidence of torture.

Importantly, the senate report does not actually corroborate all the claims raised by the PHR's report. For example, there is no evidence of human experimentation by medical officers in the CIA report. Further, if we exclude psychologists from the category of medical professionals (see footnote 1), the senate report does not provide any evidence for medical professionals designing or directing interrogations

A few abuses intrinsically required active medical officer participation, and were even justified medically, providing a prime example of the "medicalization" of war and torture. For instance, rectal rehydration was used by interrogators as an instrument of torture, while CIA medical officers also justified it medically. One medical officer wrote: "(sic) [w]hile IV infusion is safe and effective, we were impressed with the ancillary effectiveness of rectal rehydration on ending the water refusal…" In June 2013, the CIA even claimed that rectal rehydration was a "well acknowledged medical technique" (Senate Select Committe on Intelligence 2014, 100. footnote 584).

In his testimony to the US senate, CIA director Michael Hayden claimed: "Health care has always been administered based upon detainee needs. It's neither policy nor practice to link medical care to any other aspect of the detainee program." In light of the many narratives reported by the senate report, one may conclude that Hayden's testimony was false. The senate report explicitly states that, "[t]his testimony was incongruent with CIA records (Senate Select Committe on Intelligence 2014, 113, 449 (footnote 665)).

Importantly, the ethical dilemma of dual loyalty was addressed at an institutional level by positioning the military as the physician's client, rather than the individual patient. According to Defense Department Deputy Assistant Secretary for Health, Dr. David Tomberg, there was "no doctor-patient relationships for interrogatees." This reorientation of moral obligations attempts to relieve the physician-soldier from their medical obligation to the health and welfare of individual patients by rhetorically redefining the doctor-patient relationship through policy. This conceptual understanding of the physician-soldier's role was reinforced by specific policy: "Under Guantanamo's 2002 policy, medical personnel were obliged to give non-medical personnel, including members of the BSCT, medical information relative to the 'national security mission' upon request." (Miles, Oath Betrayed: Torture, Medical Complicity and the War on Terror 2009, 54).

Interestingly, others in powerful positions within the U.S. government made statements that directly contradicted these policies. While rejecting the allegations that physicians were involved in these harsh interrogation programs, Assistant Secretary of Defense for Health, Dr. William Winkenwerder Jr., stated, "…we always expected a physician to behave ethically in any circumstance" (Miles, Oath Betrayed: Torture, Medical Complicity and the War on Terror 2009, 63). This highlights the military's institutional failure to address adequately and coherently the role of the physician-soldier, while simultaneously compounding the problem with mixed institutional messages.

Doctor-Patient Confidentiality

Another significant issue related to the problem of dual loyalty is the violation of patient confidentiality under military order or in support of the military mission. Generally, these cases exist along a continuum and ethicists such as Edmund Howe believe that physicians should breach confidentiality only in limited situations, such as when the demands of military necessity are stronger (Howe 2003). An illustrative example is that of the now-repealed American policy known as "don't ask, don't tell" that was abolished by President Barack Obama. This policy had banned openly gay citizens from active military duty. The policy placed psychiatrists in a position that exemplified the problem of dual loyalty. If a patient were to confide in them about their homosexuality, military psychiatrists had an obligation to report the individual to their commanding officer, as his or her sexuality violated regulation. This regulatory obligation was problematic to psychiatrists because they felt that medical ethics called for doctor-patient confidentiality, which was breached by this policy. There may be other occasions in which physicians can be compelled to breach confidentiality—such as reporting diseases and illnesses that affect mission readiness or a soldier's ability to fulfil his or her obligations/duties. However there needs to be a clearly justifiable medical need to violate this fundamental tenet of bioethics.

6.4 An Ethical Analysis of Military Medicine

Various authors have grappled with the problem of dual loyalty presented in these and other cases. Philosopher John Moskop explains that military physicians assume a set of obligations as physicians (which he characterizes as a fiduciary relationship grounded in the four principles of Tom Beauchamp and James Childress) and another as soldiers, as framed by the institution of the military itself.[5] Moskop acknowledges that these obligations may come into conflict and seeks to highlight the important moral decision a physician faces when joining the military. Standing in contrast to other authors who posit the supremacy of one of the physician-soldiers' twin roles, Moskop recognizes both as having prima facie legitimacy (Moskop 1998). While

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[5] The four principles originally put forth by Beauchamp and Childress are autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress 2013).

acknowledging the moral difficulties of the physician-soldier, Moskop leaves it to the individual to decide his or her own ethical and professional path. According to Moskop, "a physician's decision to enter military service is thus a morally weighty one that bears reflection on the practices of the military service to which one is pledging obedience" (Moskop 1998, 163).

Some have argued that a military physician is a moral impossibility. According to this line of thought, the dual loyalties are not just conflicting but incompatible. Put another way, the use of physicians by the military and involvement of physicians in military activity is morally objectionable on the grounds of medical morality (Siden and Levy 2003). In the textbook titled, *Military Medical Ethics,* Victor Sidel and Barry Levy argue that it is unacceptable for physicians to serve as both physician and soldier (Sidel and Levy 2003). The authors ground their position in the belief that the "overriding ethical principles" of each of these professions are incompatible with the other. Sidel and Levy define the overriding ethical principles of medical practice as (1) concern for the welfare of the patient and (2) to primarily do no harm (Sidel and Levy 2003). These principles are rooted in the ethical codes of professional organizations, and further codified in the Geneva conventions and similar international documents. On the other hand, the overriding principles of military service are defined as concerning (1) maintaining the effective function of the fighting force and (2) obedience to the command structure. These are seen as incompatible because medical morality is understood as necessitating prioritization of the patient above military concerns. Due to this incompatibility, Sidel and Levy believe that the role of the physician-soldier is an inherent moral impossibility (Sidel and Levy 2003).

As a response to the arguments of Sidel and Levy, other scholars have gone so far as to posit that there is in fact no problem of dual loyalties for the physician-soldier (Madden and Carter 2003). William Madden and Brian S. Carter have argued that the values are not that different when one explores the essence or *ethos* of the profession's moral world (Madden and Carter 2003). According to Madden and Carter, the *ethos* of each profession is characterized by the values that define the profession and the professionals, establishing their collective rights and responsibilities (Madden and Carter 2003). According to these authors, both professions seek protection of the vulnerable, rendering the dual loyalties inherently compatible.

Madden and Carter ground the ethos of medicine in its professional oaths (such as the Hippocratic Oath and AMA code of ethics), which have historically existed to prevent medical professionals from becoming "agents of death" (Madden and Carter, 271). Their understanding of professional medical morality is further grounded in social and political policy, which have used "professional, civil, and criminal sanctions to prevent members of the medical profession from becoming involved in activities that led to the deaths of members of their society" (Madden and Carter 2003, 271). This professional medical morality is discussed in conversation with the morality of the profession of arms, which Madden and Carter characterize as being, "tasked with defending members of that society by becoming directly involved in activities that lead to the wounding or death of others" (Madden and Carter 2003, 271).

These authors refute the arguments of Levy and Sidel by appealing to medical necessity and a long history of physicians' involvement in war. Their involvement is necessary because of the very nature and context of war. The unsanitary and overcrowded conditions of war lead to rampant illness and infectious disease, which warrants medical attention. Beyond these conditions, the ability to maintain or conserve the fighting force is paramount to military success, necessitating the skills of a medical doctor.

Importantly, Madden and Carter recognize the physician's role in the military system in a way other authors fail to. Madden and Carter acknowledge that physicians have become part of the formal military system, joining in the initiation rites by swearing the same oath as non-medical officers and wearing the same uniform. These physicians are not just individuals doctoring in the context of war, they are doctoring within the military profession and that institution. Drawing on the work of Samuel Huntington, Madden and Carter enrich the understanding of the profession of arms as one of the historically recognized professions: namely, divinity, law, medicine, and the military (Madden and Carter 2003).

Madden and Carter define the goals of medicine as "prevention whenever possible; curative treatment when prevention fails; and healing, the relief of pain and suffering, when specific treatment will not benefit the patient" (Madden and Carter 2003, 275). The goal of the military profession is defined as security. Madden and Carter argue that men and women are "drawn to the profession of arms both by their desire to serve society and by the inherent attraction of the ultimate means of the profession—war" (Madden and Carter 2003, 279). The authors then trace the professional similarities between medicine and the military. They argue that medicine aims at aiding individuals in maintaining and restoring health or working to ease the patient's suffering if a cure is not possible. This goal serves society because society benefits from having healthy citizens. The goal of the military also seeks to benefit society by protecting it and dissuading others from attacking it. Madden and Carter offer the argument that societies need both professions, as they both serve it in preserving its future.

By appealing to the ethos of these professions Madden and Carter appeal to a normative conception of professional morality. In shaping the conception of military morality in this way and understanding the profession of arms as beneficently protecting society, Madden and Carter are able to frame military morality in a more positive way as compared to Sidel and Levy. This distinction highlights the importance of maintaining both normative theories and descriptive realities in any dialogue of professional morality.

The morality of the military profession depends on the morality of the military mission and how that mission is carried out. Since the military institution is built on the foundational values of obedience and loyalty, soldiers are trained to uphold the mission and follow orders regardless of whether they agree with the mission or not.[6] While some military missions, programs and operations do aim to protect society and uphold important values, there have been historical examples where the goal was not protection but rather colonization or imperialism. This is especially true of WWII,

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[6] There are venues for soldiers to appeal or refuse orders and missions that are illegal and immoral. That being said, many feel as though this does not represent a realistic option and could negatively affect their military career.

where the goals of Nazi genocide and domination have been universally condemned. The mission was immoral and thus anything done in support of this mission was also morally wrong.

Similarly, the morality of the medical profession depends on the morality of the medical mission. In this case, the mission is arguably always the same- caring for individual patients. Consider however the role of individual healthcare workers in research, or as officers of public health—only recently authors of an introductory book in bioethics have explicitly argued that physicians should consider public health implications in their care of individual patients (Herbert and Rosen 2020). Some form of the dual loyalty problem is thus not limited to the military.

6.5 Dual Loyalty in Non-military Settings

Analogies are often drawn between those examples just discussed and the conflicting loyalties that occur in the civilian sector. The editors of the Institute of Medicine's published workshop summary entitled *Military Medical Ethics: Issues Regarding Dual Loyalties* acknowledge that this type of dual loyalties problem exists outside of the military sphere, having many civilian analogies:

> In occupational medicine, particularly in small corporations, where the physician or nurse reports directly to corporate executives, an injured employee's desire to return to work in order to obtain full benefits may conflict with corporate productivity goals. In sports medicine, a triad of decision makers—physician, coach, and athlete—typically make a joint decision, based on a full assessment of risks and benefits offered by the physician (Institute of Medicine 2009, 2).

The military physician certainly differs from the above-mentioned professionals in terms of moral obligations and professional status. Howe points out that "the conflicting obligations military physicians face generally are greater in both magnitude and frequency than those faced by their civilian counterparts" (Howe 2003, 334). According to this argument, the main difference is the fact that the stakes in the military are substantially higher. Military physicians practice medicine in the context of war, a context seen as unparalleled in civilian medicine. Due to this fact it is possible that medical decisions could lead to the loss of the war, potentially resulting in many millions of deaths and great harm. Occasions such as that may be rare but are nonetheless real. The context of war coupled with the high stakes accompanying such an endeavour differentiates military problems of dual loyalty from those of the civilian sphere. This difference highlights the ethical dilemmas unique to military physicians.

Practitioners of sport and occupational medicine for instance may be placed in situations that challenge their obligation to care for an individual patient, but their other allegiances are not to professions in the same sense as medicine and the military. These physicians have not made a public promise as a member of two distinct professions, entering into specific relationships with inherent moral obligations in the same way as a military physician. The act of profession, of publicly promising to become a member of a specific profession, with everything that entails, is a foundational component of professional morality (Pellegrino and Thomasma 1998). Practitioners of sports medicine, or occupational medicine have only joined the profession of medicine; they have not taken an oath to the non-medical institution they serve. This oath confers both a moral and a legal obligation to follow orders that support the military mission. Beyond that, their second, non-medical roles generally lack the established professional morality of medicine, making medical obligations easier to prioritize over other, non-medical goals. Although other concerns may enter their decision-making process, including job security and pleasing their employer and patient, the second role of an occupational or sports medicine physician does not carry the same moral and legal obligations as those in the military.

Healthcare workers working in public health or research may come closer to the dilemma faced by the military healthcare worker. While they have sworn only one oath, aimed at their individual patients, they have obligations towards the public which they serve and to science—i.e. to produce generalizable knowledge. Arguably, not only public health officers hold duties towards the public but all healthcare workers, who must report cases of certain infectious diseases for instance, whether it serves the individual patient or not. While the dilemma of the clinician-researcher has been discussed *ad nauseum*, the dual loyalty of the clinician who is also a public health practitioner seems to rely on the unchallenged assumption that the two loyalties are and should be separated. Maybe time is due to challenge this assumption, especially as the tensions that arose during the Covid-19 pandemic revealed that a conflict of interests exists between public health and fiduciary focus on individual patients. In other words, the practical and conceptual separation between the clinician and public health is probably overstated and morally questionable.

Despite the existence of these conflicting identities outside of the military, the austerity and intensity of war raise the stakes for military physicians. But more than that, times of crisis have a tendency of shifting societal values for all, not just those in the military. Under threat of death or the prospect of mission failure, people can suspend their moral values. Those physicians who were integral to and complicit in the atrocities of the Holocaust were not all in uniform. The proliferation and power of the Nazi ideology within the professional community meant that the majority of physicians tolerated the expulsion of their Jewish colleagues and accepted discriminatory policies. The complicity of German medicine during the Holocaust, must recognize the communal nature of this support, as well as its widespread proliferation within the broader medical culture.

6.6 Conclusion

The problem of dual loyalty ushers in a professional identity crisis for the military physician. Research has shown that military physicians self-identify along a spectrum, and that this spectrum informs their understanding of their role (Chamberlin 2013). Some see themselves as physicians who simply work for the military and others see themselves as inhabiting a unique role as both or as a "military physician." Still others (and many in command) see this group as no different from other categories of soldiers with unique skillsets of operational relevance. While each of these moral identities brings with it challenges and issues, it is this last view that is most problematic. Viewing military physicians as soldiers with military relevant skills ignores the professional moralities outlined above and enables the instrumentalization of medicine for military purposes. According to this line of thought, military physicians are no different from airplane mechanics or combat gunners. Their skillset does not come with professional moral obligations and thus can be used as needed by the military. A soldier's only obligation is to the military and its mission. The danger of instrumentalizing medicine for military purposes is evident across history. When professional medical obligations are cast aside and military goals are prioritized, we have seen physicians involved or complicit in significant harms against the ill, disabled, and vulnerable (their would-be patients).

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Chapter 7
Medicalization of Social Policies: Defining Health, Defining Illness

Amanda M. Caleb

Abstract This chapter examines the process of medicalization as it relates to both social policies implemented during the Nazi regime and contemporary social policies. Medicalization is the process of framing a social problem as a medical condition, thereby identifying the source of the problem as one of individual accountability and emphasizes the need to treat or cure the individual. When applied to social policies, this framework perpetuates dividing practices that create categories of social health and social sickness and allow for the control of individuals and groups of individuals. Nazi social policies were grounded in their racial hygiene agenda, which meant medicalizing individuals who participated in so-called deviant behavior, who contributed, or failed to contribute, to the nation's welfare, and who were considered a threat to the citizenry and the health of the nation. This same medicalization of social policies is evident today in countries' approaches to regulating sexual and criminal behavior, limiting government assistance, and restricting borders.

7.1 Introduction

> Our starting point is not the individual, and we do not subscribe to the view that one should feed the hungry, give drink to the thirsty, or clothe the naked….Our objectives are entirely different: we must have a healthy people in order to prevail in the world.
>
> —Joseph Goebbels, Minister of Propaganda, 1938 (USHMM 2020).

The Nazi imperative for a healthy nation—executed, in part, through the literal killing of *Lebensunwertes Leben* ("life unworthy of life")—was derived from the practice of medicalization. As defined by Conrad (2007, 5), medicalization happens when "a problem is defined in medical terms, described using medical language,

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understood through the adoption of a medical framework, or 'treated' with a medical intervention." This widely-accepted definition also contends that medicalization "describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders" (Conrad 2007, 4). The emphasis on process is reflective of both the machinations and breadth of medicalization, which extend beyond the hospital into social and political arenas. Most studies of medicalization trace its emergence to seventeenth century Enlightenment thinking, grounded in scientific and medical attempts to control nature (Lock 2004). The rise in medical authority in the nineteenth century resulted in more widespread medicalization, including that of the life processes (birth, adolescence, death), and the increased use of hospitalization (Lock 2004). The emergence of eugenics in the nineteenth century signaled a shift to a politicized medicalization that was embedded in social policies and legal doctrines designed to separate (and perhaps "cure") individuals deemed medically "unfit" and therefore socially undesirable. The enactment of medicalized eugenic policies resulted in the forced sterilization of those deemed "unfit" (practiced in a number of countries throughout the twentieth century), and the mass murder of Jews, Roma, Sinti, ethnic Poles, and others by the Nazis.

Seen as "a process associated with modernity [that] reflects societal and medical practices designed to control and regulate diseases, illnesses, and injuries" (Bell and Figert 2015, 20), medicalization achieves its power through its authority to define a problem and therefore cure it (Conrad and Schneider1992). Medical power was achieved through what Michel Foucault calls "the clinical gaze," which objectifies the patient and is "the eye that knows and decides, the eye that governs" (Foucault 1973, 89). Medicalization, then, is a means of asserting power through an identified problem that is observed and then fixed, cured, or isolated. Physicians are gatekeepers to this authority (Conrad 2007), but are not the sole practitioners: society itself is medicalized, "serving to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promoting good health and productivity" (Lupton 1997). Such regulation is achieved through the scientific classification of the gaze and its applied language that medicalizes bodies, and through dividing practices that turn individuals into binaries (healthly/unhealthy) and create spaces of division (e.g., asylums) (Foucault 1995).

Medicalization can be seen as a form of biopower, which is the "power to *foster* life or *disallow* it to the point of death […and that] has to qualify, measure, appraise, and hierarchize" life (Foucault 1990, 138, 144). In other words, medicalization has the power to manage health through its qualification of healthy (and therefore unhealthy), which then, through its own power, requires the regulation of bodies—which serves to perpetuate that power (Caleb 2019). In seeking to control lives, medicalization leads to "the individualization of social problems," which situates the problem with individuals and not within a social context (Conrad 2007, 152). Medicalized social policies seek to regulate and cure these unruly individual bodies in order to improve society; examples include welfare reform policies that position the individual as the cause of alleged system abuse, or, in the case of the Nazi regime, the medicalization of Jews and others deemed unfit as a threat to Aryan health and supremacy.

This chapter will consider examples of medicalized social policies implemented by the Nazi government and parallel current medicalized social policies in three areas: so-called social deviance, unemployment and state assistance, and citizenship and immigration. For the Nazis, the medicalization of social policies supported their racial hygiene agenda: they used a medical framework of defining health and sickness to claim modes of difference that harmed the nation. Contemporary examples are not grounded in a racial hygiene agenda, but are informed by the same constructed modes of difference that are products of medicalized biases used to justify action against marginalized groups.

7.2 Medicalization and the *Volkskörper*

In mobilizing their followers, Nazi leaders evoked the concept of *Volkskörper*, frequently translated as "national body" and often understood as metaphorical (Neumann 2009), akin to the body politic (Musolff 2010). However, *Volkskörper* was more than a metaphor, just as *Fremdkörper* (foreign body) was more than a metaphor for Jews (Neumann 2009). This language was the product of medicalization that colonized language itself, so that Jews were not just *Fremdkörper* to the country. They were seen as a literal infection, a threat to the healthy nation. Both Hitler and Heinrich Himmler described Jews as diseases or disease-agents—*Rassentüberkülose* (race-tuberculosis) and *Bazillus* (bacillus), respectively—evoking the need for a medical and public health response to protect German bodies (Michman 2014). Jews, along with homosexuals,[1] political objectors, and criminals, were categorized as *Volksschädling* (parasite or vermin of the people), a threat that was both internal and external to the *Volkskörper* (Midlarsky 2005; Evans 2001). Similarly, people with so-called hereditary disabilities were seen as parasites, categorized as threats because of their perceived biological inferiority (Snyder and Mitchell 2006; Bengtsson 2018).

This medico-scientific language was an outgrowth of the Nazis' racial hygiene program, which sought to divide individuals deemed to be fit (and therefore members of the *Volkskörper*) from those deemed unfit, described as *Gemeinschaftsfremde* (alien to the community). The ability to create such division rested on the medicalization of bodies, realized biopower that was actualized in social policies which perpetuated so-called biological difference. Importantly, physicians and scientists were central to both the alleged evidence for, and implementation of, racial hygiene policies, making such medicalization manifest. As noted by Proctor (1988, 29), "the Nazis medicalized politics as much as they politicized medicine; problems of racial, sexual, or social deviance were transformed into 'surgical problems' in need of surgical solutions." These "surgical solutions" were both literal, in terms of sterilizations and medicalized murder, and social, through the development of policies that

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[1] Throughout the chapter, I deliberately use homosexual/homosexuality to refer to policies and political rhetoric that medicalize being gay.

cut off those deemed eugenically unfit. Social policies were informed and strengthened by appeals to medical authority and medicalizations of social and physical bodies: such policies included those created to address so-called deviant behavior, to limit (or expand) access to government assistance, and to deny citizenship rights to individuals.

7.2.1 Regulating the Deviant (Social) Body

The very creation of the label "deviant" is an act of social control, signaling an unwillingness or inability to conform to the expectations and requirements of one's society. Such categorization reveals the relationality of deviance, understood only through the moral and social norms defined by those in power at a given time. This label serves as a dividing process, indicating difference that is unacceptable to society and therefore an implied danger to the social order. In the nineteenth- and twentieth centuries, the rise of medicalization allowed for such social categorization to be scientifically classified. Thus, behaviors once deemed deviant because they did not adhere to social expectations were seen as medical conditions (such as homosexuality).[2] Moreover, the rise of eugenics and criminal anthropology mapped deviance onto the body, suggesting that criminal behavior was hereditary and identifiable based on one's physiology and physiognomy.[3] These shifts to the medico-scientific approaches paradoxically increased and limited the scope of defining deviance: their authority allowed for politicians and physicians to expand definitions of deviance, while the so-called biological evidence restricted claims of deviance to those which were based on medico-scientific knowledge. Thus, in order to expand their racial hygiene agenda, Nazis medicalized social policies themselves, which resulted in greater control of those deemed to be engaging in deviant behavior.

Despite the new German Imperial Criminal Code of 1871 and the classification of homosexuality as a "mental illness" by Krafft-Ebing, the criminal persecution of homosexuals was not widespread in Germany—or even enforced in Prussia—in the early twentieth century. Yet, the appointment of Hitler to the chancellorship ended any disregard for the criminal code; his attack on homosexuality is seen as both an attempt to purify the *Volkskörper* and to later justify the murder of Ernst Röhm in 1934, who was openly gay and a potential rival in the Nazi regime (Giles 2001). While the latter speaks to Hitler's political machinations, the former supports the broader medicalization that shaped Nazi thinking. In March 1933, Hitler announced the "Campaign for a Clear Reich," which forced all gay and lesbian bars to shut,

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[2] Richard von Krafft-Ebing, in his 1886 work *Psychopathia Sexualis*, classified homosexuality as a mental illness, which he argued was a product of hereditary degeneration.

[3] Francis Galton connects criminality to mental illness and hereditary, indicating the physical markers of criminality that Cesare Lombroso also discusses in his theory of criminal activism. See, for instance: Galton (1883). *Inquiries into human faculty and its development*. London: Macmillan; and Lombroso (1876). *L'uomo delinquente*. Milan: Horli.

destroyed Magnus Hirschfeld's Institute for Sexual Science, and abolished all gay presses (Spurlin 2020; Beachy 2010). The campaign indicated both a moral and medical cleansing of the *Volkskörper*, reflective of a pathologizing of homosexuality that was supported in the mid-1930s by German doctors, who claimed homosexuality threatened public health, even describing it as an epidemic (Proctor 1988).

This medicalization of homosexuality was amplified by Heinrich Himmler's 1936 creation of the Reich Central Office for the Combating of Homosexuality and Abortion (*Reichszentrale*). The association of homosexuality with abortion speaks to the Nazis' concern with reproduction, declining birth rates, and the nation's body (Spurlin 2020; Giles 2001): the martial-medical metaphor of combatting so-called social deviance positions reproduction and the national good against non-reproduction and individual threats. Combatting suggests both fighting and curing, and the *Reichszentrale*'s focused efforts on policing homosexuality manifested Nazi beliefs of homosexuality as a disease (Beachy 2010). Such efforts were divided into curing the "disease" of homosexuality and stopping its spread, the latter of which included the elimination of any individuals with hereditary-based homosexuality, labeled as "incorrigibles," by sending them to concentration camps (Beachy 2010). The prosecution of the gay community was a social policy designed to support the Nazis' racial hygiene program by isolating the "disease of homosexuality" so as not to infect others and the national body.

Another group that the Nazis viewed as a infection risk to the *Volkskörper* was the broad category of "asocials," individuals who engaged in behavior that was antithetical to the nation's goals and health, including the "work-shy," criminals, vagrants, beggars, prostitutes, unmarried mothers, alcoholics, and anyone else who was "unwilling to adapt to the life of the community" (Epstein 2015). According to Wolfgang Knorr, a physician working in the Racial Political Office, "asocials" were "conspicuous, not by occasional crime, but by their general inability to be useful in the life of the national community" (qtd. in Pine 2017, 172). As non-contributing members of the nation, they were an economic burden; as hereditary carriers of "asocial" behavior, they were a racial threat. In a rehabilitative attempt, an "asocial colony" was created in Bremen in 1936: Hashude, as it was called, was a virtual prison, with families being forced to live in houses that were guarded and inspected for cleanliness by Nazi officials. Children in Hashude were required to join the Hitler Youth and were taught about hygiene (Pine 2017; Shuter 2003). This colony created both the separation of those seen as diseased from healthy citizens and the imperative to be cleaner and therefore healthier in order to return to society—in other words, these individuals needed to be cured through commitment to the *Volk*. The closing of Hashude in 1940 coincided with a push beginning in 1938 to decrease spending on "asocials," whom many in the Nazi party deemed as uncurable because of a hereditary stain. This argument justified the sterilization of some "asocials" under the Law for the Prevention of Hereditarily Disease Offspring (1933) and their deportation to work and concentration camps (Pine 2017).

7.2.2 Gemeinnutz Geht Vor Eigennutz*: Medicalized Government Assistance*

The central tenet of Nazi medicalization was the health of the national body, which included placing the needs of the community over any individual needs, realized through the slogan *Gemeinnutz geht vor Eigennutz* ("the common need over individual need"). As such, the introduction of economic incentives and the regulation of government assistance were used to help promote and grow a stronger, healthier nation. Through these policies, the government sought to support reproductive efforts of eugenically-fit parents while limiting economic and social resources for individuals deemed to be genetically unfit or not contributing to the health of the nation.

As such, reproduction was anything but personal: as noted by the *NS-Frauenschaft* (Nazi Women's Group), "marriage is not merely a private matter, but one which directly affects the fate of a nation at its very roots" (qtd. in Stephenson 2013, 28). Marriage and procreation were acts that were medicalized through racial hygiene, which invaded the private space of a marriage and the bedroom. The enactment of the Law for the Protection of German Blood and German Honor on September 15, 1935 (part of the Nuremberg Laws) medicalized nationality and religion in order to distinguish so-called pure Aryan blood from Jewish blood by forbidding marriage or sexual relations between Germans and Jews; two months later, this law was extended to other groups deemed unfit, including Roma, Sinti, and Black people. Physician Ernst Rüdin evoked imagery of preventing sexually transmitted diseases and subsequent degeneration in his praise of the law for "preventing the further penetration of the German gene pool by Jewish blood" (qtd. in Lifton 2000, 28). This law was supplemented by the Law for the Protection of the Hereditary Health of the German People, enacted on October 18, 1935, which required individuals to seek public health certification of their eugenic fitness to marry. As Robert Proctor has noted (1988, 141, 142), "the Nuremberg Laws were generally considered *public health measures* […] Germany's leading health officials saw the prevention of human genetic disease along, with the prevention of racial miscegenation, as part of a single program of responsible public health policy." Thus, the Nuremberg Laws positioned medicine and health as central to their goals, and their execution in the middle of the marital bed.

The veneration of Aryan mothers in particular was vital to the eugenic discourse of the Nazis, as these reproductive women were seen as the source of future growth and therefore national expansion. Thus, motherhood was quantified and medicalized as central to nurturing the *Volkskörper*, with financial incentives and government support tied to the ability to reproduce eugenically-fit children. On June 1, 1933, the government introduced a marriage loan scheme under the Law to Reduce Unemployment, which granted each newly married couple a loan of 1,000 Reichsmarks with a low interest rate, provided the wife gave up her job; a quarter of the loan was forgiven for each child the couple bore (Stephenson 2013; Pine 2017).[4] The financial incentive tied to procreation and female domesticity quantified the value of reproductive and motherhood for both individuals and the State. Mothers and children were afforded additional state welfare benefits through the establishment of the Mother and Child Relief Agency in February 28, 1934. This agency provided necessities (clothing, bedlinen, and food) for mothers and their children, education on breastfeeding and childcare, and recuperation homes that allowed for mothers to recover from childbirth while being further educated in Nazi ideology (Pine 2017). The program medicalized motherhood by creating an imperative for healthy mothers, defined as loyal to racial hygiene and the *Volkskörper*, to raise their children in ways that supported the State (both in terms of their health and their education).[5]

While the Nazi government provided benefits to eugenically-fit Germans, it denied or restricted these same benefits to those who were deemed to be parasites, seen as taking from the nation without providing any benefit. In 1933, the Nazi government brought all welfare services under the offices of the National Socialist People's Welfare (NSV), eliminating private welfare organizations and distributing benefits only to individuals deemed "racially superior," which was determined by their "value for the *Volksgemeinschaft* [people's community]" (Reinhold Schleicher qtd. in Nolzen 2014, 93). "Asocials," Jews, and other *Volksschädling* were excluded from a number of state-sponsored benefits, including the aforementioned marriage loan scheme, and saw reductions in their government assistance (Wachsmann 2008). Moreover, individuals with mental health illnesses and so-called hereditary disabilities were depicted in Nazi propaganda as being an economic burden and biological threat to the health of the nation, an argument used to justify the reduction in their benefits, their forced sterilizations under the Law for the Prevention of Hereditarily Diseased Offspring, and their eventual murders (Proctor 1988). These individuals were medicalized not only because of a believed biologically inferiority, but also because they were deemed to contribute nothing to society. The label *unnütze Esser* ("useless eaters") became a justification for the policy of medicalized killing.

7.2.3 Medicalizing Citizenship

Nazi leaders believed the health of the *Volkskörper* was dependent upon individuals' physical, mental, and social health and racial purity, which included commitment to the ideals of the Nazi party: those who could not or would not conform were marginalized, stripped of their rights, and eventually killed. The Nazis redefined citizenship in particular by changing citizenship from that of the state to that of

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[4] In 1937, the government revoked the work prohibition for women (Stephenson 2013; Pine 2017).

[5] Such distinction was visualized through the creation of the Honor Cross of German Motherhood in 1939: intended to celebrate the loyal Aryan mother, it also acted as a means of dividing women who could reproduce large family from those who could not, creating both a medico-military celebration of reproduction and a shaming of a failure to reproduce (Caleb 2019).

the Reich (*Reichsbürger*) and defining membership to the *Volk* based on blood and heredity, making such citizens literal parts of the *Volkskörper*. This medicalization of citizenship was a hallmark of Nazi politics, evident as early as 1920 in their Twenty-Five Points program: "None but members of the nation [*Volksgenosse*] may be citizens of the state. None but those of German blood, whatever their creed, may be members of the nation. No Jew therefore may be a member of the nation" (German Workers' Party [1920] 2013, 12). This declaration's language identifies Jews as ethnically and racially different from Germans (given the use of the word *Volk*), setting the stage for rhetoric to become reality.

These racial claims were realized in the enactment of the Reich Citizenship Law on September 15, 1935, another of the Nuremberg Laws. Article 2, "Concept of Reich Citizenship," states, "(1) A citizen of the Reich is only that subject who is of German or kindred blood and who, through his conduct, proves that he is both willing and able to faithfully serve the German people and Reich" (Reich Citizenship Law [1935] 2013, 209). Underpinning this law was a commitment to racial hygiene, an opportunity to purge the citizenry of individuals deemed racially inferior to Germans and who were seen as infecting the *Volkskörper*—in other words, "medicalized racial discrimination" (Kelly et al. 2018, 100). The primary target of this law was Jews (and later Roma, Sinti, and Black people), and historians have thoroughly traced their persecution from the Nuremberg Laws to the concentration camps (e.g., Pine 2017; Shuter 2003; Proctor 1988). In their commentary on the Nuremberg Laws, Nazi party lawyers Wilhelm Stuckart and Hans Globke argued, "every people is damaged in its vital capacities by absorption of alien blood into the *Volkskörper*. But one of its principal concerns should be to keep its blood pure" (qtd. in Neuman 2009, 172). Their implication of Jewish blood as poisoning the *Volkskörper* was used as justification for purging the Jews from the Reich—first legally and then physically.

In the act of legally denaturalizing Jews, the Nazi government also asserted that Jews' natural state was one of inferiority to German biological superiority. Stuckart and Globke [1936] (2013, 213) rationalized that "Jews, who constitute an *alien body* among all European peoples, are especially characterized by *racial foreignness*. Jews, therefore, cannot be seen as being *fit* for service to the German *Volk* and Reich" (emphasis added). The stress on racial difference, on being unfit, and on being alien to the German social body all speak to a medicalization of Jews as a problem to be solved by medico-scientific legislation. Moreover, the subsequent classification system that determined "how Jewish" an individual was (and thus if they were given the rights of citizenship) represents eugenics-based scientific classification designed to further divide individuals through supposed medical authority and biopower. Such medico-legal language and action reduced Jews to an imposed biological status and denied rights to political action, movement, and eventually life.

While the Reich Citizenship Law guaranteed citizenship to individuals with German blood, it only did so if individuals were loyal and served the State. This additional requirement reflects the Nazi racial hygiene program that sought not only to cleanse the *Volk* of racially-inferior individuals, but also to cleanse itself of individuals that, while sharing its German blood, threatened the *Volkskörper* through their degenerative and unproductive behavior. In Stuckart and Globke's commentary

[1936] (2013, 2014), they explain that “misfits,” which included criminals and individuals who committed “offenses against the state,” could be excluded from Reich citizenship. While there is little evidence of Germans being stripped of their citizenship (excepting those that fled Nazi Germany), such language—tied to a biological understanding of citizenry—functions as biopower to maintain social order and control. Individuals would want to avoid actions that could result in the forfeiture of their citizenship because that also meant the loss of their biological status within the *Volk* and as part of the *Volkskörper*.

7.3 Medicalization Today

The pursuit of a healthy nation did not end with the Nazis, nor did the medicalization of social policies to pursue that end. While nations condemned the concentration camps and medical experimentation, they failed to make connections between their own policies of exclusion born from an over-reliance on medicine and the pseudoscience of eugenics. Forcible sterilization of individuals deemed unfit has continued across the globe through the twenty-first century, and legislative policies have sought to police bodies through public policy. While it is heavy-handed to state simply that these are continuations of Nazi policies, it is equally dangerous to ignore the fact that they are informed by the same privileging of medical authority and knowledge that allows for the social-biological regulation of people. The “sick-society” narrative that emerged in the late twentieth century was a condemnation of unruly individual bodies that failed to conform to social expectations and the need for social policies, informed by medical authority and frameworks, to cure these ailments and heal nations (Spence 2011; Schram 2000). The result was a continued medicalization of social problems that echo those discussed earlier in this chapter, i.e. controlling deviant bodies, determining government assistance eligibility, and controlling citizenship and immigration.

7.3.1 Medical Disqualification of Deviant Behavior

Medicalized social policies act as a social control that “seeks to limit, modify, regulate, isolate, or eliminate deviant behavior with medical means and in the name of health” (Conrad and Schneider 1992, 29). The continued medicalization of so-called deviant behavior (and therefore deviant bodies) is driven by some of the same forces that informed Nazi regulations of deviance—namely, the health of the nation, which includes protecting healthy individuals from the impact of deviance. While much of the pathologizing of so-called deviance is not imagined through the risk of disease transmission, there nevertheless remains a false medicalized view of contagion that is tied to behavior spread or to disease associated with such behavior.

Such fears are evident in the medicalization of homosexuality as tied to HIV/AIDS. While homosexuality was pathologized as a mental health illness for much of the twentieth century, the American Psychiatric Association's 1973 removal of homosexuality from the DSM-II marked the beginning of its demedicalization (Conrad and Schneider 1992). However, the emergence and response to HIV/AIDS returned the medical spotlight on the gay community, and for some scholars, such as Philip Kayal (2008, 197), the "situation of gay AIDS is akin to previous 'medicalization of homosexuality,'" which he connects to increased homophobia in the last decades of the twentieth century. While Conrad (2017) argues against this claim of remedicalization, stating that homosexuality itself was not repathologized during the height of the AIDS crisis, he does acknowledge an increased medical surveillance of gay communities. Such surveillance is, in fact, a form of medicalization, turning the clinical gaze onto individuals in an effort not only to diagnose but also to contain and control.

Medical surveillance "promoted the renewed stigmatization of homosexuality" (Conrad 2017, 107), perhaps most prominently in restrictions on blood donations, which tapped into fears of disease transmission. In 1983, the Centers for Disease Control and Prevention recommended that "members of groups at increased risk for AIDS should refrain from donating plasma and/or blood" (CDC 1983) due to an inability to screen for HIV, which only began in 1985. This recommendation resulted in a lifetime ban from donating blood for all men who had a male sexual partner since 1977, which was replaced only in 2015 with a requirement for all men who have sex with men (MWM) to abstain from same-sex intercourse for one year before donating; during the COVID-19 pandemic, this abstinence period was reduced to three months.[6] This ban does not account for safe sex practices, but assumes that being a sexually-active gay man is a marker for disease transmission, despite research to the contrary. HIV incidence in first-time donors was 2.62 cases per 100,000 person-years before the one-year deferral for MSM; after implementing the referral, the HIV incidence was 2.85 cases per 100,000 person-years, a difference that is not statistically significant (Grebe et al. 2020). This incidence rate is extremely low: as a comparison, HIV transmission via blood transfusion has a prevalence of 2.6 cased per 100,000 donations, whereas hepatitis B is 6.3 cases and hepatitis C is 19.0 cases per 100,000 donations (Steele et al. 2020). In December 2020, the American Red Cross, Vitalant, and OneBlood began investigating the viability of lifting this restriction, focusing on likelihood of infection rather than sexual orientation and therefore looking to actually demedicalize homosexuality (Advance Study 2021). Blood donation bans, however, echo the Reich citizenship requirement, particularly as "a method of recasting national identifications [in which] the positive associations of blood donations are symbolically transfused into the moral worth of the blood

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[6] Other countries implemented a lifetime ban that was only reduced in the last decade, including Argentina, Canada, Denmark, France, Germany, Ireland, Italy, Norway, Switzerland, and the United Kingdom.

donor" (Bennett 2015, 7). Implied in such a blood donation ban is the inferiority of the disqualified individual, both medically and morally, and their isolation from the rest of society.

Medical disqualification from society also extends to prisoners, and some social policies look to police prisoners' bodies via the pseudoscience of eugenics and a false notion of biological criminality. In the last decade, there have been increased reports of coerced sterilizations (or plea-bargain sterilization offers) of prisoners, who are often from marginalized groups. In one of the biggest cases in the United States, at least 148 pregnant prisoners (who were primarily Black or Latina) were sterilized in the California system after giving birth, and staff "target[ed] those deemed likely to return to prison in the future" (Johnson 2013). In justifying the sterilizations he and other doctors performed, Dr. James Heinrich monetized the procedure in terms of cost-savings to the state: "over a two-year period, that [$147,460 paid to doctors] isn't a huge amount of money […] compared to what you save in welfare paying for these unwanted children—as they procreated more" (qtd. in Johnson 2013). His statement can be read in two ways: a cost associated with the inmates continuing to reproduce, or the cost of their children reproducing, suggesting a continued burden on the state. These remarks are not too distant from Oliver Wendell Holmes's infamous support of eugenics in Buck and Bell (1927): "three generations of imbeciles are enough." The assumed financial burden on the state is not limited to state support of the child, but also an implied belief in criminal heredity. In 2017, a judge in Tennessee offered reduced sentences to inmates if they chose to be sterilized; while the judge claimed that this was to reduce the number of children born addicted to drugs or ending up in foster care (Adams 2018), Glenn Cohen questions the underlying motive: "one worries that it actually reflects primitive conception of heritability of criminal behavior, which are roundly rejected by modern day genetics" (qtd. in Rosenblatt 2017). When placed within the context of eugenic sterilizations, such measures signal a medicalization of crime that seeks to regulate not just the criminal's behavior but their body as well.

7.3.2 Government Assistance and the Medicalization of Benefits

The financial concerns regarding inmates and their children are echoed in politico-legal conversations about access to government assistance and the government's responsibility to care for all its residents. Former United States Speaker of the House Newt Gingrich's assertion that the US is a "sick society" and former British Prime Minister David Cameron's claim of a "Broken Britain" indicate a perceived need to improve the state of their respective nations, linked to individuals receiving government assistance and the subsequent impact on the countries' morals and economies. This language also medicalizes the problems of the nation, casting politicians in the roles of physicians to cure sickness or mend a broken limb. As Schram notes

(2000, 60), "to medicalize welfare dependency is to create the conditions for moving welfare from an income redistribution scheme to a behavior modification regime." This approach to behavior modification is reflected in changes to social policies and classification of individuals receiving benefits, thereby requiring individuals to improve ("get better") in order for the nation to recover.

Former US President Ronald Reagan's perpetuation of the "welfare queen" myth in the 1970 and 80s—an image of a Black single mother who relied on public benefits instead of working—reconceived the US welfare system as a product to be abused, casting its recipients in the role of substance abusers. This image led to a medicalization of welfare dependency, which was perpetuated by the medical surveillance of welfare use via the Welfare Indicators Act of 1994, which tasked the Department of Health and Human Services to track welfare dependency. Their research and reports are "framed as if welfare dependency were a public health problem. For instance, the fear of welfare dependency's spreading from one generation to the next or throughout a neighborhood has led to government tracking of intergenerational welfare use and neighborhood effects" (Schram 2000, 63). This recasting of welfare dependency as a public health problem turned it into an illness that could be cured through the "therapeutic interventions" of welfare reform: "in the process, welfare itself is transformed from a repudiated program of benefit allocation to a socially accepted form of therapy" (Schram 2000, 59–60). One version of this therapy was the creation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, whose title positions state assistance dependency as a problem of the individual and work opportunities as its cure. The Act's first stated finding—"Marriage is the foundation of a successful society" (Personal Responsibility 1996, Section 101)—echoes the Nazis' rhetoric of marriage prioritization to benefit society, though this act discourages reproduction more than it encourages it, targeting, in particular, single teenage mothers. Coupled with the emphasis on marriage is that of employment: the act limited the time individuals could receive benefits and required those individuals to secure employment within two years of receiving benefits (Personal Responsibility 1996, Section 402). This coupling of marriage with work is the therapeutic for welfare dependency: promote healthy reproduction and economic security independent of government support.

Similarly, the 2010 general election in the United Kingdom and the subsequent framing of the 2011 London riots were part of the Conservative party's efforts to medicalize government benefit policies, positioning the recipients of these benefits as the cause of a "Broken Britain." This twenty-first century narrative in the UK was derived from debates in the 1980s about the "work-shy," the "underclass," and growing "illegitimacy" within these groups (Slater 2012, 956, 960). Such narratives were framed by "concerns about lack of responsibility, family breakdown, the absence of communal bonds, incivilities and violent and anti-social behaviour [that] stem, in this view, from the erosion of moral standards caused by state welfare over a number of decades" (Hancock and Mooney 2012, 47). This social pathologizing was echoed in Cameron's response to the London riots, in which he diagnosed Britain as being sick: "when I say parts of Britain are sick, the one word I would use to sum that up is irresponsibility. [. . .] a complete lack of responsibility, a lack of proper parenting, a lack of proper upbringing, a lack of proper ethics, a lack of proper morals. That is what we need to change. […] it's about making sure we have a welfare system that does not reward idleness" (qtd. in Hancock and Mooney 2012, 49). The focus on individual responsibility as the cause of this so-called social sickness is reminiscent of the medicalization of the US welfare system in the 1990s, though local councils took a more surgical approach to this sickness, removing families from social housing if a family member were convicted for riot-related crimes (Hancock and Mooney 2012). In response to the riots, physician Des Spence (2011, 426) claimed "work is health" and "doctors must embrace welfare reform and advocate work." The comment is somewhat ironic, given the government's elimination of the Pathways to Work program in Spring 2011, which had job centers partnering with the National Health Services to help individuals return to work. However, the medical prescription becomes one adopted by the government and is emblematic of Cameron's cure for the sick society, manifested in the Welfare Reform Act of 2012 that focused on employing individuals to reduce the dependency on the government and thereby improve the (economic) health of the nation.

The medicalization of unemployment demonstrates the shift of responsibility from a social problem to that of an individual, likening unemployment to failing to care for one's health—rather than recognizing social determinants that impact employment and health. In Sweden, the category of "occupationally disabled" functions to medicalize unemployed individuals not through biomedical conditions but rather through social and structural obstacles that prevent them from seeking employment, such as language barriers for immigrants (Holmqvist 2009). Rather than find fault with these social structures—as seen in a social model of disability—this label acts to place blame on individuals, labeling them as disabled and therefore "not fully fit for working in Swedish society" (Holmqvist 2009, 411). The Swedish system does employ doctors to confirm disabilities that would impact the ability to work, but employees of the Swedish Public Employment Service (SPES) have taken over the role of diagnosis, countering that "sometimes we know that clients are sick even if doctors do not think so" (qtd. in Holmqvist 2009, 413). The SPES requires a classification of "occupationally disabled" to receive unemployment benefits, which SPES sees as recognition of unemployment being a problem of the individual and not the system (Holmqvist 2009), and which perpetuates a medicalized view of unemployment.

7.3.3 Policing Medicalized Borders and Regulating Immigration

The image of immigrants as carriers of disease is centuries old, based on a mix of xenophobia and racism. The unknown foreign body—physical, cultural, and economic—was a source of medicalized anxiety in the late nineteenth- and twentieth centuries, tied to eugenic assumptions of biological inferiority and immorality. Immigration policies developed during this time were also products of increased authority from public health, which helped perpetuate false claims of immigrants spreading diseases (Kraut 1995). This "medicalized nativism" (Kraut 1995, 3) is not unique to a single country, but is particularly evident in historical and contemporary US immigration policies, which continue to medicalize immigrants as diseased Others.

US immigration policy is grounded in a preference for desirable, and the rejection of undesirable, individuals, which is medicalized in the language and implementation of these policies. The first of these, the Page Law of 1875, prohibited Asian prostitutes and functionally most Asian women from coming to the US and was derived from claims by medical and public health officials of incurable syphilis transmitted by Chinese prostitutes and the "distinct germs" carried by Chinese immigrants that were deadly to whites (Luibhéid 2002, 35, 37). Racialized immigrants were cast as a medical problem by both the medical community and the federal government, which became the backbone of subsequent immigration policies and public perceptions of immigrants as disease carriers. The Immigration Act of 1891, the bedrock of current immigration policies, refused entry to individuals with "loathsome or contagious disease" and tasked steamboat companies with policing this policy through inspection and disinfection of their passengers (Markel and Stern 2002, 761). This policy led to the United States Public Health Services conducting inspections of immigrants at ports of entry, a practice still continued today. As Howard Markel and Alexandra Minna Stern note (2002, 777), "the realistic menace of imported germs—which scorn all boundaries and can incubate just as elusively and easily in an American tourist heading back from a vacation in the Bahamas as in a Russian visa applicant seeking to join her relatives in Chicago—was eclipsed by the recalcitrant connection between foreigners and disease." In other words, the examination of immigrants specifically is tied to a medicalized view of immigration itself that is not based on science but rather racialized bias.[7]

Such thinking has continued in the US into the twenty-first century under the Trump administration. From its beginnings, the Trump administration was very clear in its desire to limit or even stop immigration from countries it deemed inferior to the US and linked crime to disease in their argument to close borders, implying that actual disease was never the real issue (da Silva 2018). In particular, the administration focused on illegal immigration and migration from Central America, which President Trump claimed would "infest" the US, evoking both medicalized nativism and the Nazi rhetoric of "parasite" to claim migrants threaten national security and the nation's economy (Zimmer 2019). Former Immigration and Customs Enforcement agent David Ward claimed, "they are coming in with diseases such as smallpox, leprosy, and TB that are going to infect our people in the United States" (qtd. in Belluz 2018). The rhetoric perpetuates dividing practices of separating a "primitive" *them*

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[7] Such racism has spilled over to public rhetoric and violence in the wake of former US President Donald Trump's insistence on calling COVID-19 the "Chinese virus": a study of tweets found an increase of anti-Asian sentiments tied to #chinesevirus (Hswen et al. 2021); another study reported a near 150% increase in anti-Asian hate crimes in the US in 2020 (CSUSB 2020).

who bring seemingly historical diseases (smallpox was eradicated in 1980) to the healthy *us* of the US. Stephen Miller, Trump's chief advisor, repeatedly tried to close the southern US border (Dickerson and Shear 2020), diagnosing it as a site of disease transmission due to the immigration of racialized bodies. Claims of diseased bodies threatening US borders plays upon public fears of both disease transmission and of racialized difference—a fear that is used to justify such medicalized immigration policies, built not to protect residents' health but to regulate unruly bodies deemed unfit by a racialized biopower.

7.4 Conclusion

At the end of *The Medicalization of Society*, Conrad (2007, 164) poses the following questions: "How will medicalization affect the organization of society, and how will we deal with the consequences?" I would respond to the first question by suggesting we have seen some of the effect on social organization, most clearly in how the Nazis used the medicalization of social control to advance their eugenic agenda. We are seeing the effects of this continued process in the regulation of immigration and in restrictions on government assistance programs, which threaten the most vulnerable through a guise of protecting the health of a nation. Though by no means an exhaustive account of the medicalization of social policies, the examples in this chapter serve to demonstrate the expansive (bio)power of such practices that seek to regulate individual lives in pursuit of solving a perceived problem. Haines (2003, 26) has pointed out that "medicalization depoliticizes moral problems by reconceptualizing them in medical and scientific terms that are considered to be 'above' morality, i.e., in the realm of 'facts' and scientific certainty." This depoliticization, particularly at the policy level, contributes to the social stigma of individuals who are medicalized through such policies, creating a dangerous situation in which the public does not question this process because of the perceived authority of medicine. Medicalization, then, can contribute to stigma and othering, which can create situations in which groups do not help individuals defined as problems because of their trust in medical authority (in a best-case scenario) or because such authority confirms, through "scientific fact," their beliefs about the inferiority of those different from them (in a worse-case scenario).

Peter Conrad's second question still remains: what do we do with the consequences of medicalization? Such a question poses two threads that need answering: a response to what we do with knowledge of medicalization and a response about the perceived inevitability of medicalization. To the former, we must dedicate ourselves to understanding that historical events are not static or isolated: they inform current practices and shape the biopower that controls our lives today. To the latter, we should challenge the inevitability of medicalization, particularly with regard to social policies. As demonstrated in this chapter, such medicalization contributes to harmful dividing practices. While we need to be careful not to outright reject medicine as a discipline (or medical knowledge as scientific), we need to recognize the dangers of unchecked medical authority and question the motivations and the implications that lead to medicalization of social policies and the diagnosis of a “sick society.”

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Chapter 8
Bioethics and the *Krankenmorde*: Disability and Diversity

Edwina Light, Michael Robertson, Wendy Lipworth, Garry Walter, and Miles Little

Abstract Between 1933 and 1945, almost 300,000 people were murdered and 360,000 sterilized by the National Socialist (Nazi) regime under a group of crimes now collectively known as the *Krankenmorde*, the murder of the sick and disabled. Founded in narrow-minded and inconsistent accounts of a good and valuable life, the Nazi eugenic and "euthanasia" crimes were brutal and violent acts organized and executed by doctors, nurses and other professionals. Acknowledgement of this group of victims was delayed and obscured due to historical events as well as prevailing political and social attitudes toward mental illness and disability. As a result, the breadth of the *Krankemorde* crimes and its victims, its relationship to the Holocaust and its contemporary significance–to bioethics and society more broadly–is less recognized or understood than that of other Nazi medical crimes, such as the infamous experiments on prisoners. First presenting a history of the *Krankenmorde* and its aftermath in Germany and Nazi occupied territories, this chapter goes on to examine the value of bioethics having better knowledge of this part of its history and, in particular, engaging with its own epistemic constraints in relation to disability and ableism. These ideas are explored further in the context of contemporary bioethical issues related to the rights and treatment of people with disabilities, specifically the allocation of health resources. Throughout the chapter we seek to highlight the lives

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of *Krankenmorde* victims–those who survived and those who did not–all of whom have been historically overlooked and marginalized.

8.1 Introduction

Approximately 300,000 people were murdered and 360,000 sterilized during the National Socialist (Nazi) regime (1933–1945) under a group of crimes now collectively known as the *Krankenmorde*, the murder of the sick and disabled.

As depicted in Fig. 8.1, the *Krankenmorde* describes multiple crimes perpetrated by the Nazi regime in order to persecute and exclude people with illness or physical, intellectual or psychosocial disabilities. Though the exact number of victims is still not known, it is estimated (Robertson et al. 2019, 23, 249; Hohendorf 2016; Schneider et al. 2014) that:

- Compulsory sterilization by vasectomy, tubal ligation, x-ray or radium irradiation (1933–1945)
    - 360,000 (perhaps up to 400,000 (Schneider et al. 2014, 9)) German citizens were forcibly sterilized. More than 5,000 people died because of sterilization procedures.
- Murder by shooting, gassing, electrocution, lethal drugging, or starvation and other deliberately fatal abuse and neglect (1939–1945)

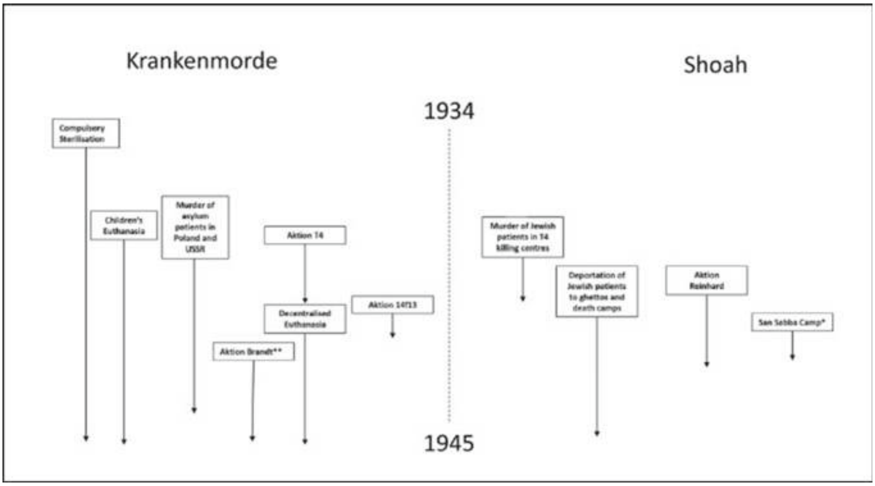


Fig. 8.1 The historical relationship between the Krankenmorde and the Shoah (Robertson et al. 2019), p. 154

- 80,000–100,000 patients were killed in eastern Nazi-occupied territories such as Poland and the USSR.
- 5,000 children were murdered in the "children's 'euthanasia'" program.
- 70,000 people were killed in the *Aktion* T4 "euthanasia" program.
- 10,000–20,000 sick or incapacitated concentration camp prisoners were killed at T4 sites under the "special treatment" 14f13 campaign.
- At least 87,000 people were killed during a "decentralized 'euthanasia'" phase, and/or as part of the emptying of hospitals and nursing homes for military and civil defence functions under *Aktion* Brandt.

8.2 "Life Unworthy of Living"

Founded in inconsistent and economically functional accounts of a "good" and "valuable" life, the Nazi eugenic and "euthanasia" crimes were brutal and violent acts organized and executed by doctors, nurses and other professionals.

As has been described elsewhere (Robertson et al. 2019), the *Krankenmorde* originated from different political, intellectual, and historical factors. The most frequently cited precondition to the persecution of the disabled in Western culture was the eugenic discourse that pervaded academic and elite social circles beginning in the late nineteenth century. Originally attributed to the English polymath Francis Galton—"whose explicit goal was to create better humans"(Goering 2014)—eugenics became a cause célèbre among social elites and the academy in many societies, which enabled exclusionary immigration policies and compulsory sterilization laws in multiple countries. While ostensibly focused on questions of how to eradicate genetic disease and disability, eugenics and racial hygiene were interwoven concepts that linked racism and ableism in public policy in many countries (Mitchell and Snyder 2003). In Germany, an influential twentieth century manifestation of these ideas was published in 1920 by jurist Karl Binding and psychiatrist Alfred Hoche. Their monograph, *Die Freigabe der Vernichtung lebensunwerten Lebens* ("Allowing the Destruction of Life Unworthy of Living"), expounded a concept of euthanasia for certain groups of people, which included an argument that an ill or disabled person's value was diminished if her social contribution was outweighed by the cost of caring for her (Robertson et al. 2019). Following Hitler's ascension to the Chancellorship and the Nazi Party's control of the Reichstag in 1933, eugenic and racist ideas flourished in public policy. As noted by Robert J. Lifton, National Socialism was as much a biological as a political movement (Lifton 1986). The Nazis trafficked in biological metaphors that enabled an extreme state paternalism, which extended from seemingly enlightened public health policy to genocide (Proctor 1999).

An under-acknowledged theme in the history of this time is the status of the German medical profession and its struggles for professional autonomy through the Wilhelmine (1890–1918) and Weimar (1918–1933) periods (Burleigh 1997; Robertson et al. 2019). The hegemonic influence of Nazi biological nostrums and the weaponization of eugenics and racism facilitated an enhanced status of *Ärzte* (doctors) in the Nazi state. German physicians were enthusiastic and early adopters of Nazism, none more so than psychiatrists (Lifton 1986; Haque et al. 2012). Under the *Aktion* T4 program and later the "decentralized euthanasia" phases of the *Krankenmorde*, psychiatrists were empowered to eliminate severely ill and disabled patients who had not benefited from the novel physical treatments introduced into the asylum system, which had arisen from the new biologism of psychiatrists such as Emile Kraepelin and Ernst Rüdin. This group of severely ill and disabled patients were themselves blamed for their failure to benefit from biological psychiatry and cast into a category of deadly clinical nihilism that led, ultimately, to their murder. In Germany and occupied territories, asylum directors routinely utilized their political master's virulent anti-disability agenda to purge the dormitories of their institution of the most severely impaired and treatment refractory cases.

Throughout the following historical account of the *Krankenmorde* crimes we have drawn attention to individual victims and survivors. As is discussed in more detail later in this chapter, the lives of *Krankenmorde* victims have until recently been overlooked, marginalized, and discredited. We respectfully seek to center their lives and experiences in this history. At the same time, we recognize the limitations of some sources of information about victims and of our roles as contemporary external observers.

8.3 Compulsory Sterilization

Forced sterilization steered our lives onto a completely unexpected course. We were children, young women and men who had the rug pulled out from under us. Klara Nowak.

The starting point of the aggregate of crimes that comprised the *Krankenmorde* is usually taken as the Reichstag's passage of the Law for the Prevention of Genetically Diseased Offspring in 1933. This mandated the establishment of a medico-legal apparatus in the form of almost 200 hereditary health courts that would, by the end of the war, have ordered the sterilization of up to 400,000 "genetically defective" people.

Under the law a person was considered "hereditarily diseased" on the basis of diagnoses of intellectual disability, schizophrenia, epilepsy, manic-depressive disorder, severe alcoholism, Huntington's disease, blindness, and/or deafness. Conscious of the lack of empirical evidence for their actions, doctors, public health officers, and health and social care institutions were involved in reporting people believed to have an "hereditary defect" and filing requests for sterilization, after which doctors and magistrates passed judgement in the courts, and gynecologists and surgeons performed the procedures (Schneider et al. 2014).

BOX 1: *Klara Nowak (1922–2003).*

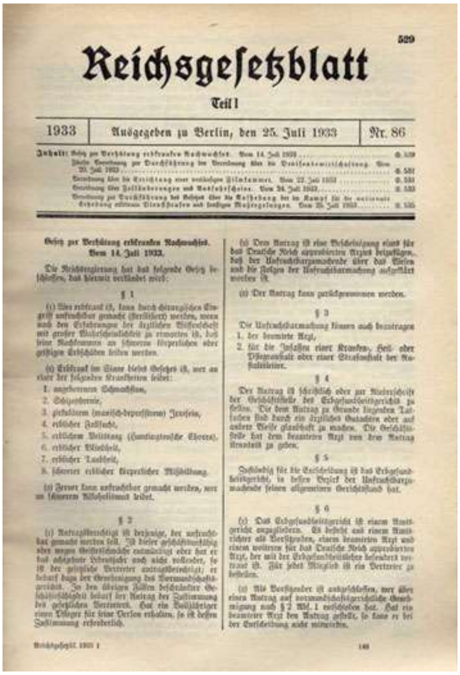
Born in Buchholz, Berlin, on March 29, 1922, Klara Nowak had just begun training as a nurse when she was committed to a mental hospital. One of her brothers was also institutionalised for a time. In 1940, the borough health office of Pankow, Berlin, requested that both of them be sterilized. They were involuntarily sterilized at the Charité in Berlin in 1941. In 1945, Klara Nowak and her mother fled Berlin to Halberstadt. Her brothers and father did not survive the war.

Later she described her situation: "Forced sterilization steered our lives onto a completely unexpected course. We were children, young women and men who had the rug pulled out from under us." Like many other victims of compulsory sterilization, she never married. After she had finished training in her chosen profession, she worked as a nurse, first in the German Democratic Republic and later in West Germany. The medial consequences of her involuntary sterilization made further operations necessary. She was pensioned in 1974. She received a one-time payment of DM 5,000 as compensation for her compulsory sterilization.

Since the 1970s, Nowak had been trying to shed light on what had happened to her. A physician friend helped her find her patient file from the Charité. "We survived the massacre of the Nazi period. But after the war, very little changed for us. We still couldn't talk about what had happened to us." In 1987, she broke the silence. Together with the psychiatrist Klaus Dörner, she founded the *Bund der "Euthanasie"–Geschadigten und Zwangssterilisierten* (BEZ), the alliance of compulsory sterilization victims and the families of "euthanasia" victims, which she chaired until 1999. She spoke openly about her wounds. Klara Nowak died on December 14, 2003 [Biographical details edited from Schneider et al. 2014, 189–190] (Image 8.1).

BOX 2: *Wilhelm Werner (1898–1940).*

Wilhelm Werner was born on September 18, 1898, in Schniegling near Nuremberg. His family lived in great financial distress, and, in 1902, his mother moved to a poorhouse with the children. His parents divorced in 1906. In 1908 or before, he was admitted to a Catholic institution, St Joseph's Home for the Feeble-Minded in Gemunden, Franconia, most likely because he was deaf. There he learned to read, write, do math–and draw. In 1919, aged 21, he was moved to the Werneck psychiatric hospital with a diagnosis of "imbecility" and lived there until 1940. He was forcibly sterilized between 1934 and 1938. On October 6, 1940, the first group transport from Werneck took Werner to the Pirna-Sonnenstein killing center, where he was murdered.



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Reichsgeſetzblatt

Teil I

1933 | Ausgegeben zu Berlin, den 25. Juli 1933 | Nr. 86

Image 8.1 Reichsgesetzblatt vom 25. Juli 1933 mit der Verkündung des "Gesetzes zur Verhütung erbkranken Nachwuchses" [Proclamation Gazette from 25 July 1933 with the Law for the Prevention of Genetically Diseased Offspring]

During his time at Werneck, Werner expressed his experiences of forced sterilization in 44 pencil drawings. The drawings were contained in a notebook that was saved for decades by an administrator from the asylum until acquired in the early twenty-first century by the Prinzhorn collection at Heidelberg University (see https://prinzhorn.ukl-hd.de/museum/publications-of-the-prinzhorn-collection/wilhelm-werner/?L=1). Marc Steene describes Wilhelm Werner's drawings as having a "theatricality… The story that these mannequins tell is harrowing, Werner directs a shocking series of tableaus, all drawn in a highly controlled way, exploring his sterilization. His characters are seeming puppets, victims lacking autonomy and under the control of cigarette smoking Nazi nurses" (Steene 2020, 2). He suggests: "We should not overlook the intention in Werner's work, this is a deliberate act of creation, an act of defiance and a statement of personal suffering drawn with great control and bravery" (Steene 2020, 2).

[Biographical details edited from Schneider et al. 2014, 54–57].

8.4 Children's "Euthanasia"

Five thousand people died from complications of sterilization procedures; however, the *Krankenmorde's* most noted first victim was the infant boy Gerhard Kretschmer, whose murder by barbiturate overdose in July 1939 in a Leipzig pediatric ward initiated the "children's euthanasia program" (Robertson et al. 2019). In February of that year, baby Gerhard was born blind, with phocomelia (malformed or absent limbs), and having seizures. When Gerhard's father petitioned Adolf Hitler for support for his child's "euthanasia," the Führer sent his escort physician Karl Brandt to examine the infant. Based on Brandt's assessment, Hitler authorized the clinic staff to euthanize Gerhard.

The "mercy death" of Gerhard would be a "threshold moment in the Nazi regime's attempted extermination of the disabled," setting in motion a large-scale pedocide that would eventually kill 5,000 children (Robertson et al. 2019). In this and other various phases of the *Krankenmorde*, the murder of children, adolescents and adults was conducted in cooperation with scientists–sometimes at the request of–who used their bodies for research.

BOX 3: *Elisabeth Jarosch (1925–1940).*

Elisabeth Jarosch was born in Lanietz, Upper Silesian, in 1925. Just one year after starting school, she was sent to a school for children with learning difficulties and finally removed from lessons completely. In 1935/6, Elisabeth, who experienced arbitrary twitches, was examined several times but a diagnosis could not be made. In 1936, she was admitted to Potsdam State Hospital, where doctors assumed that an organic brain disorder was the cause. Elisabeth fitted in well with institutional life. Although she usually played alone, she was friendly, sometimes even tender toward other children.

As of 1937, the entries in Elisabeth's file changed, stressing a lack of progress and an inability to communicate well. These negative comments also continued after the Potsdam institution moved to Brandenburg-Gorden. Because her symptoms could not be explained, scientists viewed her as an interesting case. She was one of more than 50 children from Gorden that were murdered for research purposes in the Brandenburg killing center on October 28, 1940. Her brain was made available to the Institute of Brain Research of the Kaiser Wilhelm Society in Berlin-Buch. At least 340 children and adolescents from the nearby Brandenburg-Gorden State Hospital were murdered in the Brandenburg killing centre.

[Biographical details edited from Ley and Hinz-Wessels 2012, 107].

8.5 Murder of Asylum Patients in Eastern Occupied Territories

Within a few months of Gerhard Kretschmer's death, SS and Wehrmacht units would perpetrate sporadic massacres of patients in psychiatric asylums and nursing homes in the newly occupied western Poland. Independent of the "euthanasia" activities emanating from Hitler's Chancellery, from early September 1939 *Einsatzgruppen* units began committing mass killings of psychiatric patients in Poland by shootings and later in static and mobile carbon monoxide gas chambers–killing methods that would later be adapted on a larger scale for the extermination camps of the Shoah (Robertson et al. 2019; Evans 2010). These special units continued their murder of people with disabilities as part of mass killing operations in the Soviet Union following Germany's invasion in 1941. Henry Friedlander writes that although their focus was on the killing of Jewish, Roma and Sinti people and Soviet prisoners of war, the *Einsatzgruppen* did not overlook the disabled (Friedlander 1995; Evans 2010). This included the execution of people to clear institutions for wartime use, "for reasons of hereditary health", and in the course of testing different killing methods, for example, the use of dynamite and gas (Friedlander 1995). An estimated 100,000 people in the eastern occupied territories were murdered in this largely underacknowledged component of the Nazi persecution of the disabled.[1]

8.6 Aktion T4 and Sonderbehandlung 14f13

Meanwhile, in October 1939, Hitler wrote an order to the head of his Chancellery, Philipp Bouhler, and his physician Karl Brandt:

> Reichsleiter Bouhler and Dr Brandt MD, are charged with the responsibility of enlarging the authority of certain physicians to be designated by name in such a manner that persons who, according to human judgement, are incurable can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death (USA v Karl Brandt et al).

Backdated to September 1, 1939, the day Germany had started the war, this order enabled the establishment of a secretive formal state system that empowered certain medical professionals and bureaucrats to decide which persons were "incurable" or "useless," what that meant to society, and what was to be "done" about it (Robertson et al. 2019, 142). Led by Bouhler and Brandt, the *Aktion* T4 "euthanasia" program–the bureaucracy for which operated out of a villa at number 4 Tiergartenstrasse, Berlin–commenced its work with the gathering of information about certain groups of patients from hospitals and nursing homes across the Reich. A central committee of medical assessors reviewed this registration information and any medical files to decide a person's death or survival. A person's work capacity and "curability" was often a factor in decisions. The names of patients condemned to death were placed on transport lists to ensure they were located and then taken to one of the six *Aktion* T4 killing centers, often via an intermediate institution to better organize and conceal these activities.

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[1] Less is known about the fate of patients in other occupied territories, such as France, where it is not agreed upon whether the estimated 48,588 patients who died of starvation in psychiatric hospitals between 1940 and 1944–half of all patients–was due to an intentional "euthanasia" policy or because of non-assistance due to the circumstances of war and Occupation (Hohendorf 2016; Mouchenik and Fau-Vincenti 2019; Lemoine and Stahl 2018).

Image 8.2 Bernburg gas chamber (Author photograph [Michael Robertson], 2015, Gedenkstätte Bernburg)

These initial coordinated phases of the *Krankenmorde* involved a bureaucratic process that identified and centrally registered victims, transported them to killing centers, and sought to deceive victims, their families and the broader community. At the killing centers–Brandenburg an der Havel, Bernberg, Hadamar, Pirna-Sonnenstein and Grafeneck in Germany, and Hartheim in Austria–victims were murdered in carbon monoxide gas chambers (Image 8.2). Their families would receive a bogus death certificate and sometimes (non-specific) ashes taken from the crematoria. "In effect, this operation provided the model for the Nazi's 'Final Solution'–the planned mass extermination of Europe's Jewish population and many other 'undesirables'" (Robertson et al. 2019, 23). More than 2,000 *Aktion* T4 victims were Jewish psychiatric or medical patients–killed solely because of their Jewish origin and regardless of their illness or ability to work–making them among the first victims of the Holocaust (Ley and Hinz-Wessels 2012). Some 90 T4 staff would also go on to put their experiences of mass killing to work at the Reinhard extermination camps of Belzec, Sobibor and Treblinka.

Aktion T4 was halted in August 1941–after the death of 70,000 people–however the criminal work of some of the killing centers continued under the program *Sonderbehandlung* (special treatment) *14f13.* This additional killing phase–again co-led by Bouhler, this time with SS chief Heinrich Himmler–focused on the elimination of sick and disabled concentration camp prisoners who were no longer able to work. Selected for death by former T4 doctors, prisoners were transported to Bernberg, Pirna-Sonnenstein and Hartheim. The first 269 victims came from Sachsenhausen concentration camp in June 1941 and were killed at Pirna-Sonnenstein (Robertson et al. 2019). The markings used to identify “seriously ill” prisoners included being forced to wear armbands inscribed with the word *Blöd* (indicating “feeble-minded”) or to wear large signs around their necks that read “I am a moron” (Evans 2010, 66). Between 10,000 and 20,000 prisoners were murdered by the time the program ended in March 1943.

BOX 4: *Otto Hampel (1895–1940).*

Otto Hampel was born in Breslay in 1895 and trained to become a typesetter after school. For his contributions in World War I, during which he survived being buried alive, he was awarded the Iron Cross Second Class and the Hungarian Commemorative Medal of World War I. After the war, Otto Hampel soon found work as a sales representative in Berlin. He came into conflict with the law several times in the 1920s (burglary, receiving stolen goods and fraud). In the 1930s, he was also twice admitted to Municipal State Hospital and Nursing Home Berlin-Wittenau where he was treated for fever. In May 1937, Otto Hampel was sentenced by the district court of Berlin to nine months in prison on account of “continued homosexual acts.” At the same time, the court ordered him to be housed in an institution.[2] After he had served his sentence, Otto Hampel was transferred to the hospital in Berlin-Buch. He unsuccessfully applied several times to be released. On March 30, 1940, he was taken in a collective transport to the killing center in Brandenburg and murdered.

[Biographical details edited from Ley and Hinz-Wessels 2012, 101, 103].

BOX 5: *Alma Pinkus (1898–1940).*

Alma Pinkus was born the youngest child of a livestock dealer in Goritz an der Oder in 1898. After attending high school, she helped in the family home. Despite a serious stomach condition, she learned how to take care of babies and occasionally worked as a governess. After an acute gastric hemorrhage in the spring of 1931, she repeatedly expressed feelings of being “poisoned, hypnotised and influenced,” after which she was committed to Landsberg/Warthe State Hospital in Brandenburg. Her treatment, with insulin, was stopped on account of her poor physical state. In March 1932, she was allowed home. Two years later she had to be admitted to Landsberg again, where she remained, with some breaks, until the summer of 1940. In July

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[2] One group deliberately included in the T4 killing was forensic patients, the number of which had increased considerably due to the 1933 “Law Against Dangerous Habitual Criminals and on Measures of Security and Recovery”. The law allowed people to be committed to a hospital if “public safety” demanded it and also permitted “preventive detention”, which the Nazi regime also used to persecute political opponents and social groups on the margins of society (Ley and Hinz-Wessels 2012, 99).

1940, she and all other Jewish patients at Landsberg were taken to an intermediate institution and then on to the Brandenburg killing center where they were murdered. Officially she died of "furuncle of the nose and meningitis in the 'Chelm Lunatic Asylum'" near Lublin on January 28, 1941.

[Biographical details edited from Ley and Hinz-Wessels 2012, 159].

BOX 6: *Theodor Kynast (1904–1940).*

Theodor Kynast was born June 28, 1904, and lived with his parents in Göppingen, Württemberg. As a young man he was diagnosed with schizophrenia and was admitted to the Christophsbad private sanatorium in Göppingen. On October 14, 1940, by order of the Württemberg Ministry of the Interior, he and 74 other male patients were transferred from Göppingen to the Württemberg sanatorium in Winnental. On November 29, 1940, 16 of the Göppingen patients, including Theodor Kynast, were transported together with patients from other institutions to the Grafeneck killing center and gassed there on the same day. The false death certificate issued by the Grafeneck registry office and the so-called "consolation" letter to the parents in Göppingen have been preserved in the original and are now in the Grafeneck memorial archive. They are dated December 3 and December 4, 1940. After his murder his parents received his personal belongings, among which they found a cookie into which he carved the words "Abt. Morder" [ward of murderers].

[Biographical details edited from Gedenkstätte Grafeneck Dokumentations Zentrum 2016; Bruggemann and Schmid-Krebs 2007].

8.7 De-Centralised "Euthanasia" and Aktion Brandt

The current historiography of the *Krankenmorde* portrays it as progressing from a centrally coordinated process of killing selected victims in six dedicated killing centers with static gas chambers (*Aktion* T4), to a more murderous regionalised phase of killing in hospitals and asylums by starvation, poisoning or electrocution. This decentralized phase of "euthanasia" took place in more than 30 different state hospitals and asylums and also expanded the scope of victims to include the frail and elderly, laborers who had fallen ill, and injured or incapacitated soldiers (Robertson et al. 2019; Image 8.3). At Mesertitz-Obrawalde hospital, for example, an estimated 97% of patients–pre-existing patients and those transferred from other institutions–were murdered by overdose, in total approximately 10,000 people (McFarland-Icke 1999; Benedict et al. 2007). Many were dead on arrival at Obrawalde hospital or died soon after, particularly children (Benedict et al. 2007).

Aktion Brandt (1943–1945) describes the lethal displacement of patients from psychiatric hospitals and nursing homes for military and civil defense purposes, making space for wounded soldiers and for physically ill or injured civilians as urban

Image 8.3 Page from register of deceased patients at the Eglfing-Haar institution (1944), where more than 330 children died by poisoning in a Kinderfachabteilung (special children's ward). Other Eglfing-Haar patients were also murdered by poisoning, neglect or malnutrition caused by a special "starvation diet" or were sent to the killing centres Grafeneck and Hartheim. (Author photograph [Edwina Light], 2013, Psychiatriemuseum am kbo-Isar-Amper-Klinikum München-Ost)

hospitals were destroyed in bombings. There is disagreement among historians as to whether *Aktion* Brandt was a sporadic process or a systematic revival of a centrally organized program to murder the sick and disabled–notably argued by Götz Aly among others–in addition to the regional "decentralized euthanasia" activities that occurred at individual hospitals and other care institutions after *Aktion* T4 ended (Aly et al. 1985; Aly 1989; Burleigh 1994; Schwarz 2002; Hohendorf 2016).

It was so-named because former T4 co-leader Brandt, now *Reichskommissar für das Sanitäts- und Gesundheitswesen* (Reich Commissioner for Sanitation and Health Care), managed decisions about and the coordination of the transfers of patients from areas affected by increasing air bombardments to the region's institutions (Schulze 2010). Schulze (2010) writes that despite the continuity of these events with *Aktion* T4, "there existed at that time no centrally managed extermination programme within which patients would be liquidated en masse in specially appointed institutions adapted for such a purpose."

It is estimated that after *Aktion* T4 stopped in August 1941–following growing public disquiet, direct protest from some community leaders, and the mounting demands of the regime's war in the East– at least 87,000 people in institutional care (perhaps 100,000 (Schulze 2010)) died as part of the *Krankenmorde.*

BOX 7: *Babette Fröwis (1929–1943).*

Babette Fröwis was born in Munich in July 1929. From birth, Babette demonstrated numerous feeding and settling problems and spent the first five months of her life in an institution for children with disabilities. Babette returned to live with her family and continued to show signs of significant developmental delay. As a child she suffered numerous seizures and exhibited increasingly distressed behavior, including tearing out her hair and screaming uncontrollably. Babette's parents became concerned that her behavior posed a risk to her younger siblings. Pediatricians declared her an "imbecile" and "ineducable." In August 1934, Babette was placed in permanent institutional care at the Schönbrunn Sanatorium in the city of Dachau. She remained at Schönbrunn until late 1943. In early October the Schönbrunn medical director, a pediatrician named Dr. Hans-Joachim Sewering, informed Babette's parents that due to her behavior she could no longer be properly cared for at Schönbrunn. On October 23, 1943 Sewering signed a transfer order for Babette to be sent to the *Kinderfachabteilung* at the hospital in Eglfing-Haar on the outskirts of Munich. Babette Fröwis died there on November 16, 1943. In her Eglfing-Haar medical file an entry reads "inadequate food intake for five days, frequently chokes while eating. In the last few days tracheobronchitis. Died today." Despite this statement, Babette had been assessed as being of robust physical health when admitted to Eglfing-Haar three weeks earlier. The lies documented in her medical file were intended to conceal the fact that she had died after being overdosed fatally on a medication, most likely the barbiturate Luminal.

[Biographical details edited from Robertson et al. 2019, 209–210].

8.8 *Krankenmorde* Memory, Meaning and Bioethics

Acknowledgement of *Krankenmorde* victims was delayed and obscured for decades due to historical events as well as prevailing political and social attitudes toward mental illness and disability. Detailed accounts of delays to recognition of the *Krankenmorde* are provided elsewhere, describing barriers to acknowledgement and restitution (such as the division of Germany post-war, the scope of legal processes, and societal indifference), as well as recent activities to recognize the crimes, the victims, and the responsibilities for the perpetration and latter suppression of the crimes (Light et al. In press; Schneider et al. 2014; Robertson et al. 2019).

Post-war legal processes predominately focused on the Nazi's medical research crimes and although some *Krankenmorde* perpetrators were prosecuted, many were never held accountable. Alexander Mitscherlich's well-known 1949 account of the Nuremberg Doctors' Trial[3]–which indicted 23 doctors for various roles in medical experiment crimes and/or "euthanasia"– illustrates some of the early equivocation about the criminality of the *Krankenmorde*: "The granting of 'dying aid' in the case of incurable mental patients and malformed or idiot children may be considered to be still within the legitimate sphere of medical discussion," he wrote, suggesting that it was only of greater concern as the scope "moved more and more openly to purely political and ideological criteria for death…" (Mitscherlich and Mielke 1949, 117). The Nuremberg judges similarly appeared to take the position that the Nazi state had the right to implement euthanasia on medical grounds (Burdett 2011; Knittel

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[3] United States of America v Karl Brandt, et al., Nuremberg Military Tribunal (NMT) No.1.

2015). Among other contemporary scholars, Emmeline Burdett emphasises that the "dismissive and paternalistic assumptions and stereotypes about disabled people" at Nuremberg were not unique to that time or to those judges (Burdett 2011). She argues, "[I]t remains true that there is a widespread assumption that (a) people subjected to non-consensual 'euthanasia' are not in possession of any characteristics bar that of irredeemable suffering; (b) killing such people is simply not the same as the murder of another sort of person would be; and (c) the person or people in question do not suffer from being killed" (Burdett 2011, 8–9).

Politically, survivors, families and advocates have also had to fight against marginalization, discrediting and shaming (Light et al. In press). It was only in 1998 that a national law passed to overturn the hereditary health court sterilization orders (Surmannn 2014). In 2010, the German psychiatric profession officially apologized (Schneider et al. 2014), and in 2017 the Bundestag focused on the victims of the *Krankenmorde* in its annual Holocaust Remembrance Day, including an acknowledgment of decades of suppression and denial (Lammert 2017).

These themes have been echoed in the scientific literature. In her analysis of *Krankenmorde* historiography, Emmeline Burdett argues that study "has been hindered–if not totally prevented–by historians' casual dismissal of the murder of hundreds of thousands of people" because of an almost exclusive focus on protests against the "euthanasia" program and those who perpetrated this agenda (Burdett 2014, 39). Reviewing the literature from the 1950s onward, she builds on explanations (Kudlick 2003) for why historians and the general public doubt the criminality of "killing people who are frequently perceived to be a burden on society." Burdett argues that "historians have perceived the victims of the Nazi euthanasia programme in ways that are commensurate with the ways in which disabled people are perceived in their societies" (Burdett 2014, 39). Early studies of the Nazi period and medical crimes largely ignored the *Krankenmorde*, while in subsequent decades they focussed on protests against it (often in contrast to the lack of protest against other victims of Nazi criminality), public perceptions and reactions to it, and the roles and motivations of doctors and other perpetrators. These works treated it "as a dry ethical issue" and rendered the victims invisible, she says (Burdett 2011, 2014). Burdett points to later works (Burleigh 1994; Friedlander 1995; Evans 2010; Gallagher 1990) as examples of changes in historians' attitudes that have led to greater investigation of the *Krankenmorde*, which has "mirrored positive changes in social attitudes toward disability" (Burdett 2014, 48). These historical accounts have been central to much of the bioethical analysis of the *Krankenmorde.*

A unique challenge to the study of the *Krankenmorde* is emphasised by Susanne Knittel: how to center the voices of witnesses and survivors when there are few or no survivors (except of sterilization), there has been no community of memory, and key sources–sometimes the only documentary sources–of this memory are the medical records created by the perpetrators (Knittel 2015, 23). These questions are put in the context of the work of memory studies, but apply equally to other disciplines such as history, medical ethics and bioethics. Referring to the work of Snyder and Mitchell (2006), Knittel situates the silencing of *Krankenmorde* victims and survivors in the context of dominant Holocaust discourse and memory which "brackets off" the "euthanasia" program, casts Nazi medicine as an "unprecedented aberration of the healing professions," and decouples the international eugenics movement from the Holocaust thereby reinforcing an "imaginary line between 'medical intervention' and murder'" (Knittel 2015, 19,20,23). She sets out some approaches to this problem–proposing an engagement with disability studies and the concept of "vicariousness"–that "can go some way toward recovering and imagining these victims' stories" (Knittel 2015, 23). Throughout this chapter we have sought to highlight the words and lives of *Krankenmorde* victims–those who survived and those who did not–however, we acknowledge the same limitations and ramifications of what we present here. They are mostly sourced from medical and state records. Furthermore, where we can look to first-hand expressions by victims about their experiences–such as the words of Klara Nowak, the art of Wilhelm Werner, and the message from Thomas Kynast–we must remain mindful that the meanings we attribute to them come from our own values as external twenty-first century observers. It is also important to draw attention to contemporary challenges, where patients/consumers and survivors have fought to have their experiences and voices centered within bioethics and health law discourses, particularly in relation to ongoing contests about coercive practices in mental health care and the treatment of people with intellectual or psychosocial disabilities more generally.

The need for a greater engagement by bioethics with disability studies and human rights has been emphasised by the UN Special Rapporteuer on the Rights of Persons with Disabilities, Catalina Devandas Aguilar, who in a 2019 report called for bioethics to move toward a "disability bioethics" or "disability-conscious bioethics" (United Nations Special Rapporteur on the Rights of Persons with Disability 2019). The report on ableism in medical and scientific practice states, "Unlike the widespread moral revulsion and outrage against comparable atrocities of the twentieth century, the significance of the eugenics movement and its impact on how societies continue to dismiss the value of the lives of persons with disabilities has long remained confined to disability circles" (pp. 3–4). It argues that ableism–defined as "a value system that considers certain typical characteristics of body and mind as essential for living a life of value"–continues to dominate important debates that impact the rights of people with disabilities, debates which often take place primarily in the field of bioethics (p.5). Acknowledging "a close but conflictual" historical relationship between bioethics and disability, the report says, "Much of the work in bioethics to date has been based on a thin or inaccurate understanding of the diversity, complexity, and socially embedded nature of disability." And while some bioethical work has begun to take into account the perspective of persons with disabilities, ableist views "dictate most bioethical discussions, from prenatal testing to assisted dying. They therefore fail to address the bioethical questions that actually concern persons with disabilities" (United Nations Special Rapporteur on the Rights of Persons with Disability 2019, 5). The report concludes that the "hegemony of ableism in society has perpetuated the idea that living with a disability is a life not worth living"–privileging prevention and cure over other responses to disability and limiting people's opportunities to be included and participate in society. "While the eugenic programmes of the late nineteenth and early twentieth centuries have disappeared, eugenic aspirations persist in current debates related to medical and scientific practice concerning disability, such as prevention, normalizing therapies and assisted dying" (United Nations Special Rapporteur on the Rights of Persons with Disability 2019, 17).

Like Knittel (2015), Snyder and Mitchell (2006) and others, the UN Special Rapporteur's study highlights how relevant areas of bioethics–and other disciplines–are made inadequate by the excision of the *Krankenmorde* from the history of the Holocaust, by any ambivalence about its status in the crimes of the Nazi period, and by ignoring the experiences and perspectives of people with disabilities. It would suggest that bioethics needs to know its history better and to turn some of its analysis onto itself in terms of disability and ableism. It draws attention to significant lacunae in some of the theoretical perspectives of bioethics, reflecting certain epistemic limitations to its work. As part of this, a shift is required from the idea that events like the *Krankenmorde* were one-off, local events from the past, not related to the current time or place. Writing more broadly about bioethics and disability, philosopher Shelley Tremain argued that despite the regularity of medical and scientific abuses upon various marginalized groups during the twentieth century, bioethicists have tended to cast such practices and programs "as anomalies and rarities, as disturbing relics of days gone by, and as disruptions in the history of an otherwise noble, emerging endeavor … the scope of these critiques has for the most part been limited to arguments against a particular biomedical practice or the position of a certain bioethicist, leaving the historical conditions of possibility for the overall enterprise of bioethics unexamined and unchallenged" (Tremain 2020).

In an important report on disability and bioethics to the UN Rapporteur, Jackie Leach Scully and Tom Shakespeare highlight the significance of bioethics to people living with disability today (Scully and Shakespeare 2019). "Bioethics helps societies decide which sorts of interventions into and supports for disability are morally good. But we also note that disability is important for bioethics, in that the diversity of human bodies that can exist is a central focus of biomedicine's, and therefore bioethic's, attention," they wrote (Scully and Shakespeare 2019, 55). They concluded, "It is vital that bioethics acknowledges the limitations of its approach to disability, and that efforts are made to encourage more disability-inclusive bioethical work."

8.9 Disability and Bioethics

"The greatest involvement of bioethics with disability has been in areas that are very directly about life and death", write Leach Scully and Shakespeare, providing examples such as prenatal diagnosis, preimplantation genetic diagnosis and preconception screening to prevent the birth of children with disabilities; the reproductive rights and freedoms of disabled people; and issues at the end of life, such as assisted suicide, euthanasia and decisions about continuing medical treatment when a person is seriously ill or dying (Scully and Shakespeare 2019, 4). Other topics where bioethics contributes include healthcare rationing as it affects disabled people and the use of biomedical technologies to normalize anomalous bodies or minds (Scully and Shakespeare 2019).

Euthanasia and medically assisted dying are examined in a separate chapter in this book. At the time of writing, voluntary assisted dying (euthanasia and assisted suicide) was lawful in 18 jurisdictions in eight countries.[4] In Germany, political and cultural debates on the provision of assisted dying re-emerged after a Constitutional Court ruling in 2020 overturned a ban on professionally assisted suicide (Richter-Kuhlmann 2020; Hyde 2020; Ethikrat 2020). The sensitivity to legalizing euthanasia in Germany relates in part to the history of the *Krankenmorde* (Hyde 2020) and the Nazi regime's euphemistic use of the term "euthanasia" to describe its campaign of murderous violence, abuse and neglect of people with disabilities and others deemed unworthy of life.

The UN Special Rapporteur recommended that where member states permit assisted dying, they should implement strong measures to protect the life of people with disabilities on an equal basis with others (United Nations Special Rapporteur on the Rights of Persons with Disability 2019). In her 2019 report, the Special Rapporteur noted that assisted dying was a contentious issue within the disability community. "From a disability rights perspective, there is a grave concern that legalising euthanasia and assisted suicide could put at risk the lives of persons with disabilities. If assisted dying is made available for all persons with a health condition or impairment, regardless of whether they are terminally ill or not, a social assumption might follow that it is better to be dead than to live with a disability" (United Nations Special Rapporteur on the Rights of Persons with Disability 2019, 9). Additionally, people with disabilities may decide to end their lives because of social factors–including loneliness, social isolation and lack of access to support services–or they may be vulnerable to explicit or implicit pressures, "including expectations from family members, financial pressures, cultural messages and even coercion" (United Nations Special Rapporteur on the Rights of Persons with Disability 2019,10).

Some of these concerns were highlighted in intense public debate in 2020 about proposed changes to existing medical assistance in dying (MAID) laws in Canada, which included criticism that the reforms would "single out disability" in a manner inconsistent with human rights and "promote stigma and prejudice against persons with disabilities and suggest that some lives are not worth living" (Legal and Constitutional Affairs Standing Committee 2020; Nicol and Tiedemann 2020; Lemmens and Krakowitz-Broker 2020). Philosopher Shelley Tremain's submission, strongly opposed to Bill C-7, expressed her concern that the bioethical advice to the Standing Committee represented "biased philosophical assumptions and contextually specific and socially-situated perspectives" (Tremain 2020). She was "deeply concerned that

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[4] Australia (Victoria, Western Australia, Tasmania (commencing 2022), South Australia and Queensland (commencing 2023)); New Zealand; the US (Oregon, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, District of Columbia, and Montana); the Netherlands; Belgium; Luxembourg; Canada (federal and Quebec); Colombia; and Switzerland (End of Life Law in Australia 2020).

a handful of bioethicists have represented their positions on MAID and expansions of it… as objective and value-neutral responses to the question of how Canadian society should treat disabled people who may feel hopeless, may be socially isolated, may live in poverty, and may lack social resources" (Tremain 2020). In her testimony to a Canadian parliamentary study of Bill-7, Catherine Frazee, Professor Emerita at Ryerson University School of Disability Studies and former Chief Commissioner of the Ontario Human Rights Commission, argued that there was no evidence to support claims about the assumed suffering caused by a disabling condition, unlike the suffering that is caused by social exclusion and deprivation such as those related to institutions and bureaucracies (Frazee 2020).

In the next part of this chapter, we examine a contemporary issue in bioethics– the allocation of health resources –where disability is a central feature and which also challenges and critiques the work of bioethics itself. The literature and cases presented below are not necessarily intended to be representative of all events or viewpoints. Rather they seek to highlight key issues and important perspectives around current events that are not always centered in bioethical discourses. In this way we hope the reader has opportunities to engage with some of the ideas raised in this chapter and to consider the ongoing legacies of the *Krankenmorde.*

8.10 COVID-19 and the Allocation of Health Resources

The ableism I write about in my professional capacity became a frightening and damning reminder that I am dispensable in order to save 'real' people." Rosemary Kayess.

In July 2020, the memorial institutions commemorating the Nazi "euthanasia" crimes released a joint statement of concern about discussions being had during the COVID-19 pandemic about intensive care triage decisions for older people and people with prior illnesses or disabilities (Gedenkstätten zur Erinnerung an die nationalsozialistischen Euthanasie-Verbrechen 2020). The concern of the signatories–including those of the Bernburg, Brandenburg, Hadamar, Pirna-Sonnenstein and Hartheim memorials–was expressed against a background of their work conveying the history of Nazi crimes and dealing with current medical-ethical questions in educational programs and events." Following the publication of resource allocation recommendations by German medical societies, the representatives of these memorial institutions wrote that there was a "danger that the groups mentioned [seniors and people with disability] could be excluded from intensive care if the health system is overloaded." Though Germany had not yet had such a state of emergency, the group argued it was "more important now to discuss the ethical, medical and legal implications of triage decisions in a broadly societal manner and without time pressure." They called on the German Bundestag to take up the issue and to involve self-advocacy organizations for people with disabilities and the elderly in the discussion of whether the specialist societies' recommendations could guide action. "The establishment of regulations for triage decisions cannot be left solely to medicine," the representatives of these institutions said (Gedenkstätten zur Erinnerung an die nationalsozialistischen Euthanasie-Verbrechen 2020).

Similar concerns were raised in multiple countries, by disability, bioethics and human rights scholars, advocates and practitioners among others, as various guidelines for the allocation of pandemic critical care–or other potentially limited resources such as vaccines and therapies–suggested unjust and discriminatory criteria for excluding older people and people with disabilities (Goggin and Ellis 2020; Scully 2020; UN Committee on the Rights of Persons with Disabilities 2020; Disabled People's Organisations Australia 2020).

This was one of a "rolling series of interlocking threats to disabled people's lives" in the pandemic, according to US writer Andrew Pulrang, who captured a broader concern: "The COVID-19 pandemic has revealed much that is usually hidden. For people with disabilities, the most revealing and terrifying aspect of the crisis is the sharper, more critical view we are getting of long-standing strains of ableism in health care policy and medical ethics" (Pulrang 2020). Among suggestions for practical steps his readers could take to protect their rights should they get sick and need to go to the hospital in the US, which at the time had the highest global case incidence of COVID-19–(World Health Organisation 2020) Pulrang identified the #NoBodyIsDisposable campaign (Pulrang 2020). In addition to a "Know Your Rights" patient toolkit, the US-based coalition lobbied care providers, hospitals, and policymakers for policies to avoid discrimination in triage. Its messages of protest and solidarity included: "Don't let #COVID19 triage kill disabled, fat, old, HIV + and sick people!" and "#noICUgenics" (#NoBodyIsDisposable 2020).

In the Australian context, international experts in human rights, bioethics and disability studies together released a "COVID-19 Statement of Concern" which emphasised key rights and standards needed to underpin ethical decision-making (Disabled People's Organisations Australia 2020). Statement signatory and Vice-Chair of the United Nations Committee on the Rights of Persons with Disabilities, Rosemary Kayess, said they were "concerned that any increasing demand on critical health treatment and intensive medical care will require decisions to be made about life-saving treatment that could seriously undermine the rights of people with disability." Reflecting on her own experiences during the pandemic, Ms. Kayess stated elsewhere that "the devaluing of people with disabilities is embedded in law, policy and practice, prejudicing the decisions about who is deserving of critical health care and life saving measures. The ableism I write about in my professional capacity became a frightening and damning reminder that I am dispensable in order to save 'real' people" (Kayess 2020). At the global level, the United Nations Committee on the Rights of Persons with Disabilities expressed its "grave concern" at the devastating impacts of the COVID-19 pandemic on persons with disabilities, highlighting that, "pre-existing discrimination and inequality means that persons with disabilities are one of the most excluded groups in terms of health prevention and response actions and economic and social support measures, and among the hardest hit in terms of transmission risk and actual fatalities" (UN Committee on the Rights of Persons with Disabilities 2020).

In a paper examining the impact of disablism[5] on pandemic care decisions, bioethicist (and signatory to the Australian Statement of Concern) Jackie Leach Scully wrote: "One interpretation of this discrimination is a straightforward disvaluing of the lives of people with disability. In practice, it is more likely to be evidence of a complex (but no less unacceptable) form of disablism, defined as those practices of contemporary society that exclude, eradicate, and oppress people with sensory, physical, or intellectual impairments" (Scully 2020 online, p2). The paper identifies three underlying disablist assumptions about disability, namely: overall health status, quality of life, and social utility. In relation to health status, for example, it notes that some triage protocols "appear to rely on the assumption that disability *necessarily* goes hand-in-hand with compromised health. In fact disability per se often has no overall health impact. …What makes the ethical terrain here more complicated is that some disabling conditions *do* involve health issues that are relevant to recovery from COVID-19. …Nevertheless, the amount of individual variation means that global categorizations based purely on diagnostic labels can easily create injustice" (Scully 2020, online, p2). Distinguishing between the general and the individual is vital, "especially since bioethics and medical ethics both have dismal track records for oversimplifying the theoretical and experiential diversity hidden under the label of disability" (Scully 2020, online, p2).

In their analysis of disability, communication and the COVID-19 pandemic, Gerard Goggin and Katie Ellis wrote that the time of the pandemic represented "a new phase in the profound disablism that is woven into the foundations of what humans think life is, and who should live" (Goggin and Ellis 2020, p.174). They argue that the treatment of disability in the pandemic had revealed the "biopolitics of disability" (invoking the account by Mitchell and Snyder (2015)), which undermines "the prospects for securing health and well-being and further degrades social equality and participation" (Goggin and Ellis 2020, 174). They concluded: "Not to put too fine a point on it, recrudescent and repugnant disablism underpinned conceptualisation, affect, plans, and practices for who would be cared for; especially in the extreme situations where medical resources ran out such as the scarce yet indispensable Personal Protective Equipment (PPE, an acronym etched in our hearts) and the totemic ventilator. … we find out, courtesy of disability, truths about our societies and who and what matters, after all" (Goggin and Ellis 2020, 175).

8.11 Conclusion

Based in prejudiced and inconsistent accounts of a good and valuable life, the Nazi crimes of the *Krankenmorde* first aimed to prevent the lives of those who might be

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[5] Scully notes that the relevant focus of the paper's discussion is disablism, rather than ableism: "Disablism is often discussed in conjunction with ableism. In disablism, the focus is on the exclusion of certain kinds of body; in ableism, focus is turned onto the kinds of body that society values and promotes" and refers readers to the work of (Goodley 2014).

born with hereditary illness or disability (or some other characteristics also deemed socially undesirable), and then expanded those aims to "euthanize" those people living lives deemed unworthy of life. Between 1933 and 1945 almost 300,000 people with illness and disabilities were murdered and 360,000 sterilized by doctors, nurses and health bureaucrats of the Nazi regime, using brutal and violent methods.

Historical, legal and political delays and obfuscation to the acknowledgement of these crimes and this group of victims has been paralleled in bioethics. As a result, the breadth of the *Krankenmorde* crimes and its victims, its relationship to the Holocaust and its contemporary significance–to bioethics and society more broadly–is less recognized or understood than other Nazi medical crimes, such as the infamous experiments on prisoners. Despite the limitations of much of the documentary sources– often medical or perpetrator records and all presented in the context of our contemporary values and discourses–we have sought here to draw attention to the lives of *Krankenmorde* victims, historically overlooked and marginalized.

We agree with arguments that bioethics theory and practice has much to gain from better engagement with this history (and with disability studies, human rights, and memory studies) not the least of which is to challenge the ableism that continues to dominate bioethical debates that affect the rights of people with disabilities. Contemporary bioethical and disability issues related to the allocation of health resources provide important opportunities to reconsider the ongoing lessons of the *Krankenmorde* and the work of bioethics.

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Chapter 9
Race, Eugenics, and the Holocaust

Jonathan Anomaly

Abstract This chapter will focus on how the Holocaust shaped the concepts of race and eugenics in bioethics. I will begin with a brief account of how these terms were used before the Second World War, and then discuss how the Nazi eugenics programs and the Holocaust altered how scholars think about race and eugenics. In particular, I will discuss the 1948 United Nations Declaration of Human Rights and 1950 Statement on Race, which signaled a change in how race and eugenics would be used in the second half of the twentieth century. Finally, I will consider how liberal eugenics in contemporary bioethics differs from older forms of eugenics, and how newer views about human populations (as genetic clusters) differ from older views of race. In doing so, I will explore how the Holocaust shaped modern taboos related to human genetics research.

9.1 Introduction

The terms "eugenics" and "racism" have become so closely tied together by journalists and public intellectuals that they are sometimes interchangeable terms of abuse hurled at anyone who gives a biological explanation of human behavior. To take a recent example, when *New York Times* staff writer Brett Stephens mentioned in an editorial that Ashkenazi Jews have a higher than average IQ, possibly for biological reasons, he was called a racist and a eugenicist (Jones 2020), and many activists on the internet demanded that he resign from his position or be fired by the newspaper.

It may seem odd for a Jewish intellectual to be slandered with terms often associated with Nazi atrocities. It is to some extent an understandable overreaction to history and a conflation of ideas that were forever shaped by the Holocaust. In this chapter, I will review how the concepts of race and eugenics were used before and after 1945, with special focus on the implications for bioethics.

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9.2 What Was "Race" then and What is It Now?

9.2.1 Before the War

The first modern scientist to categorize people by race was Johan Blumenbach, a German physician. Blumenbach separated humanity into five basic groups: Caucasian, Mongolian, Malayan, Ethiopian, and American (1775). These groups correspond with European, East Asian, South Asian, African, and Native American. Unlike some of his contemporaries, Blumenbach was not especially interested in ranking races by their relative level of achievement. He instead wanted to classify them by reference to their continent of origin and physical similarities. It is striking how close Blumenbach was to the five genetic groupings picked out by recent mathematical cluster analysis (Rosenberg et al. 2002, 2005).

While serious scientific attempts to classify human populations did not improve much until the advent of computational genetics in the early twenty-first century, many Europeans speculated about the nature of race and the value of different racial groups. For five centuries Europeans explored the world, colonized novel territory, and encountered new and seemingly strange people. Like the Greeks and Romans of the classical era, modern Europeans saw themselves at the center of civilization, and regarded other groups as barbaric. The observations philosophers made about race were often couched in negative value judgments. David Hume, for instance, confessed in an essay on human differences that:

> I am apt to suspect the negroes, and in general all the other species of men (for there are four or five different kinds) to be naturally inferior to the whites. There never was a civilized nation of any other complexion than white, nor even any individual eminent either in action or speculation. No ingenious manufactures amongst them, no arts, no sciences (1748, 20, note 6).

In the final edition of his essay, Hume restricted his claim of inferiority only to Black Africans: "I am apt to suspect the negroes to be naturally inferior to the whites. There scarcely ever was a civilized nation of that complexion, nor even any individual eminent either in action or speculation" (1777, 20, note 6). In a rare point of agreement, Immanuel Kant echoed David Hume's view of Africans:

> The Negroes of Africa have by nature no feeling that rises above the trifling. Mr. [David] Hume challenges anyone to cite a single example in which a Negro has shown talents, and asserts that among the hundreds of thousands of blacks who are transported elsewhere from their countries, although many of them have even been set free, still not a single one was ever found who presented anything great in art or science or any other praiseworthy quality, even though among the whites some continually rise aloft from the lowest rabble, and through superior gifts earn respect in the world. So fundamental is the difference between these two races of man, and it appears to be as great in regard to mental capacities as in color (1760, 110).

Hume and Kant relied primarily on anthropological reports from other authors to justify their claims. Speculation about race and racial differences had to be based on casual observation, since genetics and the theory of evolution by natural selection had not yet emerged.

An example of a crude and pernicious anthropological report is that of Arthur de Gobineau. An influential French author, his *Essay on the Inequality of Human Races* (1853) separated humanity into three races corresponding to skin color—white, yellow, and black. Gobineau described Aryans as the most exalted race, with Alpine and Mediterranean ethnicities as degenerative versions of the pure Aryans. This view was popularized by the American author, Madison Grant, and adopted by Adolf Hitler. Unlike Grant and Hitler, Gobineau had complimentary things to say about Jews, describing them as a "free, strong, and intelligent" people (p. 59). Despite his attitude to Jews, Gobineau's idea that Aryans were a "master race" influenced antisemites like Richard Wagner, Grant, and eventually Hitler.

Charles Darwin discussed human races, and race differences, though he didn't focus on them much. The full title to his most important book is *On the Origin of Species by Means of Natural Selection, or the Preservation of Favoured Races in the Struggle for Life* (1859). Despite the subtitle, which sounds provocative to modern ears, by "race" Darwin just meant a group of related organisms. He did not specifically focus much on human races, but instead was interested in how various populations throughout the natural world evolved through variation and selection. Nevertheless, in *The Descent of Man* Darwin discussed human racial differences, describing Native Americans as "utterly indifferent to the sufferings of strangers" and as "lacking in feelings of sympathy and kindness" to people outside their tribe, and to animals (1871, 90). Darwin also argued that some races of people were better adapted to the modern world, and he predicted (but did not advocate) that they would eventually exterminate the other races:

> At some future period, not very distant as measured by centuries, the civilized races of man will almost certainly exterminate, and replace, the savage races throughout the world.…The break between man and his nearest allies will then be wider, for it will intervene between man in a more civilized state, as we may hope, than the Caucasian, and some apes as low as a baboon, instead of as now between the negro or Australian and the gorilla (1871, 193).

It is worth remembering that Darwin wrote these words at a time when Europeans had conquered or colonized a large part of the earth's surface, so it was unclear how they would use their power over other groups.

In the decades leading up to the Nazi ascent to power, there was disagreement among German scientists about race and racial differences. In particular, there were deep disputes about the status of Jews. Antisemitism was on the rise in Germany, including among cultural icons like Richard Wagner (whom Friedrich Nietzsche broke away from, in part because of Wagner's increasingly rabid antisemitism and conversion to Christianity).[1]

Antisemitism began to take a racial (rather than religious) turn decades before the National Socialists took power. Influential German biologist and eugenics advocate Eugen Fischer considered Jews to be ethnically distinct from Germans (owing to their origin in the Middle East), but also a group with exceptional mental abilities.

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[1] See *Nietzsche contra Wagner* (1889).

Going against Fritz Lenz, the first Professor of "racial hygiene" under the Nazi regime, Eugen Fischer argued that Jewish-German intermarriage might actually be beneficial. Indeed, Fischer's sympathetic view of Jews is likely the main reason he was replaced by the Nazi party in 1933 as the Director of the Kaiser Wilhelm Institute for Anthropology, Genetics, and Eugenics (Proctor 1988).

Some have suggested that Hitler's Aryan ideal was adopted more from American authors than from German scientists (Proctor 1988). For example, it is well known that Hitler greatly admired the work of the American naturalist, Madison Grant, who followed Gobineau in exalting the Nordic (or "Aryan") race as the most physically beautiful and psychologically capable of all Europeans. Grant complained that America had been admitting fewer Nordic immigrants and more Celts, Jews, and Italians. Upon reading Grant's *Passing of the Great Race* in the late 1920s, Hitler declared "This book is my Bible" (Spiro 2009, xi). Whether Grant was a primary cause of Hitler's antisemitism, or simply helped him justify it, is hard to know.

9.2.2 During the War: Race Under Hitler's Regime

As I will argue in the second part of this chapter, the relationship between eugenics and race in Nazi Germany, as in America and Britain, was complicated and subtle. Many people seem to think that those who supported forced sterilizations also supported racially discriminatory laws. However, this view is incorrect. Some influential racists did not support eugenics, and some influential eugenicists did not support the implementation of racist policies. Some of the most famous proponents of eugenic thinking—including Francis Galton, Hermann Muller, Ronald Fisher, and Julian Huxley—thought that instituting eugenic policies was a way to encourage the best members of each race to have more children. This was as true in Germany as it was in the US and the UK.

When German scholars formed an organization dedicated to using advances in biology to improve the gene pool, they coined the ambiguous term "rassenhygiene" (translated as "racial hygiene"), which meant essentially the same thing as "eugenics" in English (Turda 2010). Just as we use "human *race*" to refer to the human *species*, so too in German "rassen" was sometimes used to refer to people in general, and sometimes to particular races. "Rassenhygiene" did not necessarily refer to race-based eugenics.

In fact, many of the early members of the largest German eugenics society, the Racial Hygiene Society, were Jewish (Friedlander 1995). Some Gentile members of the Society were antisemitic, but many were not. Germans who advocated for the separation of the races did not always think of the Jews as "inferior," but simply as a different race, and thus as a people who should not mix with Germans. According to the historian Henry Friedlander, "before the victory of the Nazis altered the rules of the game for academics, they did not consider Jews inferior or demand their exclusion. They only argued that Jews were different and that racial mingling of Jews and Aryans was undesirable" (p. 33). Historian Paul Weindling concurs that "the Nazi takeover [of the Racial Hygiene Society] marked a shift from an inclusive biological approach to welfare to one based on race, coercion, and violence against those deemed undesirable for biological and racial reasons" (2010, 321).

As soon as the Nazis took power, they passed sweeping laws intended to segregate non-Germans, including Jews, and prevent them from marrying Germans. The goal was not only to keep the German race pure from outside elements, but also to improve it. Thus, when the first eugenic sterilization laws were passed in 1933, they were primarily aimed at "defective" Germans, not Jews: "The 1933 Sterilization Law made no provision for sterilization on racial grounds. (Jews, for example, were never specifically targeted by the law)" (Proctor 1988, 112).

In 1935, however, the Nuremberg Laws were passed, specifically forbidding marriage between Jews and Germans. Jews who violated the laws were sent to concentration camps. Many Jews were fired from high status jobs at universities. By 1938 Jews were banned from all occupations. The mass killing of Jews did not begin until late 1941, well after the eugenics programs had sterilized and killed tens of thousands of Germans. It is important to distinguish the mass killing of Jews from the broader German eugenics programs, in part because the rationale seems to have been different and the informal orders authorizing the mass killing of Jews were separate from the official decrees that authorized the Racial Hygiene program meant to improve the genetic stock of the Aryan race (Friedlander 1995).

"The Final Solution," which authorized the mass killing of Jews, was a response to "the Jewish Question," which originated several centuries earlier in Europe. The question in its original form was whether European Jews should be given the same rights and privileges as Christians, given that Christianity was the official religion of nearly all European countries. Answers to the Jewish Question were often infused with assumptions that Jews were untrustworthy because they rejected Jesus as the Messiah.

Hitler posed the Jewish Question in purely racial terms. He portrayed Jews as ruthless capitalists and as parasitic communists. He blamed them for Russian Bolshevism and for controlling world affairs through international finance. Finally, Hitler even blamed the Jews for "provoking" a Second World War, despite the fact that Germany obviously started the war by invading Poland. Hitler had said in a speech earlier that year that "if the international Jewish financiers in and outside Europe should succeed in plunging nations once more into a world war, then the result will not be the bolshevization of the earth and the victory of Jewry, but the annihilation of the Jewish race in Europe!" (Hitler, 1941).[2] Whether Hitler *believed* that the Jews actually started either of the two World Wars is hard to know. It's possible he had deluded himself into believing this, perhaps to help him come to terms with the fact that he would be sending millions of German troops to their death in a war that could have been easily avoided. Either way, Hitler invoked the idea of a Jewish threat to

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[2] For an overview of Hitler's transcribed speeches blaming the two world wars on Jews, see The Jewish Virtual Library: https://www.jewishvirtuallibrary.org/hitler-s-threats-against-the-jews-1941-1945.

Europe as a pretext to launch the Final Solution, which would end with the killing of nearly six million Jews.

The best evidence suggests that the Final Solution was initiated through informal channels in late 1941 (Friedlander 1995). Despite meticulous documentation of most aspects of the war, Nazi officials were careful to conceal the authorization and details of the Final Solution presumably because they understood that ordinary people, even those who supported National Socialism, could not stomach the mass torture and extermination of people they had known as neighbors and co-workers just a few years earlier. Whatever the reasons, it is noteworthy that the Final Solution was not an extension of Nazi eugenic policies. The main connection between eugenic euthanasia and the Final Solution is the *method* used to kill large numbers of people. The mass murder of millions of Jewish prisoners was conducted primarily through the same methods as the *Aktion* T4 euthanasia program, named after the street address at which it was conceived.

The T4 program was first tested when, in 1939, Hitler authorized physicians to kill patients deemed unworthy of life. Henry Friedlander summarizes the connection between gassing Germans and Jews:

> The murder of the handicapped preceded the murder of Jews and Gypsies, and it is therefore reasonable to conclude that T4's killing operation served as a model for the final solution. The success of the euthanasia policy convinced the Nazi leadership that mass murder was technically feasible, that ordinary men and women were willing to kill large numbers of innocent human beings, and that the bureaucracy would cooperate in such an unprecedented enterprise (1995, 288).

The Final Solution began when the SS was authorized to shoot Jews captured in Russia. However, this was too public and inefficient, so SS officers began deporting Jews to concentration camps. By 1942, the SS had moved from shooting Jews in the open, to killing them in vans with carbon monoxide, and then to stationary gas chambers in more clandestine death camps like Treblinka and Auschwitz (Friedlander 1995). By the time Auschwitz was liberated in 1945, millions of Jews and hundreds of thousands of Sinti and other perceived enemies of the Nazis had been killed.

9.2.3 After the War: The United Nations' Statement on Race

Within months of the war's end, the United Nations (UN) had emerged. By the end of 1945 it had ratified a preliminary Constitution, and, by 1948, the UN Declaration of Human Rights was adopted. While the Declaration's ideals are part of a much longer tradition of liberal political thought that emphasizes individual liberty, responsibility, and equality under the law, its first ten provisions are clearly a reaction to Nazi policies. They include a repudiation of racism, as well as the most egregious forms of coercive eugenics. Article 16, for example, contends that "[m]en and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family" (Declaration 1948). By implication, this provision expressed opposition to forced sterilization and the unequal application of laws to different racial groups.

In 1946, Julian Huxley wrote an influential manifesto defending the UN's aim to create a Declaration of Rights, as well as a division tasked with promoting science and education. In defense of the Declaration, Huxley argued that all nations should enable every individual within every group to flourish, even if there are genetic inequalities between individuals and groups. He stressed that there should be "equality of educational opportunity without regard to race, sex or any distinctions, economic or social" (p. 4). And he emphasized that the preamble to the UN's 1945 Constitution "expressly repudiates racialism and any belief in superior or inferior races, nations, or ethnic groups" (p. 6).

After the Declaration was ratified, the UN assembled a group of scientists and public intellectuals to craft a statement on the science and morality of race. The statement was crafted by UNESCO (the United Nations Educational, Scientific and Cultural Organization), of which Huxley was the first Director. From the outset, UNESCO's statement on race was politically fraught, since the people selected for the task had strong political views and were drawn primarily from the humanities and social sciences rather than from the natural sciences. This is no surprise, since the stated purpose of the Declaration on Race was "to make known the scientific facts about race and *to combat racial prejudice*" (1969, 5, emphasis added).

The 1950 Statement on Race defined "race" as "a group or population characterized by some concentrations, relative as to frequency and distribution, of hereditary particles (genes) or physical characters" (1969, 30). While this conception of "race" was fairly standard, the authors also asserted that there were probably no socially significant racial differences, arguing that "the range of mental capacities in all ethnic groups is much the same" (1969, 34). After the Statement on Race was published, a handful of biologists, including Ernst Mayr, Ronald Fisher, and Julian Huxley, harshly criticized it. They objected not only to the politicization of science, but also to the implicit attempt to connect moral equality (which they all wished to affirm) with the scientific claim of biological equality (which many of them doubted).

Ernst Mayr affirmed that "equality of opportunity and equality in law do not depend on physical, intellectual, and genetic identity" (1952, 18).[3] Like Mayr, many of the biologists who were asked for feedback on the Statement on Race worried that the committee was under pressure to manipulate the science to fit a political agenda. For example, biologist Walter Lindauer concluded that "the UNESCO document was written on the assumption that from a certain body of scientific facts necessarily flowed certain ethical commandments" (1952, 19). The geneticist Kenneth Mather was concerned that the committee may be telling "noble lies"—*scientifically* inaccurate statements about race in order to promote the *moral* goal of toleration: "I felt that at times it was bending over backwards to deny the existence of race in the sense that this term has been used for political purposes in the recent past. I, of course, entirely agree in condemning Nazi race theory, but I do not think that the

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[3] More than five decades later, Mayr reaffirmed this view in "The Biology of Race and the Concept of Equality" (2002).

case against it is strengthened by playing down the possibility of statistical differences in, for example, the mental capacities of different human groups" (1952, 25). Agreeing with other dissenting scientists, the biologist Sir Ronald Fisher concluded that "the practical international problem is that of learning to share the resources of this planet amicably with persons of materially different nature, [but] this problem is being obscured by entirely well-intentioned efforts to minimize the real differences that exist" (1952, 27).

9.2.4 After the War: Race in Contemporary Bioethics

While we do not have good survey evidence on what bioethicists believe, some of the most influential bioethicists today explicitly argue against the tendency to tie moral equality together with genetic equality (Singer 2011; Buchanan 2009). Outside of bioethics, however, many people seem to implicitly connect moral status with genetic abilities. For example, people who have stronger egalitarian political concerns are more likely to dismiss scientific findings that purport to reveal group differences (Anomaly and Winegard 2020b). As *New York Times* science writer Nicholas Wade put the point, "[m]any people, including social scientists and much of the academic left, have long made what seems to me an unsupportable choice, that of basing their opposition to racism not on principle but on the claim that race is a social construct, not a biological reality" (2014, viii).

The persistence of the post-war attitudes about race can be illustrated by the furious condemnations by many journalists and academics of Richard Herrnstein and Charles Murray's *The Bell Curve* (1994). The book's main focus was on the relationship between measured intelligence (IQ) and social outcomes, but they included a chapter on average *group* differences in intelligence. Although they said they were agnostic about the causes of racial differences in intelligence, the book provoked a furious reaction by many journalists and academics who saw the book as a means to support racist inequalities. More recently, as Nathan Cofnas has documented (2016, 2020), many professional philosophers, including some who work in bioethics, have called for research on race and intelligence to be banned or otherwise shunned. This is yet another illustration of how political considerations altered the conception of race in philosophy (Sesardic 2010) and informed taboos around investigating racial differences (Pinker 2002).

It is likely that biological conceptions of race fell out of favor after the war in part because of their invidious use by Germany and Japan to justify their conquest of other nations. Anthropologists after the war began to increasingly describe race as a "social construct," rather than a natural fact or natural kinds. Philosophers, too, began embracing this view of race, and it is only recently, with the advent of cluster analysis in genetics, that "race realism"—the view that some of our common concepts of race map onto biological reality—has made a comeback. One would be hard-pressed, though, to find an academic race realist who thinks some races are *better than* others, or that average group differences *justify* treating members of other groups better or worse than one's own group simply by virtue of their membership in that group.

Roughly speaking, there are three views of race in contemporary philosophy: *race realism*, which holds that race is a biologically and metaphysically real category in the world (Hardimon 2017); *social constructionism* (or "anti-realism"), which holds that race is a social category separate from any biological categorization of human populations (Haslanger 2012); and *pragmatism*, which holds that there are differences between human genetic populations that may correspond with our ordinary concept of race, but whether we should divide the world up in this way depends on the practical value of doing so (Kitcher 2007). As with any philosophical dispute, there are more than three ways of thinking about race, and each position includes plenty of subtleties. But these three views provide a simple way of thinking about the different conceptions of race held by philosophers in general, and bioethicists in particular.

Nearly all philosophers who think about race concede that there are more or less useful ways of grouping people together. And nearly all of them agree that race is—like other categories—socially constructed. How we divide up the world is a function of how we wish to navigate the world. We may wish to do so in some contexts to investigate how and when groups of humans diverged from one another and populated the world (Reich 2018). In another context, we may wish to divide groups into categories based on susceptibility to disease, which may more neatly map onto sub-groups within a larger group (e.g., Ashkenazi Jews are more susceptible to Tay Sachs than Sephardic Jews; sub-Saharan Africans are much more likely to develop sickle cell anemia than North Africans).

The biologist Theo Dobzhansky anticipated this view in his response to UNESCO's 1950 Statement on Race:

> Populations which are geographically remote show greater genetic differences, on the average, than do populations which reside close together. It is, then, an arbitrary matter whether we divide mankind, for purposes of classification, into few or into many races. The number of races recognized by giving them names is a matter of convenience. Some anthropologists find it useful to distinguish only few major races, while others prefer finer subdivisions.
>
> But while the number of races which we recognize is, thus, arbitrary, the existence of racial differences is an objectively ascertainable fact. Mankind is not a single breeding population, but a very complex system of breeding communities. These communities are maintained by geographic, cultural and economic barriers. And these communities are racially distinct when they differ in the frequencies of various hereditary traits. We set up races and give them names for the purpose of describing human diversity; racial differences between human populations are a biological reality. (1952, 80-81).

As Dobzhansky argues, to ask whether something is socially constructed or metaphysically real is often a false dichotomy. We distinguish between tables and chairs, for example, because doing so helps us decide whether we should sit on an object, or put our food and drinks on it. The distinction between a table and a chair can be blurry, and categories don't have strict implications for what we should do. For example, we can use tables to sit on and chairs to eat on if we feel like it. Likewise, race realists can concede to social constructionists that it is up to us how to divide the world into groups, and concede to pragmatists that some divisions are more useful than others for social or scientific purposes. But race realists, in contrast to pragmatists and social constructionists, think some divisions are more scientifically fruitful than others.

In a recent editorial in the journal *Science*, a number of scholars argued that since "race" is vague, and potentially invidious, it should be eliminated from biomedical discourse. According to Michael Yudell et al., "Phasing out racial terminology in biological sciences would send an important message to scientists and the public alike: Historical racial categories that are treated as natural and infused with notions of superiority and inferiority have no place in biology" (2016, 565). The authors seem to think that people find it hard to disentangle racial categories from moral judgments, so we should throw out racial categories.

In a rejoinder to Yudell and his colleagues, a prominent philosopher of race has argued that the way people talk about race corresponds quite closely with the underlying genetic structure of human populations (Spencer 2019). According to Quayshawn Spencer, "In a landmark study by Noah Rosenberg et al. (2002), which was cross-checked by Rosenberg et al. (2005), five levels of genetic structure were detected," and these clusters closely match the categories the US government uses to divide populations up (2019, 18). Spencer agrees that "race" is, in part, a sociolinguistic convention, and thus our language may change as our concepts do. It may be that conceptions of race in bioethics will diverge from those in biology or that English conventions will move away from "race" altogether, in favor of "population" or "ethnicity." Only time will tell. However, it is clear that the divisive ways racial categories were used to justify the Nuremberg Laws and the Holocaust have led some scholars to reject the concept of race and the possibility of group differences (Yudell et al. 2016), while other scholars still consider race to be a meaningful concept, and argue that group differences are a likely result of Darwinian evolution (Winegard et al. 2020).

9.3 What Was Eugenics, and What is It Now?

9.3.1 Before the War: American and British Eugenics

The idea of eugenics was born in England around the same time naturalists were beginning to piece together how evolutionary forces shape different populations. Long before genetics emerged as a distinctive science, it became obvious that traits are somehow transmitted from parents to children. In formulating his theory of evolution by natural selection, Charles Darwin drew on the knowledge farmers had gained through the intentional breeding of animals, and discussed how different environmental niches could unintentionally do the same thing (1859). Darwin's cousin, Francis Galton, figured that if we could understand the mechanisms of heredity, we could use that knowledge to direct evolution down a path of our own choosing.

Long before Galton, Plato and Aristotle argued that a successful political society will have a strong set of norms and laws aimed at promoting good breeding, since the qualities of the citizens who comprise a polity will determine its success or failure (Ojakangas 2016).

Francis Galton coined term "eugenics," and defined it as "the science which deals with all influences that improve the inborn qualities of a race; also with those that develop them to the utmost advantage" (1904). Galton's definition captures two aspects of eugenics: it is both the *scientific study* of how traits are transmitted (which later became the field of genetics), and a *moral commitment* to harnessing our knowledge of genetics to improve the traits of our children. Galton and most classical eugenicists focused on populations, while many modern bioethicists who advocate for *liberal* eugenics focus more on the choices parents make to shape the traits of their kids. This ambiguity between whether the focus of eugenics should be on specific parental choices to have children with traits deemed beneficial for the child, or whether we should be concerned with the average traits in a population, persists in how the word is used in bioethics. For example, in a recent book called *The Ethics of the New Eugenics*, the term eugenics is defined as involving "strategies or decisions aimed at affecting, in a manner which is considered to be positive, the genetic heritage of a child, a community, or humanity in general" (MacKellar and Bechtel 2016, 3). This definition encompasses the individual and collective aspects of eugenics.

While Francis Galton and Charles Darwin were concerned that civilization might have begun to have a dysgenic[4] effect on the population of England, neither advocated extensive coercion to solve the problem. Galton, in particular, was mainly concerned with documenting demographic trends and with publicizing findings from (what we now call) behavior genetics so that parents would make informed choices about whether and with whom they would have children. For example, Galton provided evidence that in modern industrialized societies, more educated couples tend to have fewer children than less educated couples, and they tend to delay reproduction so that they can pursue other ambitions. The cumulative effect of this, Galton thought, is that civilization tends to encourage dysgenic reproductive trends. Galton appeared to be vindicated by independent scholarship which, by the turn of the nineteenth century, "demonstrated an inverse correlation between fertility and socioeconomic status, with the birthrate apparently falling much more sharply among the middle and upper-middle classes than among workers and agricultural laborers" (Paul and Moore 2010, 12).

Like Galton, Darwin worried about successful and ambitious people having fewer children, but also speculated about the potentially dysgenic effects of social welfare programs:

> With savages, the weak in body or mind are soon eliminated; and those that survive commonly exhibit a vigorous state of health. We civilized men, on the other hand, do our utmost to check the process of elimination; we build asylums for the imbecile, the maimed, and the sick; we institute poor-laws; and our medical men exert their utmost skill to save the life

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[4] *Dysgenic* is the opposite of *eugenic*: the idea is that socially valued traits like intelligence, kindness, or conscientiousness might be in decline rather than increasing in the general population.

> of every one to the last moment… Thus the weak members of civilized societies propagate their kind. No one who has attended to the breeding of domestic animals will doubt that this must be highly injurious to the race of man. It is surprising how soon a want of care, or care wrongly directed, leads to the degeneration of a domestic race; but excepting in the case of man himself, hardly anyone is so ignorant as to allow his worst animals to breed (1871, 168).

Darwin did not altogether oppose social welfare programs. He did, however, worry about their long-term genetic consequences. He also counseled that "both sexes ought to refrain from marriage [procreation] if they are in any marked degree inferior in body or mind," but he cautioned that "such hopes are utopian and will never be even partially realized until the laws of inheritance are thoroughly known" (1871, 403). Darwin worried that, "as Mr. Galton has remarked, if the prudent avoid marriage, whilst the reckless marry, the inferior members will tend to supplant the better members of society" (1871, 403).

While eugenics originated in England, it flourished in the United States. Unlike the British eugenics movement, which never produced much in the way of legislation, the American eugenics movement led just over half of American states to pass forced sterilization laws for those deemed especially "unfit" for reproduction. The British biologist and first Professor of Eugenics in England, Karl Pearson, had a race-based view of eugenics, and one that favored Northern Europeans. Pearson anticipated Hitler's view that life is a struggle between different groups, or races, for living space and raw materials (Paul and Moore 2010). Nevertheless, Hitler seems to have been more directly influenced by the British author Houston Chamberlain, whose unscientific writings about race reflected the influence of authors like Gobineau rather than Karl Pearson, who located himself more in the Darwinian tradition (Richards 2013).

9.3.2 During the War: German Eugenics

The Racial Hygiene Society of Germany began in 1905 and concerned itself with purifying the race of unwanted traits (Weindling 2010). To this end, it pursued environmental efforts to reduce the intake of alcohol and tobacco, and its members considered ways to reverse some of the same demographic trends that were occurring in England: successful people in Germany were moving to cities, marrying later, and having fewer children than those with less ability, ambition, and education.

Although antisemitism been on the rise since the late nineteenth century in Germany, Jews played an active role in the Racial Hygiene Society (which was not overtly antisemitic), until they were purged from the society when the National Socialists came to power (Weindling 2010). The first eugenic sterilization law was passed in 1933. By the time the war was over, at least 375,000 Germans were sterilized due to eugenic considerations (Weindling 2010).

Like the eugenic sterilization laws, the eugenic euthanasia program was primarily directed at Germans, not Jews. Unlike the sterilization laws, the euthanasia program was never formally legislated. The euthanasia program began after Hitler signed an internal memorandum authorizing physicians to kill patients with birth defects, or with serious mental or physical problems that made them a public charge. The number of Germans killed in the euthanasia program has been estimated at almost 300,000 (Proctor 1988).

The Final Solution was initiated by a separate order, beginning at the end of 1941. Although it might be construed as a eugenics program in the broad sense that it aimed to purge Europe of a group Hitler considered parasitic, the rationale for the Final Solution was not that the Jews were disabled or intellectually inferior to Germans. It was instead that they were a threat to all Europeans, in part because of their presence in positions of power, including academic jobs, journalism, banking, and the arts.[5] Because Jews were widely considered to have exceptional intellectual ability, an editorial in *The Eugenics Review*, published in Britain, opposed his treatment of the Jews, arguing "Herr Hitler has still not realised… that in declaring that the small number of Jews in Germany have achieved an altogether disproportionate measure of success…he has publicly acknowledged their superiority" (Bland and Hall 2010, 218).

Hitler saw Jews as a rival group competing with Germans for scarce resources and cultural influence. Whatever the psychological explanation is for Hitler's obsession with Jews, The Final Solution succeeded in killing most European Jews, and Hitler's war claimed tens of millions of European lives around the world. When the totality of torture and death was uncovered at the Nuremberg Trials after the war, there were two major consequences that remain with us today. First, Western nations crafted treaties that attempted to prevent future genocides by requiring European countries to accept refugees fleeing political persecution. Second, academics in Europe and the United States distanced themselves from anything that seemed connected to Nazi medicine, including what seemed to be scientific justifications for "racism" or "eugenics." Even the mention of race, or of genetic influences on human behavior, fell out of favor in universities.

9.3.3 After the War: UNESCO and Eugenics

UNESCO (the branch of the UN tasked with promoting scientific education) was formed soon after the founding of the United Nations, and by 1948 the UN General Assembly ratified the Declaration of Human Rights. As discussed above, article 16 of the Declaration rejected state-sponsored, coercive eugenics by guaranteeing that "[m]en and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family" (UNDHR 1948). Nevertheless, UNESCO's first Director, Julian Huxley, defended eugenics throughout his life (despite his brother's objections, expressed in *Brave New World*). Huxley opposed most coercive forms of eugenics, while embracing voluntary eugenics, and opposed

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[5] The arts were especially targeted by Hitler in part because new forms of art and entertainment, including sexually explicit artwork and film, were thought to be subversive to traditional society.

racism and prejudice, while maintaining that race differences almost certainly exist. Many other influential biologists of the age agreed with Huxley on this, including JBS Haldane, Theodosius Dobzhansky, and Hermann Mueller (Crew et al. 1939).

In his 1946 manifesto explaining the aim of UNESCO, Julian Huxley argued that we need to acknowledge genetic differences in order to have fair institutions with policies that work for the good of all. According to Huxley, "Biological inequality is, of course, the bedrock fact on which all of eugenics is predicated… [The] primary aim of eugenics should be the raising of the mean level of all desirable qualities. While there may be dispute over certain qualities, there can be none over a number of the most important, such as a healthy constitution, a high innate general intelligence, or a special aptitude such as that for mathematics or music" (1946, 21).

Moreover, Huxley maintained that UNESCO should promote non-coercive eugenics:

> At the moment, it is probable that the indirect effect of civilization is dysgenic instead of eugenic; and in any case it seems likely that the dead weight of genetic stupidity, physical weakness, mental instability, and disease-proneness, which already exist in the human species, will prove too great a burden for real progress to be achieved. Thus even though it is quite true that any radical eugenic policy will be for many years politically and psychologically impossible, it will be important for UNESCO to see that the eugenic problem is examined with the greatest care, and that the public mind is informed of the issues at stake so that much that now is unthinkable may at least become thinkable (Huxley 1946, 21).

Huxley was not alone. Although many intellectuals distanced themselves from eugenics after the war, it never entirely went away. Eugenic sterilizations continued to occur in various countries around the world, including Sweden and the United States, until the late twentieth century (Kevles 1985). Moreover, the Supreme Court decision that authorized coercive eugenics in the United States in 1927, *Buck v Bell*, has never been overturned. Although eugenic sterilizations are only rarely performed in the early twenty-first century, many states do have laws that permit physicians to sterilize patients with serious mental disabilities who are at risk of becoming pregnant.

Eugenics has not (yet) become a social movement in the way it did in the early twentieth century, but many prominent intellectuals continued to support some version of eugenics after World War II, despite its general decline. In 1963 the CIBA Foundation sponsored a symposium called "Man and His Future," which was attended by some of the most well renowned scholars of the twentieth century, including Julian Huxley, and Nobel laureates like Hermann Muller, Francis Crick, and James Watson. Some of the ideas entertained included parental licensing, paying especially successful people to reproduce, and subsidizing the provision of genetic information so that parents could make informed reproductive choices (Crick 1963; Muller 1963).

9.3.4 After the War: Eugenics in Modern Bioethics

What people publicly say and privately believe are often very different. In the United States, survey evidence suggests that support for eugenic policies increases when people believe a condition is heavily influenced by genes (Zigerell 2020). Many ordinary people don't seem to understand just how powerfully our traits are sculpted by genetics, perhaps because experts in behavior genetics are routinely denounced when their findings contradict egalitarian and environmentalist orthodoxies (Pinker 2002; Plomin 2018). These taboos are plausibly explained by the legacy of the Second World War.

Bioethicists often *reflect* popular consensus as much as they *shape* it. And their views on eugenics fit this pattern. It is safe to say that most bioethicists reject eugenic sterilizations. However, many support the use of government power to redistribute resources in a way that empowers women to use techniques like in vitro fertilization and embryo selection (Daar 2017). These techniques enable parents to screen embryos for diseases such as Tay Sachs and will soon allow them to select for more complex traits (Greely 2018; Anomaly 2020). Many also support laws forbidding incest, and some even support the use of "wrongful life" laws to prevent parents from knowingly imposing genetic burdens on their children (Archard 2004). These examples show that "coercive eugenics" comes in different forms and enjoys different degrees of support.

Many bioethicists, including members of the US Presidential Bioethics Commission, have argued that reproductive rights are limited by the interests of future people, especially when children impose foreseeable harms on others (Buchanan et al. 2000; Brock 2005; Benatar 2010). Some suggest in addition that parents have a moral obligation to produce children with the best chance of the best life (Savulescu and Kahane 2009), or to produce children who are most likely to improve the welfare of other people (Douglas and Devolder 2013). These moral obligations are difficult to discharge without expert advice, and widespread access to enhancement technologies (Gyngell and Selgelid 2016, as well as social norms that encourage eugenic choices (Anomaly and Jones 2020a).

Contemporary bioethicists disagree about whether we should use the word "eugenics" to describe debates about the obligations parents and political institutions have in shaping the genetic endowment of future people (Cavaliere 2018). Some authors in bioethics prefer using the euphemism "genetic enhancement" rather than "eugenics" in order to avoid associations with Nazi eugenics (Wilkinson 2008; Camporesi 2014). Others prefer using "eugenics" to describe any actions we take to shape the traits of our children, focusing less on the word and more on the ethical issues surrounding particular kinds of interventions (Agar 2019; Anomaly 2018; MacKellar and Bechtel 2016; Selgelid 2014).

Another debate in bioethics concerns whether the word "eugenics" should be used solely to designate actions or laws that *intentionally* shape the traits of children, or also include actions or laws that *predictably affect* the genetic composition of future people (Veit et al. 2021). The historian of eugenics Daniel Kevles argues that if policies that subsidize genetic counseling and contraception affect the gene pool, they are *eugenic* (or *dysgenic*) policies, even if this is not their intent (1985, 258). The philosopher Philip Kitcher agrees: “Once we have left the garden of genetic innocence, some form of eugenics is inescapable” (p. 174). This is because, Kitcher thinks, the choice to use *or not use* genetic screening, contraception, or abortion predictably influences what kinds of people are born, and what kinds of traits they will have. As Kitcher understands the term (consistent with Galton’s usage), eugenics is “a mixture of the study of heredity and some doctrines about the value of human lives” (1997, 191). He suggests that even if a parent or policy is not attempting to alter the human gene pool, insofar as policies that affect the genetic endowments of future people are shaped by values and beliefs about genetics, they constitute a form of eugenics.

Nobody has the power to unilaterally change the meanings of words, or the concepts words represent. Of course, scholars, journalists, and influential celebrities probably influence how words are used more than ordinary people do. But because language shapes how we frame political debates, we should be careful not to castigate people with whom we disagree by simply labeling their views as “racist” and “eugenicist.” Terms that have emotional associations with Nazi Germany are likely to lose their force if they continue to be used in imprecise ways by influential people in order to achieve political goals.

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Chapter 10
Physician-Assisted Suicide, Euthanasia, and Bioethics in Nazi and Contemporary Cinema

Sheldon Rubenfeld and Daniel P. Sulmasy

Abstract Today, physician-assisted suicide and/or euthanasia are legal in several European countries, Canada, several jurisdictions in the United States and Australia, and may soon become legal in many more jurisdictions. While traditional Hippocratic and religious medical ethics have long opposed these practices, contemporary culture and politics have slowly weakened opposition to physician-assisted suicide and euthanasia. Our chapter examines how assisted suicide and euthanasia have been presented in cinema, one of the most powerful influences on culture, by Nazi propagandists during the German Third Reich and by Western filmmakers since the end of World War II.

Almost all contemporary films about assisted suicide and euthanasia, including six winners of Academy Awards, promote these practices as did *Ich klage an* (*I Accuse*) (1941), the best and archetypal Nazi feature film about euthanasia. The bioethical justifications of assisted suicide or euthanasia in both *Ich klage an* and contemporary films are strikingly similar: showing mercy; avoiding fear and/or disgust; equating loss of capability with loss of a reason to live; enabling self-determination and the right-to-die; conflating voluntary with involuntary and nonvoluntary euthanasia; and casting opposition as out-of-date traditionalism. Economics and eugenics, two powerful arguments for euthanasia during the Third Reich, are not highlighted in *Ich klage an* and are only obliquely mentioned in contemporary cinema. One dramatic difference in the cinema of the two periods is the prominence of medical professionals in *Ich klage an* and their conspicuous absence in contemporary films about assisted suicide and euthanasia. A discussion of the medical ethos of the two time periods reveals how cinema both reflects and influences the growing acceptance of assisted suicide and euthanasia.

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10.1 Introduction

Anthony Trollope's satirical, tragicomic novel, *The Fixed Period*, depicted a country with legislation forcing retirement at age 60 followed by a year of contemplation before a peaceful departure via chloroform (Trollope 1882). In 1905, American filmmakers screened *Oslerizing Papa*, a satirical film based upon William Osler's facetious comments about the solution to the infirmities of old age proposed by Trollope (Pernick 1996, 139; Millard 2011). It was the first film about euthanasia, but it would not be the last.

Serious American silent films about euthanasia followed, such as *Doctor Neighbor* (1915) and *Has Man the Right to Kill?* (1915) before the release of *The Black* Stork (1915), a controversial film that played in theaters until 1942 about mercifully withholding life-saving medical care for infants born with congenital anomalies (Pernick 1996, 140). In 1936, recognizing the persuasive power of film, the Nazi government began making propagandistic documentaries, such as *Dasein ohne Leben* (*Existence without Life*) (1941), to "educate" health care workers about eugenics, sterilization, and eventually euthanasia. As public opposition to the secret euthanasia programs grew, German filmmakers turned their attention away from propagandistic documentaries toward commercial, feature films promoting euthanasia (Burleigh 1994, 202) such as *Ich klage an* (*I Accuse*) (1941), a melodrama whose justifications for euthanasia anticipated many contemporary films portraying the intentional ending of a patient's life by a third party.

In this chapter, we will present the history of euthanasia during the Third Reich, describe contemporary physician-assisted suicide (PAS) and euthanasia legislation in the Western world, and explore the many similarities and few differences between the justifications in favor of euthanasia in Nazi and contemporary movies.[1]

10.1.1 Terminology

To place our discussion of cinematic depictions of euthanasia in the proper context, we must discuss euthanasia during the Third Reich and at the present moment. To discuss this history clearly, a word about terminology for end-of-life decision-making

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[1] An external reviewer for this chapter stated, "There is a huge gap between criticizing euthanasia of patients who conscientiously want to die and Nazi (and dystopian) programs of eliminating the sick and 'unfit' as a policy with no regard to personal values and wishes. Contemporary defence of baby's euthanasia [sic] rests on the presumption that the baby would have chosen not live a life of misery had he or she could choose [sic]. It is about compassion and not about burden. As the authors note, the Nazi's hid their euthanastic [sic] activity whereas contemporary activists promote transparency, legitimization and public awareness of their ideas and practices." The reviewer's comments illustrate rather than refute our arguments. The very point of our chapter is that by producing popular films depicting voluntary euthanasia in a glamorous way, the Nazis aimed to pave the way for public acceptance of non-voluntary euthanasia of disabled adults and children under the guise of mercy and compassion and that this idea expanded in scope thereafter.

is in order. While others have advocated a variety of alternative words and phrases, we adopt the terms that most simply and clearly describe the actions. *Suicide* refers to persons taking their own lives—undertaking actions with specific intention of making themselves dead. *Assisted suicide* denotes assistance in the act of suicide by another person or persons. When that other person is a physician, we adopt the simplest and most descriptive terminology, *physician-assisted suicide* (PAS). Others may use more equivocal terms such as *death with dignity*, *physician-assisted death*, *physician aid in dying*, and *physician-assisted dying*, all of which are compatible with a wide variety of actions that are not necessarily assistance in suicide and are, therefore, equivocal.

We use the term *euthanasia* to refer to intentionally ending the life of a person suffering from a medical illness, whether by a physician, other medical personnel, or anyone else. Some prefer terms such as *medical assistance in dying* to refer both to physician-assisted suicide and to euthanasia, but that term is, like the others discussed above, far too ambiguous, not only conflating the meaning of different death-hastening actions but also invoking other forms of care at the end of life such as the palliation of symptoms. The term *euthanasia* may be usefully subdivided into three categories. The first is *voluntary euthanasia*, which refers to the intentional termination of the life of a patient with decision-making capacity at the patient's request. *Nonvoluntary euthanasia* refers to the intentional termination of the life of a patient who lacks decision-making capacity, such as a child or a mentally incompetent adult, with either parental, guardian, or family concurrence or the presumptive consent of the patient. *Involuntary euthanasia* refers to the intentional termination of the life of a patient who objects, or whose loved ones object.

Withholding life-saving measures (sometimes confusingly dubbed "passive euthanasia") should not be confused with either PAS or euthanasia as we have defined these terms—in ethically appropriate cases of foregoing life-saving measures the intention is to end the treatment, not the life of the patient, even if death can be anticipated (Sulmasy 1998, 55–64).

10.1.2 Euthanasia During the Third Reich

In 1920, lawyer Karl Binding and psychiatrist Alfred Hoche wrote a short influential book *The Permission to Annihilate Life Unworthy of Living*. They argued that some lives were not worth living and promoted beneficent voluntary and nonvoluntary euthanasia for selected patients with incurable physical and/or mental disorders. Among their arguments in favor of euthanasia, two stand out. First, they argued that a higher morality should replace Western religions' moral imperative to preserve life:

> There was a time, now considered barbaric, in which eliminating those who were born unfit for life, or who later became so, was taken for granted. Then came the phase, continuing into the present, in which, finally, preserving every existence, no matter how worthless, stood as the highest moral value. A new age will arrive—operating with a higher morality and with

> great sacrifice—which will actually give up the requirements of an exaggerated humanism and overvaluation of mere existence. (Binding and Hoche 1920)

Binding and Hoche also dismissed longstanding Hippocratic ethical objections to euthanasia: “The young physician enters practice without any legal delineation of his rights and duties-especially regarding the most important points. Not even the Hippocratic Oath, with its generalities, is operative today” (1920).

While imprisoned in 1924 for his failed Munich putsch, Hitler read *Menschliche Erblichkeitslehre und Rassenhygiene (Human Heredity and Racial Hygiene)* by Erwin Baur, Eugen Fischer, and Fritz Lenz (1921), the holder of the first chair in eugenics in Germany. The ideas in this book may well have provided Hitler with the basic substrate for the strange concoction of eugenics, anti-Semitism, politics, and violence that led Lifton (1986, 27) to describe National Socialism as a “biocracy.” Hitler relied heavily on physicians to annihilate “life unworthy of life.” He told attendees at a 1929 Nazi Physicians’ League meeting that, if necessary, he could do without builders, engineers, and lawyers but that “you, you National Socialist doctors, I cannot do without you for a single day, not a single hour. If not for you, if you fail me, then all is lost. For what good are our struggles, if the health of our people is in danger?” (Proctor 1988, 64). In the same year, at the Nuremberg Party rally, Hitler praised Sparta’s policy of selective infanticide as a model policy (Welch 1983, 121).

Because physicians were pioneers, not pawns, in eugenics and euthanasia, they responded positively to Hitler’s flattery, incentives for academic and economic advancement, and opportunities to exercise power and gain prestige in his program of “Applied Biology” (Proctor 1988, 7). They willingly and enthusiastically chose to eliminate Jews from medicine, involuntarily sterilize nearly 400,000 German citizens to prevent transmission of their allegedly inferior genes, prohibit marriage and sexual relations between Aryans and non-Aryans, and, ultimately, murder nearly 200,000 people whose lives were considered not worth living.

The Nazi euthanasia programs began with an autonomous request directly from a family to Adolf Hitler to euthanize their child, Gerhard Herbert Kretschmar, who was blind, epileptic, physically disabled, and diagnosed as an “idiot”—it was approved (Schmidt 2002, 241–242). The Reich Committee for the Scientific Registration of Serious Hereditary and Constitutional Illnesses was created to secretly oversee the Children’s Euthanasia Program that claimed the lives of 5,000–7,000 children between 1939 and 1945 in 30 special children’s wards, most often by a nurse administering an overdose of tranquilizers (Hohendorf 2020a, 63–65).

The adult euthanasia program began in 1939 with the required registration of almost all patients in nursing homes and neuropsychiatric hospitals. The registration forms were sent to the recently formed Charitable Foundation for Institutional Care located at Hitler’s Chancellery whose address was *Tiergartenstrasse* 4, hence the name *Aktion* T4 for the adult euthanasia program. Three psychiatric experts reviewed the forms without examining the patients, and, together with the medical director of *Aktion* T4, initially psychiatrist Werner Hyde and, later, psychiatrist Paul Nitsche, selected which institutionalized patients were to be killed, primarily those deemed unable to do productive work and all Jews (Hohendorf 2020a, 65).

Patients selected for euthanasia were transported by the Charitable Society for the Transportation of the Sick from one transit institutions to another to obfuscate the program's true purpose and to obscure the patients' location from their families. Finally, the patients arrived at one of six killing centers in Germany and Austria where they were killed by physicians in gas chambers designed by physicians, chemists, and engineers according to Viktor Brack's motto, "the syringe belongs in the hand of the physician" (Lifton 1986, 71; Sulmasy 2020, 229). Physicians then fabricated a cause of death for the death certificate that was sent to the patients' families.

Significant public opposition to *Aktion* T4 arose after Clemens Count von Galen, the Bishop of Münster, addressed the issue of nonvoluntary euthanasia in an August 1941 sermon, which led to the end of the gassing but not the killing (Lifton 1986, 39). Some medical directors of institutions other than the six killing centers had already been starving their patients to death, and soon many more institutions were killing their patients by starvation, tranquilizers, neglect, exposure, and untreated infections in what was termed *wild euthanasia* (Hohendorf 2020a, 67). Nazi documents confirm 70,273 murders in the six killing centers, and the estimated number of murders during the period of decentralized euthanasia is between 90,000 and 130,000 (Friedlander 1995, 151–163).

The medical procedure for euthanizing large numbers of disabled persons in gas chambers became the preferred technique to implement "The Final Solution." The bridge from gas chambers for eugenic euthanasia to gas chambers for mass murder was Operation (or "Special Treatment") 14f13 (Lifton 1986, 135). Experienced *Aktion* T4 psychiatrists were enlisted to select "asocial" patients from concentration camps for "special treatment" in gas chambers at a euthanasia center, which "widened indefinitely the potential radius of medicalized killing" (Lifton 1986, 136). Thus, after considering several potential methods for the mass murder of Europe's Jews, the Nazis chose gas chambers because "the technical apparatus already existed for the destruction of the mentally ill" (Proctor 1988, 207). Physicians like Josef Mengele, the "Angel of Death" at Auschwitz, selected and gassed many of the 4,500,000 Jews considered undesirable or useless.

10.1.3 Euthanasia in the Contemporary Western World

The United States was the world's leader in eugenics prior to World War II, and Germany both learned from and surpassed the US in its zeal to catch up. For example, Germany patterned its 1933 Sterilization Law after Virginia's model sterilization law, which the US Supreme Court declared constitutional in 1927 (Proctor 1988, 101). Germany modeled its anti-miscegenation and anti-Semitic Nuremberg laws on US Jim Crow laws (Whitman 2017). German racial scientists admired America's restrictive eugenic immigration policies (Proctor 1988, 100).

Eugenics was also popular in Scandinavian, the Baltic states, and Switzerland (Roelcke 2020, 52). Eugenics and euthanasia, while not intrinsically linked, often go hand in hand (Roelcke 2020, 53). Article 115 of the Swiss Criminal Code of 1937 prohibits assisted suicide for selfish motives but permits it for altruistic reasons. This distinction was incorporated into a 1941 law permitting altruistic help to severely ill people seeking to end their lives, a law the Swiss Academy of Medical Sciences did not support. Exit and Dignitas, membership corporations that currently promote assistance with suicide, were founded in 1982 and 1998, respectively (Hurst and Mauron 2003).

According to Eduard Verhagen, the co-author of the 2005 Groningen Protocol for Newborn Euthanasia in Holland, "It is probably fair to say that during the past decades, the Dutch have been 'obsessed' by death and dying, with the majority of the population in favor of euthanasia since 1966 in public opinion polls." In the 1973 Postma decision, the Leeuwarden District Court convicted a doctor of "death on request" and sentenced her to one-week probation instead of a possible 12-year prison term. The physician had administered a lethal dose of morphine to her 78-year-old deaf and partially paralyzed mother who had repeatedly pled with her daughter to end her life (Sheldon 2007). In 1984, the Alkmaar case led the Supreme Court to introduce a potential legal justification for not prosecuting physicians who euthanize their patients. Thus, while euthanasia remained illegal in the Netherlands, courts did not prosecute doctors performing euthanasia or assisted suicide (Verhagen 2020, 91).

In 1990, the Remmellink committee investigated Dutch end-of-life practices and found hundreds of reported cases of euthanasia with very few prosecutions, many dismissals, and nearly 1,000 cases of "termination of life without an explicit request" (Lewis 2007). In 2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act legalized euthanasia in the Netherlands under certain conditions for legally competent adults (16 years of age or older) and children 12–15 years of age making a valid request. Belgium and Luxembourg (Atwill 2008) passed similar legislation in 2002 and 2008, respectively. In Australia, voluntary PAS and euthanasia were implemented in Victoria in 2019 and are expected to begin in Western Australia in 2021 (End of Life Law in Australia, n.d.).

In general, the increasing number of deaths of terminally ill patients by PAS and euthanasia in the Netherlands and Belgium and, in particular, the increasing number of deaths by PAS and euthanasia among psychiatric patients who are not expected to die within the foreseeable future has heightened concern about "eligibility creep" in vulnerable populations (Dierickx et al. 2017; Evenblij et al. 2019; Kim et al. 2016, 362–368; Verhofstadt et al. 2019, 150–161). In 2015, Lerner and Caplan expressed unease about a slippery slope in the Netherlands and Belgium after one study reported data from a Dutch End-of Life Clinic in which some patients that were categorized as "tired of living" obtained PAS and euthanasia and another reported an alarming increase beginning in 2013 in the rate of euthanasia of Belgian applicants experiencing "tiredness of life" (Lerner and Caplan 2015, 1640–1641).

Until recently, there has been resistance to the legalization of PAS and euthanasia in Germany. However, on February 26, 2020, the German Federal Constitutional Court repealed the prohibition of "business-like" assistance with suicide, the type of assistance provided in Switzerland by Exit and Dignitas. Simultaneously the court ruled that physicians are not legally obligated to provide assistance with suicide, which accords with the German Medical Association's rejection of both PAS and euthanasia. The future of PAS and euthanasia in Germany is uncertain. (Sahm 2020, 126–128).

Euthanasia is currently prohibited everywhere in the US. Two rulings by the Supreme Court of the United States, however, permitted individual states to enact PAS legislation while simultaneously denying a constitutional right to PAS (Vacco v. Quill, 521 U.S. 793, 1997; Washington v. Glucksberg, 521 U.S. 702, 1996). In 1997, Oregon became the first state to legalize PAS; it is now permitted in nine additional jurisdictions—Washington, Colorado, Hawaii, California, District of Columbia, Montana, Vermont, New Jersey, and Maine.

Not only is the number of states permitting PAS increasing, but there is also evidence of eligibility creep in the US. For example, in 2019, Oregon's legislature considered including "a degenerative condition that will, at some point in the future, be the cause of the patient's death" in the definition of a terminal disease in its Death with Dignity Act (Oregon Legislative Assembly 2019). If passed, this provision would greatly enlarge the number of patients eligible for PAS. Similarly, in Canada, in October 2020, three cabinet ministers reintroduced legislation to remove the requirement for a person's natural death to be reasonably foreseeable in order to be eligible for medical assistance in dying (MAID) (Government of Canada 2020). In the Fall of 2020, the US-based and well-funded "Completed Life Initiative" produced a twelve-hour webcast which was characterized, without opposition or objection, as promoting the idea that persons without a terminal disease "may autonomously judge that their lives are complete, therefore no longer worth living, and may justifiably choose to make themselves dead with the sanction of the state and the assistance of the medical profession" (Completed Life Initiative 2020). This objective appears very similar to that of the Dutch and Belgian end-of-life clinics, and it seems likely that the US will eventually follow their lead unless there is a groundswell of serious opposition.

10.1.4 Why Film?

We have chosen in this essay to highlight the ways in which film presents assisted suicide and euthanasia. Understanding history is important, understanding the impact of culture on medical practice may be more important still. The medical ethos—the distinguishing character, sentiment, moral nature, or guiding beliefs of patients, health care professionals, medical organizations, or medical institutions—is derived from three interacting factions: medicine, culture, and government (Roelcke 2016, 183). In Western democratic countries, we contend that the cinema is one of the most powerful influences on culture, and therefore, is very influential in determining the medical ethos.

When filmmakers portray difficult bioethical questions, they tend to present dramatic narratives that seemingly offer credible solutions to insoluble problems, thereby providing audiences a measure of relief from the anxiety such questions provoke. These films present either relatively simple and satisfying personal solutions to complex and frightening bioethical issues the audience might one day confront in real life, or palatable (if improbable) political solutions by casting the protagonists as heroic champions of causes fought out in courts, popular referenda, or legislation. By having an appealing central character hold a film's center of gravity, these melodramas also give viewers the impression that they, like the film's hero, have the power within their autonomous selves to assert control and solve the complex problem presented in the film (Gabbard and Gabbard 1999, 3–34).

The powerful images created in films often stay with us and create a myth about how life ought to be or how we would like it to be. Think of Ali McGraw as Jenny, dying of leukemia at the end of *Love Story* (1970). Unlike most patients treated unsuccessfully for leukemia, Jenny remains articulate and beautiful right up to her tragic end. Improbable portrayals of illnesses can create problems for patients confronting a similar ailment. For example, films such as *Ordinary People* (1980) and *Good Will Hunting* (1997) can generate unrealistic expectations that affect patients' attitudes toward their care (Gabbard and Gabbard 1999, 176–182). Of particular concern is the power of culture and of mass communications such as film to stimulate and increase the behaviors they portray, such as suicide. This well-documented phenomenon is known as the copycat or contagion effect (Coleman 2004, 217–235; Marzuk, Tardiff, and Leon 1994, 1813–1814; Marzuk et al. 1993, 1508–1510) or the Werther effect (Coleman 2004, 1–5; Kogler and Noyon 2018; Phillips 1974, 340–354).

The subject of euthanasia has been treated in many contemporary films—at least 21 between 1971 and 2006—and Hollywood has responded favorably to cinematic versions of end-of-life decision-making, almost all of them promoting euthanasia (Gabbard 2010, 153–162). Three films, *One Flew Over the Cuckoo's Nest* (1975), *The English* Patient (1996), and *Million Dollar Baby* (2004), received Academy Awards for Best Picture and three more, *The Barbarian Invasions* (2003), *Mar adentro* (*The Sea Inside*) (2004), and *Amour* (2012) won Oscars for Best Foreign Film.

10.2 Medical Films Under National Socialism

Hitler loved films and understood their persuasive power. In his 1925 autobiographical manifesto *Mein Kampf*, he wrote:

> At most a leaflet or a poster can, by its brevity, count on getting a moment's attention from someone who thinks differently. The picture in all its forms up to the film has greater possibilities. Here a man needs to use his brains even less: it suffices to look or at most to read extremely brief texts, and thus many will more readily accept a *pictorial presentation* than *read an article* of any *length*. The picture brings them in a much briefer time, I might almost say at one stroke, the enlightenment which they obtain from written matter only after arduous reading. (Hitler, 420; italics in the original)

The Nazi government coordinated and unified each and every aspect of German life into a single, hierarchical structure responsible to a vertical chain of command, a process known as *gleichschaltung*. For example, the Propaganda Ministry under the leadership of Joseph Goebbels was responsible for the Nazi propaganda campaign to secure the allegiance and collaboration of German citizens through any and all forms of mass communication (Kater 2019). Goebbels understood the power of cinema as a propagandistic tool as did leading bureaucrats such as Kurt Zierold who stated:

> Propaganda as a means of coordinating the purposeful ambitions of a people naturally has to be designed for the masses because it cannot do without the instrument of suggestion. Propaganda for a small number of people is a contradiction in terms. Film as a product of the most modern technique, with its unlimited possibilities of copying, is by nature aimed at the masses. (quoted in Schmidt 2002, 59)

To secure the power of the cinema for propaganda, Goebbels drafted the Reich Film Law (Schmidt 2002, 63), which centralized control over all educational and medical films (Schmidt 2002, 127). Consequently, almost all independent educational film production companies were out of business by 1935 (Schmidt 2002, 81).

Because many physicians had been advocating eugenics and euthanasia for nearly three decades before Hitler came to power in 1933, they readily accepted appointments to a scientific advisory committee to evaluate and edit existing medical films and to oversee the production of new medical films (Schmidt 2002, 96–101). In addition to military training films such as *Kampf dem Fleckfieber* (*Struggle Against Typhus*) (1941/1942), propagandists produced films to promote eugenics (racial hygiene, or *rassenhygiene*, in Germany) and Social Darwinism, such as *Erbkrank* (*Hereditarily Ill*) (1936) and *Alles Leben ist Kampf* (*All Life is a Struggle*) (1937), both silent films. In 1936, Hitler requested a more polished and professional sound film endorsing eugenics, *Opfer der Vergangenheit* (*Victim of the Past*), and ordered it shown in all German movie theaters (Burleigh 1994, 183–202).

Filmmakers encouraged physician compliance with the 1933 Sterilization Law that led to the involuntary sterilization of nearly 400,000 German citizens with training films like *Sterilisation beim Manne durch Vasektomie bzw. Vasoresektion* (*Sterilization in the Male by Vasectomy*) (1937) for surgeons (Schmidt 2002, 137–173) and propagandistic educational films like *Hereditary and Acquired Epilepsy* (1935) and *Wilson-Pseudosklerosis* (*Wilson's Pseudo-Sclerosis*) (1938) for neurologists, psychiatrists, and other medical personnel (Schmidt 2002, 196–208).

The approximately 200,000 victims of the Nazi children's and adult euthanasia programs gave opportunistic medical researchers and filmmakers a chance to correlate clinical and cinematographic observations with pathological specimens obtained from patients previously identified with neuropsychiatric illnesses of interest. For example, in 1937, psychiatrist Gerhard Kujath, under the supervision of Karl Bonhoeffer, made a silent black and white film, *A 41/2-Year-Old Patient with Microcephaly* (1937), in which they conducted torturous medical examinations and experiments on Valentina Z. When the Children's Euthanasia Program was established in 1939, Valentina Z was transferred to Berlin Wittenau, one of thirty pediatric centers for "special treatment" of children with disabilities—involuntary killing, usually by luminal.

After many more additional experiments, Valentina Z was most likely killed on October 28, 1941, and immediately transferred to the Rudolf Virchow Hospital where research specimens were collected during her autopsy, including brain specimens collected by Dr. Kujath (Schmidt 2002, 249–262).

The leaders of the Children's Euthanasia Program and *Aktion* T4, the adult euthanasia program, used these shocking documentaries to induct and indoctrinate medical subordinates into the system that killed between 5,000–7,000 disabled children and nearly 200,000 disabled adults. Then, in 1940, Dr. Paul Nitsche, the head of the adult euthanasia program, commissioned Hermann Schweninger to film institutionalized children and adults for sophisticated propagandistic documentaries about medicalized murder. These films would document the high cost of caring for neuropsychiatric patients in asylums, the extreme suffering of these patients and their families, the genetic measures such as sterilization and marriage counseling that could prevent the birth of the "incurable and life-unworthy," and finally, the euthanasia program's scrupulous selection process for "the course of action," the killing of the patients (Burleigh 1994, 195–197).

Schweninger and a producer from Tobis Films, a German film production and distribution company, visited 20 to 30 asylums and shot about 10,000 m of film that were eventually edited into several versions of the educational film *Dasein ohne Leben* (*Existence Without Life*) and the 1942 scientific documentary *Geisteskrank* (*Mentally Ill*) (Burleigh 1994, 197–202). Film clips from *Dasein ohne Leben* showing some of these mentally and physically disabled patients can be seen on the website of the United States Holocaust Memorial Museum (Special Collections 2001.359.1, n.d.) and in Michael Burleigh's documentary *Selling Murder: The Secret Propaganda Films of the Third Reich* (1991).

Despite the Nazi's best efforts to keep the details and the extent of their secret euthanasia programs from the public, opposition grew. Because he was unhappy about the public outcry, Heinrich Himmler, the main architect of the Holocaust, wrote to Victor Brack, the administrator of *Aktion* T4, to encourage public education about euthanasia through films (Reitlinger 1953, 132). Brack took the hint and persuaded Tobis Films to make commercial feature films both to give a compassionate and sound bioethical basis to their medicalized murder and to pave the way for potential legalization of "mercy killing." A justificatory document from the filmmakers stated:

> We were given the task of writing a script for a film about euthanasia, about the extinguishing of unworthy life. Because of the circumstances of the time, we became convinced that it was necessary to avoid everything which seemed like deliberate propaganda, but also everything which hostile opinion could construe as a threat emanating directly from the state. In our film we have let the dictates of the heart speak in the belief that this will pave the way for the dictates of the law. (Burleigh 1994, 202)

Schweninger produced three feature films. The epigraph for the first film, a fitful romance entitled *Drei Menschen* (*Three People*) (1941), was Nietzsche's dictum: "What causes more suffering in the world than the stupidity of the compassionate?" The second film, *The* Foreman (1941), which included a final courtroom scene with ethical and legal arguments in favor of euthanasia, was bad enough that Wolfgang

Liebeneiner, an up-and-coming director that Hitler's chancellery brought in to make a feature film about euthanasia, avoided making it (Burleigh 1994, 205).

Schweninger chose *Ich klage an* for his third film, an adaptation of a 1936 novel *Sendung und Gewissen* (*Vocation and Conscience*) written by ophthalmologist Helmut Unger, a participant in *Aktion* T4 who had already written 50 fiction and nonfiction works including one used by Tobis Films as the basis for its biopic on Robert Koch. When the book and Schweninger's original treatments proved unsatisfactory for the film project, Liebeneiner met with Victor Brack, Hans Hefelmen, and Dr. Paul Nitsche, leaders of *Aktion* T4. After discussions with a neurologist, Liebeneiner concluded that the film's female lead should have multiple sclerosis (MS). Harold Bratt, Tobis's chief dramatist, developed the storyline of the script: "Two doctors love a woman. She marries one of them. As she falls ill with multiple sclerosis, she asks one of them to kill her. Her turns her down. Thereupon she asks the other, who does her bidding. A trial results, in which the case is discussed" (Burleigh 1994, 210). Bratt's storyline was then developed into a script by Eberhard Frowein (Herzstein 1987, 307; Romani 1992, 108). The film was released on August 29, 1941, a week after Hitler ended the secret mercy killings in gas chambers at the six euthanasia centers (Waldman 2008, 227).

10.3 Euthanasia in *Ich klage an* and in Contemporary Cinema

We will compare the arguments in favor of PAS and euthanasia presented *in Ich klage an* and in contemporary cinema. We focus on *Ich klage an* because it is the archetypal, best, and most popular Nazi propagandistic, commercial, feature film promoting euthanasia. Its explicit and implicit arguments will be identified and compared to those presented in one or more contemporary films that showcase similar if not identical arguments.

Because film is primarily a visual medium, we recommend that readers watch *Ich klage an* (available on Amazon with English subtitles), the six contemporary Oscar-winning films that promote euthanasia, and Michael Burleigh's documentary *Selling Murder*, which has clips from rarely seen Nazi euthanasia films like *Daisen ohne Leben* (Burleigh 1991). While other authors have written (Burleigh 1994; Pernick 1996) and spoken (Gabbard 2016) eloquently about *Ich Klage An* and contemporary cinema, they did not focus on their bioethical arguments.

Ich klage an is strikingly different from the Nazi euthanasia documentaries. It contains almost no references to Nazism and has the look and feel of a contemporary melodrama. As Michael Burleigh puts it: "Apart from the fact that the judges have Nazi emblems on their robes, and that the jury chamber is adorned with a modest bust of Hitler, the film could just have well been set in the 1950s as in the 1930s" (Burleigh 1994, 215).

To encourage as large an audience as possible to view the movie, the filmmakers recruited well-known actors for the lead roles, including Heidemarie Hatheyer as Hanna Heyt, the bubbly, attractive, and intelligent wife who contracts MS, Paul Hartmann as Professor Thomas Heyt, her academic physician/scientist husband, Matthias Wiemann as Dr. Bernhard Lang, her former paramour who is now her friend and very conscientious general practitioner caring for her, and Christian Kayssler as the presiding judge at the murder trial. Hatheyer, in particular, was one of the premier actresses of German-speaking cinema (Romani 1992, 103–110). Adding the engrossing medical and courtroom dramas, skilled camerawork, and popular composer Norbert Schultze's moving score to the fashionable but formulaic triangular love story yielded an effective and popular melodrama that was seen by 15.3 million Germans (Burleigh 1994, 216).

10.3.1 Cinematic Justifications of Physician-Assisted Suicide and/or Euthanasia

We suggest that there are at least eight bioethical justifications for PAS and euthanasia that have been presented through the medium of film: (1) showing mercy; (2) avoiding fear, disgust, and prioritizing the quality of life; (3) equating of lost capability with loss of a reason for living; (4) allowing self-determination and rights; (5) conflating voluntary with the involuntary and nonvoluntary euthanasia; (6) casting all opposition as out-of-date traditionalism; (7) avoiding the financial toll of terminal illness, or economics; and (8) preventing the transmission of undesirable genetic traits, or eugenics.

Ideally, we would also discuss and compare contemporary feature films that are even marginally opposed to assisted suicide and euthanasia, but very few such films have been made. Those few include the romantic fantasy *Just Like Heaven* (2005), *Dr. Cook's Garden* (1971), a rarely seen made-for-television movie, some documentaries like *How to Die in* Oregon (2011), and, possibly, the ambiguous *Miele* (*Honey*) (2013).

10.3.1.1 Mercy

A popular justification for legalizing PAS and euthanasia is that it is the kind and merciful thing to do for someone in pain. Popular anecdotes abound regarding dying persons writhing in pain and begging to be killed while cold doctors are either absent or stand by and do nothing, claiming that to help the patient would be a violation of the Hippocratic Oath. This presentation is, of course, a complete caricature, but it makes for wonderful melodrama. The suffering of the sick is also sometimes presented as more existential than physical, but the argument is always that euthanasia is an act of mercy, and, erroneously, that there are no alternatives.

In *Ich klage an*, during a break in the trial of Dr. Heyt, the jury discusses the case and one juror says, "There must be proof that [Hanna Heyt] stated an express wish to die." When another juror responds, "And then?", the first juror says, "It would be mercy killing, not murder." Earlier in the movie, we see a research colleague of Dr. Heyt euthanize a mouse with disabilities similar to Hanna's by pouring the fatal liquid into a beaker filled with cotton balls. As she places the mouse into the beaker and covers it, she says, "Poor animal. I haven't forgotten you. There. Soon you'll feel no more pain."

Immediately following this doctor's clear expression of mercy for the "poor animal," the scene fades to a closeup of the hands of Hanna's doctor and friend, Bernhard Lang, as he, too, pours liquid morphine into a glass container. Hanna, who appears to be in physical pain, asks him to leave the bottle, saying, "Promise me that you'll help me when I am [that sick]. Promise me that you'll spare Thomas and me." If the doctor's mercy is good for the mouse, why not for the beloved friend?

Lang denies her request: "I'm your best friend. But I'm also a doctor, and a doctor is a servant of life." A few scenes later her husband Thomas also refuses her request to "help" her if she gets worse because he is hoping his research will quickly yield a cure. When it becomes clear that he will not find a cure, Thomas surreptitiously administers the entire bottle of morphine to Hanna who dies as peacefully and calmly as only an actor can do in a movie with great camera work and beautiful background music. Thomas then leaves her room, tells Bernhard what he has done, and an argument ensues between the two doctors:

BERNHARD. She asked me, too, but because I love her, I didn't do it.

THOMAS. Because I loved her more, I did it. Because her suffering was inhumane, because man must be above death, that's why I set her free.

In *Mar adentro* (*The Sea Inside*), based on a true story, the central character Ramón Sampedro (Javier Bardem), who is quadriplegic, echoes Thomas's declaration about love and mercy. Ramón tells Rosa, a woman who loves him, "Don't burden me with your love. The person who actually loves me will be precisely the one who helps me die. That's loving me."

Inadequate relief of *physical* pain is presented as a primary problem in *The Barbarian Invasions*, leading the main character's son to illegally obtain heroin for Rémy, his father, who is dying from cancer. A nurse eventually administers an intentionally fatal dose of heroin, and Rémy dies in a bucolic country house surrounded by his loving family. Similarly, Count László de Almásy (Ralph Fiennes), the protagonist in *The English Patient*, receives multiple daily injections of narcotics, presumably to relieve the physical pain he experiences as a result of the extensive, disfiguring burns he received when his airplane was hit by gunfire.

While inadequate relief of physical pain features in both these films, inadequate relief of psychological pain is a much more common argument in favor of PAS and euthanasia in the cinema. In *Ich klage an*, for example, Hanna is dying of MS and her course is characterized more by suffering from what she is unable to do, even though she does fall and suffer some physical pain. In actuality, the data from patients requesting PAS in Oregon supports the prevalence of psychological over physical rationales for PAS requests. Of the nine most common reasons offered by patients for the request, illness-related experiences—feeling tired, weak, and uncomfortable and loss of function—ranked first and second while physical pain ranked only seventh. Loss of sense of self, desire for control, fears about future quality of life and dying, and negative past experiences with dying ranked three to six in almost as high percentages as the illness-related experiences (ProCon.org 2018). While the public may believe otherwise, today most patients' physical pain at the end of life can be relieved by competent palliative care professionals (Quill 2020, 160).

Miele (*Honey*), an Italian film, addresses the issue of psychological pain directly. It features a young woman, Irene, known as Honey, who assists in the suicide of terminally ill patients by providing fatal doses of illegally obtained barbiturates. She then discovers that one client, Grimaldi, is not sick. He is simply tired of living and wants to die. An argument ensues about why he wants to die:

GRIMALDI. Is there a list of acceptable reasons? Would you rather I told you I have a terrible secret, a crime to atone for? I don't owe you an explanation. You sell, I buy.

HONEY. That's not exactly the case. I help. But not people like you, you can live…

GRIMALDI. For all I know, not all your clients are on the verge of death…Believe me, I've lost interest in everything. It's all so boring and insignificant. I can understand, it's easier to help the terminally ill. Nobody can stand the sight of a body falling apart. It's natural to feel pity then. But if the illness is invisible, then what? Is it just a whim, heresy? This thing you do for money, everybody should be able to do it. The sick don't have more rights than me.

Honey struggles with her next assisted suicide, visits Grimaldi again and again, and eventually stops providing her special services, telling him, "Nobody really wants to die. None of these people I assisted in these three years wanted to kill themselves. They want to live. They all want to live. But they no longer can call it a life. They can't take it anymore … I can't do it anymore."

In the end, Grimaldi appears to commit suicide, possibly with the barbiturates Honey had initially left with him. The ambiguous ending corresponds with the situation in Italy where PAS and euthanasia were illegal until Italy's top court issued a ruling in the 2019 prosecution of euthanasia activist Marco Cappato who accompanied Italian disc jockey Fabiano Antoniani, or DJ Fabo, to his death at Dignitas in Switzerland in 2017. In October 2018, the court suspended proceedings and gave the Italian parliament one year to address assisted suicide, which it did not do (Schiavi 2018). The court, therefore, ruled that assisted suicide could be legal when a patient's irreversible condition is "causing physical and psychological suffering that he or she considers intolerable" (EuroNews 2019).

The ruling came a week after Pope Francis told a delegation from the Italian Doctors Order, "We can and we must reject the temptation, which is also favoured by legislative changes, to use medicine to satisfy a sick person's wish to die" (EuroNews

2019). He also quoted his predecessor Pope John Paul II, “Every doctor is asked to commit himself to absolute respect for human life and its sacredness” (BBC News 2019).

Cinema also reflects and promotes cultural trends undermining the idea that human life has special value. When asked who they would save, their drowning dog or a drowning stranger, more than two-thirds of high school students would save their drowning dog (Prager 1990), and over 25 percent of medical students at the Ben-Gurion University of the Negev hesitated in choosing the human over the animal (Glick 1995). This blurring of the distinction between humans and animals, promoted by well-known public intellectuals such as Peter Singer and Cass Sunstein, leads to the idea that acts of mercy toward animals, especially pets, are ethically equivalent to those same acts toward humans, especially at the end of life (Singer 1977; Sunstein and Nussbaum 2004). In fact, such principles of equality and justice would seem to make them required. For example, the president of the World Federation of Right to Die Societies advocates euthanizing humans just as we do our beloved pets in her article entitled “Love Thy Neighbor as Thy Dog” (Davies 1991).

In *Ich klage an*, during a break in the trial, one juror presents the common argument of showing mercy toward pets: “…just a few weeks ago I had to give my old hound the mercy shot. He was blind and lame, but otherwise, he had faithfully served me his entire life. And if a hunter doesn’t do that, then he’s a harsh fellow, not an honorable huntsman.” Another juror says, “Yes, but those are animals,” to which the first juror responds, “Yes, but are people to be treated worse than animals?”.

Harrison, the quadriplegic protagonist in *Whose Life Is It Anyway?* (1981), makes a similar argument to the judge: “Your honor, if you saw a mutilated animal on the side of the road, you’d shoot it. Now, I am only asking for the same mercy that you would show that animal.”

Million Dollar Baby makes the same argument. Early in the movie, before she becomes quadriplegic, Maggie visits her hometown with Frankie, a father figure as well as her trainer. While there, she realizes that her family is disreputable, did not support her in the past, and never will. She relates a story to Frankie about her dead but idealized father:

MAGGIE. You ever own a dog?
FRANKIE. Nope. Close as I ever came was a middleweight from Barstow.
MAGGIE. My daddy had a German Shepard, Axel. Axel’s hindquarters were so bad he had to drag himself room to room by his front legs. Me and [my sister] Mardell’d bust up watchin’ him scoot across the kitchen floor. Daddy was so sick by then, he couldn’t hardly stand himself, but one morning he got up, carried Axel to his rig and the two of them went off into the woods, singing and howling. Wasn’t till he got home alone that night that I saw the shovel in the truck. Sure miss watchin’ the two of them together. I got nobody but you, Frankie.

Later, when she is lying in bed, quadriplegic on a respirator, and just before her soliloquy and her request of Frankie to euthanize her, Maggie reminds him of that story.

MAGGIE.	I got a favor to ask you, Boss.
FRANKIE.	Sure, anything you want.
MAGGIE.	Emember what my daddy did for Axel?
FRANKIE.	Don't even think about that.
MAGGIE.	I can't be like this, Frankie…

10.3.1.2 Fear, Disgust, and the Quality of Life

It is sometimes argued, to this day, that euthanasia is necessary because the quality of a person's life can be so low that no reasonable person would want to continue to live that way. Such cases typically involve severe physical deformities or neuropsychiatric conditions. Alzheimer's disease, for instance, is depicted in its late stages in medical films designed as aids for advance care planning (Volandes et al. 2009). The films present patients who are bedbound, incontinent, tethered to feeding tubes, unable to recognize relatives, screaming out in pain, and/or delirious. At the other end of the lifespan, children with deformities are depicted by pro-euthanasia activists as monsters or vegetables in ways that alarm, frighten, or disgust us. The argument for euthanasia for these conditions may be rooted in fear and disgust, but it is rationalized by describing such individuals as not having "interests," and so their deaths are not accounted as murders (Singer 1993, 160–169).

In *Ich klage an*, when Hanna asks Bernhard to assist with her death, she says, "You know, I am not afraid of dying but I don't want to just lie there for years, not being human, but only a lump of meat. It would be torment for Thomas if I deteriorated like that." When Hanna asks Thomas to assist with her death, she says, "You must help me remain your Hanna to the very end, before I turn into something else, deaf, blind, or demented. I couldn't bear that…Promise me, Thomas, that you'll release me before that. Do it Thomas, if you really love me. Do it."

Contemporary discussions of *Ich klage an* pay too little attention to the subplot of the reversal of fortunes of the little girl with meningitis whom Bernard saves from death and its relevance to the arguments in favor of euthanasia. In a follow-up visit with a colleague, Bernhard asks, "Where is she now?" The colleague responds, "In an institution. She's blind, she's deaf, too, and demented. Wonderful, you healed her, Doctor, instead of letting that poor creature die." Bernhard goes to the institution to see the child and wistfully tells a colleague:

BERNHARD.	Now the mother tells me she hoped I'd come one more time to help her child. You know what she meant by "help." I'm about ready to leave the profession … I also had another case at the time. You know I treated Hanna Heyt? … How can the nurse take that?
HIS COLLEAGUE.	She's a woman and loves anything helpless.

Later on, when Bernhard appears as a witness in the trial of Thomas Heyt, who is accused of murdering Hanna, he says, "She asked me once, if she took a turn for the worse, and if her life would no longer be humane, that I help her die … At that time, I didn't see her request as compatible with my oath…" Soon thereafter Thomas says to him, "You said to me, Bernhard, 'You murdered her.'" Bernhard responds, "Yes, Thomas, and today I say to you, you're not a murderer."

Historian Michael Burleigh has pointed out how skillfully and subtly the plot lines are interwoven so that the equation is inevitably made between the voluntary euthanasia of Hanna, the beautiful pianist and wife of a physician, and the wished-for involuntary euthanasia of the child with severe disabilities (Burleigh 1994, 216). Both suffer the loss of beauty—one who will never have it and one who has lost it. Both suffer the loss of control—one who will never have it and one who is losing it. Both suffer the loss of cognition—one who will never have it and one from whom it is slipping away. The subtle message is that just as Hanna is revolted by her present and prospective condition, so we should feel the same disgust on behalf of the institutionalized "blind…deaf…and demented" child. This shields us, the audience, from believing that the disgust is a matter of our own attitudes. As Hanna deserves a merciful death, so does the child.

Amour, a French film, presents in painful, plodding, and pointed detail the ravages of dementia on a cultured music teacher and her husband. By the time he suffocates her with a pillow, the audience is more than ready to end the movie. In *The English Patient*, the horribly disfigured appearance of the formerly handsome Almásy, whose face is now burned beyond recognition is, at the very least, disagreeable and unappealing. In *One Flew Over the Cuckoo's Nest*, the formerly lovable, lively, and entertaining McMurphy (Jack Nicholson) appears lifeless and catatonic with a big, ugly scar from a frontal lobotomy just before the Chief suffocates him with a pillow and bursts through the asylum's window thereby freeing both of them. The argument in all these films is the same—euthanasia is the solution if one wishes to avoid or escape states that horrify or disgust.

10.3.1.3 Equating Loss of Capability with Loss of Reason for Living

In his *Poetics*, Aristotle says, "Tragedy is a form of drama exciting the emotions of pity and fear. Its action should be single and complete, presenting a reversal of fortune, involving persons renowned and of superior attainments, and it should be written in poetry embellished with every kind of artistic expression" (Brooklyn College n.d.). Films often present the loss of great talent as an argument for euthanasia, evoking in the audience a sense of tragedy and pity as they appeal for moral acceptance and legalization of PAS and euthanasia. This form of argument is especially appealing to contemporary Western academics, such as Norman Cantor, who fear the loss of their academic talents through a disorder such as Alzheimer's disease, and argue that the tragic quality of this loss justifies suicide (Cantor 2018).

In *Ich klage an*, the first hint of Hanna's future decline is her left hand's unexpected and inexplicable difficulty in playing the piano at a celebratory dinner party. The tragedy to come is heightened by Hanna's belief or hope that the cause of her weakness is a pregnancy she has been yearning for. When Bernhard suspects she has a neuromuscular disease, she responds, “Having a baby is not a disease.” Before long, she is bedridden, unable to joyfully dance about as she did before.

Million Dollar Baby describes the tragic life of a poor, adrift, relatively older and stubborn female boxer, Margaret “Maggie” Fitzgerald (Hillary Swank), who finally gets a world championship boxing title match with the aid of her trainer Frankie Dunn (Clint Eastwood). During the fight, an illegal punch drops her head onto her corner’s stool leaving her quadriplegic on a respirator. Ultimately, she asks Frankie to assist her in dying:

MAGGIE. I can’t be like this, Frankie. Not after what I done. I seen the world. People chanted my name. Well, not my name, some damn name you gave me. But they were chanting for me. I was in magazines. You think I ever dreamed that’d happen? I was born at two pounds one-and-a-half ounces. Daddy used to tell me I fought to get into this world, and I’d fight my way out. That’s all I wanna do, Frankie. I just don’t wanna fight you to do it. I got what I needed. I got it all. Don’t let them keep taking it away from me. Don’t let me lie here till I can’t hear those people chanting no more.”

FRANKIE. I can’t. Please. Please, don’t ask me.

MAGGIE. I’m asking.

FRANKIE. I can’t.

Of course, in the end, he can and he does.

In *Me Before You* (2016), whose box office take was more than $208 million, a wealthy quadriplegic man with supportive parents and a woman who loves him chooses euthanasia in Switzerland because he is not the man he was before his crippling accident. His attitude and behavior can be contrasted with that of a similarly wealthy quadriplegic man in a movie based on a true story, *The* Intouchables (2011). Incidentally, *Me Before You*, *A Short Stay in Switzerland* (2009), and documentaries like *The Suicide Tourist* (2007) highlight in a favorable way the role of Swiss nonprofit organizations like Exit and Dignitas that promote and provide assisted suicide to patients from around the world.

In *Mar adentro*, we meet beautiful Julia, a lawyer who suffers from Cadasil syndrome, a hereditary leukodystrophy that will ultimately lead to dementia and serious physical disabilities, a subplot that heightens the melodrama. Julia, who supports quadriplegic Ramón in his legal case for euthanasia, does not tell him about her own illness before this interview:

JULIA. If we end up going to trial, you’ll be asked why you don’t seek an alternative to your handicap. For instance, why do you refuse a wheelchair?

RAMÓN. Accepting a wheelchair would be like accepting the crumbs of what used to be my freedom. Look, think about this: You’re sitting there, right? A little less than five feet away. Well, what’s five feet? An insignificant journey for any human being. Well, those five feet necessary to reach you, let alone to even touch you, is an impossible journey for me. It’s a false hope, a dream. That’s why I want to die.

An explicit dialogue about the loss of talent takes place in *Whose Life Is It Anyway?*. An informal hearing has been convened to respond to a quadriplegic former sculptor's request to be discharged from the hospital to die. The judge interrogates the protagonist, Ken Harrison (Richard Dreyfus):

JUDGE. You tell me why it is a reasonable choice that you decided to die.

HARRISON. The most important part of my life was my work, and the most valuable asset I had for that was my imagination. Now it's just too damn bad that my mind wasn't paralyzed along with my body because my mind, which had been my most precious possession, has become my enemy and it tortures me. It tortures me with thoughts of what might have been and what might be to come, and I can feel my mind very slowly breaking up.

Harrison also says that he is filled with "an absolute sense of outrage that you, who have no knowledge of me whatsoever, have the power to condemn me to a life of torment because you cannot see the pain." In the end, the judge rejects the majority medical opinion that Harrison is depressed and rules that Harrison can be discharged or "set free," saying, "I am satisfied that Mr. Harrison's a brave and thoughtful man who is in complete possession of his mental faculties…" The judge also neglects the fact that the accident resulting in Harrison's quadriplegia is relatively recent and that, according to Glen Gabbard, psychoanalyst and author of several books on the depiction of psychiatry and mental illness in films, Harrison "may be in a state of grief that will ultimately lift with the passage of time and adjustment to the illness" (Gabbard 2010, 156).

10.3.1.4 Self-Determination and Rights

Whose Life Is It Anyway? argues, in no uncertain terms, that patient autonomy trumps medical and government resistance to PAS and euthanasia. The autonomy argument runs continuously in the background of all contemporary films promoting euthanasia, but this movie brings it front and center. Moreover, unlike most contemporary euthanasia movies, *Whose Life Is It Anyway?* explicitly and directly confronts the medical profession's competence and ethics in the management of patients with chronic but not necessarily terminal illnesses.

Whose Life Is It Anyway? is also unique among contemporary films in that it demands that the state, in the person of the judge conducting an informal trial, respond favorably to the individual's autonomous request to an assumed right to die.

Ich klage an uses the same plot device—a trial—as *Whose Life is It Anyway?* to promote State involvement in end-of-life decision-making:

JUROR 1. But can these decisions on life and death be left to doctors?

JUROR 2. Of course not. They'd take on the responsibility for it. Commissions must be appointed, proper tribunals made up of doctors….

JUDGE. It's not that simple. The right to kill shouldn't be given to a doctor alone. These final medical decisions should be left to the state. We would have to pass laws for such "medical courts." But as soon as possible.

JUROR 3. I'm an old soldier, gentlemen. It's evident to me that our state demands a duty to die if need be. But then it should have to give us the right to die, if necessary.

JUDGE. Sure, Major, but the laws applicable here are still different.

JUROR 3. Of course we will judge Professor Heyt under current law. That goes without saying. But allow me to say, the law is not here to prevent people from worthy moral acts. If that's the case, the law must be changed.

In an ironic way, the appeal to the State made in both films undermines the argument from autonomy by making the individual dependent upon the State. In both National Socialist and contemporary Western liberal arguments for the "right to die," the State must grant and safeguard the purported right to PAS and euthanasia. In the contemporary Western formulation, the State is compelled to do so out of its respect for autonomy. In the Nazi formulation, the State is compelled to do so out of reciprocity given its demand for a duty to die. Both, however, are fundamentally arguments for a right to PAS and euthanasia.

10.3.1.5 Conflation of Voluntary, Involuntary, and Nonvoluntary Euthanasia

Philosophical and legal arguments for PAS and euthanasia always begin by making the case for voluntary death by competent adults. The requirement of a *voluntary* request is proposed as a "safeguard" to protect against the possibility of ever moving in the direction of involuntary euthanasia as practiced by the Nazis. Yet the arguments based on mercy and disgust as well as norms of equal treatment for all suffering persons push against such a boundary. The initial move is from the first-person voluntary request, "Please help me die," to the third-person, nonvoluntary judgment, "She would not want to live this way" and seems simple and logical. From here, the move to the generalized, nonvoluntary, "No rational person would want to live this way" is inexorable. The European experience with euthanasia seems to confirm this conflation. Movies often present a central case for the voluntary but foreshadow the argument for the nonvoluntary in their depictions of euthanasia.

As noted above, *Ich klage an* masterfully intertwines the two plotlines (Burleigh 1994, 216). Hanna's voluntary request for euthanasia calls forth equivalent mercy from the parents of a neurologically damaged child who has no first-person voice and is unable to make such a voluntary request. It becomes, therefore, the moral duty of the parents to make the third-person request on their child's behalf. And, as his dialogue at the trial demonstrates, the principled and noble Dr. Lang has changed his mind about refusing requests for both voluntary and nonvoluntary euthanasia, and so should we, the audience.

Several contemporary films portray the nonvoluntary but compassionate killing of cognitively impaired patients and/or loved ones, such as *One Flew Over the Cuckoo's Nest*, *The Leisure Seeker* (2017), and *Monsieur & Madame Adelman* (2017). The overriding message is that the judgment, "I would want assisted suicide or euthanasia for myself" can be generalized to decisions made on behalf of others.

10.3.1.6 Casting All Opposition as Out-of-Date Traditionalism

The makers of *Ich klage an* were unlikely to attack either traditional medicine or religion. German physicians and medical scientists, arguably the best in the world at the time, were held in the highest regard in Germany and around the world. For example, famed surgeon Michael DeBakey studied in Germany during the Third Reich because it had the best doctors and medical researchers (DeBakey 2010, 221). Furthermore, the Nazi government did not want to alienate the medical profession because it was badly needed to implement the Sterilization Law, examine potential marriage partners for genetic fitness, euthanize children and adults, and carry out the Final Solution by making selections on the ramps, supervising the gas chambers, and performing military and other medical research. In addition to the portrayal of Drs. Heyt and Lang as competent, thoughtful, and moral physicians, this exchange between the jurors during a break in Dr. Heyt's trial demonstrates the filmmakers view of physicians:

JUROR 1. Professor Heyt should be acquitted precisely because he is a role model for all doctors.

JUROR 2. What if doctors started relieving suffering? Wouldn't people say no? Prefer even terrible pain to dying? People would condemn doctors.

JUROR 1. Come on. Everyone knows what doctors do and continue to do for us. They discovered X-rays and radiation, and became cripples doing it. If someone is terminally ill and would rather die, why should he keep living? If someone asks to die, as the last help who can spare him, doctors should be allowed to help.

Indeed, it would appear, the medical profession was not alienated by its depiction in the film. The *Sicherheitsdienst* (Security Service, or SD, the Nazi intelligence service), issued a "Report from the Reich" that evaluated the response to *Ich klage an*. The opening remarks about medicine's response were: "As regards *medical circles*, a mostly positive response is reported to the questions raised by the film. Younger doctors in particular, apart from a few bound by religious beliefs, are completely in favour" (Leiser 1974, 147; italics in original).

Similarly, the Nazi government wanted to avoid creating more internal and external enemies by alienating organized religions. Here is the one exchange about religion in *Ich klage an*, which also occurs during a break in the trial:

JUROR 3. It is God's will. He sends suffering so that men will follow his cross and attain eternal bliss.

JUROR 4. My dear sir, I would like to believe that God is not that cruel, nor the pastor, by the way.

The SD "Report from the Reich" described a much less favorable response to the film from the Church than from medical circles: "The *attitude of the Church*, both Catholic and Protestant, is one of almost total rejection" (Leiser 1974, 146; italics in original).

Contemporary filmmakers routinely paint opposition to PAS and euthanasia as dependent upon a quaint, irrational clinging to the traditional moral codes of religion and "dead white men" like Hippocrates as opposed to the bold, progressive embrace of seemingly new ideas. Priests and religious institutions are portrayed as unhelpful or useless in several contemporary films, such as *The Sea Inside, Million Dollar Baby*, and *The Barbarian Invasions*. In the surprisingly few contemporary movies that either mention or include medical personnel, they are depicted as cold and unfeeling at best, as in *Million Dollar Baby* or *Whose Life Is It Anyway?*, or malevolent at worst, as in *One Flew Over the Cuckoo's Nest* where Nurse Ratched is portrayed as the embodiment of evil. Indeed, just as in *Ich klage an*, where both the self-sacrificing medical scientist and the principled general practitioner ultimately support euthanasia, nurses in both *The English Patient* and *The Barbarian Invasions* also reverse their initial opposition and finally administer lethal doses of medication to Almásy and Rémy, respectively.

In contemporary euthanasia films, any friends, loved ones, or family members who oppose assisted suicide and euthanasia are either given short shrift or, more likely, reverse course and lend support to the patient's decision, as in *The English Patient*, *Million Dollar Baby*, and *Mar adentro*. Also, little consideration is given to the impact of a completed assisted suicide and euthanasia on loved ones, family members, the medical profession, and society. For example, in *Mar adentro*, Ramón asks of Julia, rhetorically and laughingly: "Why do people get so shocked when I say that I want to die? As if, as if, as if it were something contagious." Indeed, studies have shown that PAS and euthanasia are contagious—states that permit PAS and euthanasia have a higher rate of unassisted suicides than states that do not permit PAS (Jones and Paton 2015, 599–604) and euthanasia (Boer 2017).

10.3.1.7 Economics

Nazi ideology and propaganda documentaries were very explicit in arguing for the elimination of the economic burden imposed on the state by caring for the disabled—these costs were a primary justification for euthanasia. Yet, in *Ich klage an*, the burden is primarily psychological and perhaps physical but not economic. In contemporary cinema, economic motivations are generally associated with the "bad guys." Therefore, appeals to economic reasons in support of euthanasia are rarely made explicit. In both *Mar adentro* and *Amour* there are only brief and vague references to the economic cost of home care for someone with serious disabilities. Be that as it may, economic arguments do seem to play a significant background role in actual end-of-life decision-making (Trachtenberg and Manns 2017, E101–E105; Sulmasy et al. 1998, 974–978).

One contemporary film, however, *The Barbarian Invasions*, explicitly makes the economic argument. The powerful visual display of hospital overcrowding, the ability of Rémy's son to get improved care for his father by spreading money around the hospital, and the son's indifference to the expense of purchasing heroin illegally imply that economics influence end-of-life decision-making in Canada. One can only wonder about the influence of this Oscar-winning 2003 film on the Canadian debate about PAS and euthanasia.

10.3.1.8 Eugenics

As we have noted, one major argument for euthanasia has been its purported eugenic benefit, a major ideological force behind the Nazi euthanasia programs. Eugenicists throughout the Western world argued that Judeo-Christian and Hippocratic commitments to caring for the sick had resulted in many genetically unfit persons surviving and reproducing in ways that violated the natural struggle for life that would have eliminated undesirable traits from the human gene pool. Sterilization and euthanasia were proposed as correctives. Early pro-euthanasia films commissioned by the Nazis took this approach directly, depicting "genetically sick" (*erbkranken*) patients such as Valentina Z in *A 41/2-Year-Old Patient with Microcephaly* as subhuman and interspersing disturbing scenes from neuropsychiatric and other chronic care institutions with lectures given by dynamic professors to young, healthy, and enthusiastic students. Such documentary and docudrama films, however, did not make for popular cinema and, while perhaps of use in schools for health care professionals, did not reach the general public.

Overt arguments for euthanasia on the basis of negative eugenics are almost unheard of in the Western world today and are not evident in movies. American eugenicists, however, consciously transformed eugenics into medical genetics (Comfort 2012) and exported eugenic policies to the Third World for decades after World War II (Connelly 2008). Also, a systematic campaign to eliminate Down syndrome through abortion is underway in Iceland (Quinones and Lajka 2017), and others call for "liberal eugenics"—enhancing the human race through genetic engineering (Agar 1998; Buchanan et al. 2000; Persson and Savulescu 2019).

Ich klage an avoids a direct link between eugenics and euthanasia, even though its subplot of the care of the child with meningitis gestures in that direction, and allusions to lab animals and the struggle for life also clear the ground for such arguments. The film was, therefore, a mature development in German cinematic depictions of euthanasia during the Nazi period.

Contemporary films avoid eugenics, but one made-for-television movie adapted from Ira Levin's play, *Dr. Cook's Garden*, tackles the issue head-on. The film tells the story of a genial general practitioner played by a cast-against-type Bing Crosby whose New England town appears to be blessed because the "nice" people live to a ripe old age and the “mean” ones die prematurely. As it turns out, Dr. Cook has been weeding both his garden and his town of “life unworthy of living.” Also, a very beautiful and powerful German Oscar-nominated historical drama, *Werk ohne Autor* (*Never Look Away*) (2018), portrays the heartbreaking *Aktion* T4 euthanasia of a woman who is the beloved schizophrenic aunt of an artist (inspired by Gerhard Richter) who mourns her death when he is a child and then, as an adult, unwittingly falls in love with and marries the daughter of the man who personally ordered his aunt’s death.

10.4 Discussion

As demonstrated above, there are many similarities in the arguments used to promote PAS and euthanasia in Nazi and contemporary feature films. These similarities include enthusiastic deployment of the argument from mercy, the argument from fear and disgust, the depiction of lost talent as the loss of a claim to life, and the suggestion that opposition is out-of-touch traditionalism. Feature films regarding PAS and euthanasia in both eras downplay economic and eugenic arguments, although these arguments sometimes make cameo appearances. The Nazis were a bit more likely to conflate the voluntary with the nonvoluntary, although a few contemporary films depict third party judgments that the patient would have wanted PAS and euthanasia. Films from both eras make appeals for mercifully euthanizing animals, although the Nazis were more likely to color that appeal with the hue of natural selection. Both defend a right to PAS and euthanasia, although, for the contemporary West, this right is derived from autonomy, and for the Nazis, it was owed to the citizen who had a duty to defend the State to the point of death.

The films of both eras were similar and yet dissimilar in their goals. In a general sense, their goals were the same: to promote public acceptance of PAS and euthanasia. In another sense, however, their goals may have been different. Nazi propagandists made *Ich klage an* to promote societal support for legalization of an ongoing but secret program of medicalized euthanasia for patients whose lives the government declared not worth living. By contrast, contemporary Western filmmakers have made euthanasia films to promote societal and governmental support for legalization and medicalization of PAS and euthanasia for patients who declare their *own* lives not worth living.

10.4.1 The Medical Profession’s Ethic

This difference in goals may help explain one marked disparity in films from the two eras: the prominence of principled physicians throughout *Ich klage an* and the almost total absence of physicians in the six Oscar-winning and most other contemporary euthanasia films. This absence is, at first, surprising because existing and proposed legislation in virtually all jurisdictions except Switzerland require physician participation. One possibility for this omission is that including physicians in the storyline would unnecessarily complicate the film. Another possibility is that the filmmakers might actually be promoting physician-free, altruistic assisted suicide as practiced in Switzerland. All efforts to legalize assisted suicide in the US, however, have designated physicians as those charged with administering the practice.

Perhaps the strongest possibility is that contemporary filmmakers concluded they did not need the support of the medical profession at all. Once society favored PAS and euthanasia, the government would legalize it regardless of the medical profession's objections, if any. Society and government would define the medical ethos.

As we argue below, because the medical profession increasingly has abdicated its moral authority and abandoned its professional responsibilities, the filmmakers may have reasonably concluded that society and the government would have little trouble getting the medical profession to both accept patients' declarations that their lives were not worth living and to assist with patients' suicides. The pressure both within and without the medical profession to declare official "neutrality" on the subject of PAS strongly suggests this may be the case (Sulmasy et al. 2018).

While many Western societies and governmental jurisdictions have social policies and legislation that clearly favor PAS and euthanasia, medicine has become, in fact, confused about its position. Focusing single-mindedly and successfully on science, Western medicine continues the Nazi preoccupation with, to use Leon Kass's term, *science as salvation* in the utopian quest for a more perfect human. He goes on to explain how, in Western liberal democracies, "A free people, choosing for ourselves, can and very likely will produce similar deadly fruit from the same dangerous seeds, unless we are ever vigilant against the dangers" (Kass 2010, 110).

In regard to PAS and euthanasia, medicine increasingly accepts the belief that medicine is "morally neutral." Whereas some professional organizations like the World Medical Association (World Medical Association 2019), the American Medical Association (American Medical Association n.d.), and the American College of Physicians (Sulmasy and Mueller 2017) officially oppose PAS and euthanasia, they are under pressure within and without to drop their opposition. When medical organizations opposed to PAS and euthanasia change their positions to "neutral," as the California Medical Association has done, the results are predictable: PAS is now legal in California (Kheriaty 2019, 23). When professional medical organizations assume a neutral position on PAS and euthanasia, they are abdicating their responsibilities to patients and physicians alike, thereby creating an ethical void eagerly filled by the many nonphysician strangers at the bedside.

By abandoning traditional religious and Hippocratic medical ethics with their commitment to life and healing in favor of secular, philosophical bioethics that includes a commitment to social justice (Abbott 2019), medical educators are further distancing medical students from the ethics of the individual doctor-patient relationship in favor of the population-based, state-*volk* relationship. If medical schools incorporate additional "social justice" issues into their curricula at the expense of education about healing patients, then they will crowd out basic medical training, or, as Stanley Goldfarb, former associate dean of curriculum at the University of Pennsylvania's medical school, bluntly says, "If this country needs more gun control and climate change activists, medical schools are not the right place to produce them" (2019).

This delegation of ethics to others on the part of the medical profession today is not unlike what happened to medical ethics in Germany in the 1930s and 40s. The pioneering German medical profession became the first in the world to require medical ethics education. Rudolf Ramm's *Medical Jurisprudence and Rules of the Medical Profession* (*Ärztliche Rechts- und Standeskunde*) became the standard textbook for the required Nazi medical school medical ethics course (Bruns 2020, 78). In the introduction to the first English translation of Ramm's textbook, Melvin Cooper writes, "A constitutive feature of a mature *profession* is that it is 'self-regulating,' that is, that it has an internally generated and adjudicated code of behavior" (2019, xviii). Similarly, "A profession is an occupation which has assumed a dominant position in a division of labor, so it gains control over the determination of the substance of its own work. Unlike most occupations, it becomes autonomous or self-regulating" (2019, xxii). German physicians ceded control of their ethics to Nazi ideology, and enthusiastically embraced it. What *Ich klage an* shows is the awakening of both practicing and academic physicians to that ideology in the persons of Bernhard and Thomas, respectively.

10.4.2 Lives Not Worthy to Be Lived

Ich klage an and almost all euthanasia films made by contemporary commercial feature filmmakers also demonstrate striking and disturbing similarities in their storylines, the beauty of the leading actors, stunning settings, stirring soundtracks, and the promotion and justification of PAS and euthanasia. These films share the attitude that individuals' lives can be declared not worthy to be lived, whether by the State, doctors, autonomous individuals, or their surrogates, and that such a declaration is morally sufficient to consider and sometimes implement PAS and euthanasia. During the Third Reich, eugenics and anti-Semitism compelled the state to direct physicians to declare some lives not worthy to be lived, while, in the current debate, respect for autonomy and a commitment to mercy compel the State to direct physicians to ratify the judgments of at least some patients that their lives are no longer worth living.

Dr. Leo Alexander, a medical psychiatrist and advisor to the Nuremberg Medical Trial (NMT), stated that the Nazi medical crimes began with a

> … subtle shift in emphasis in the basic attitude of the physicians. It started with 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 of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted, and finally all non-Germans. (Alexander 1949, 44)

German intellectuals had been promoting a "right to die" at least since 1895 when Adolf Jost published his book with that title (1895). The Nazi transformation of the Hippocratic doctor-patient relationship into a state-*volk* relationship seemed to offer moral justification for a right to die and, perhaps, even a duty to die. *Ich klage an* fleshed out this transformation with arguments that are common in today's films promoting PAS and euthanasia.

Because they promoted euthanasia for decades before Hitler became chancellor, German doctors eagerly supported his programs for the elimination of lives declared not worth living. *Ich klage an* was designed to persuade the public to accept this attitude, but also to convert the dwindling number of physicians who still clung to the old Hippocratic mentality.

Kass notes the search for the sources of ethical principles beyond medicine is driven by "the widely shared belief that medicine—whether regarded as a science or as an art—is in its essence *morally neutral*, or as our jargon has it, value free," and the searchers "would deny autonomy to the [medical] profession because it denies the existence of a medical ethic as such" (1985, 225; italics added for emphasis). Kass argues forcefully against this thesis through an explication of the traditional Hippocratic Oath and by arguing that, "the medical and the ethical are as hard to separate as the concave and the convex" (1985, 226–228). To concur with a patient's judgment that his or her life is no longer worth living is not value free.

10.5 Conclusion

The medical ethos is derived from three interacting factions: medicine, culture, and government. At the beginning of the Third Reich, medicine was strong, but culture and the central government were weak. Had Hitler not taken control of the central government, his anti-Semitic and murderous ideas would have been a footnote in history. Instead, he formed a strong government that joined forces with a strong medical profession to create a "biocracy"—a culture that forged his political goals with the goals of a medical profession that was in the process of jettisoning its moral authority in favor of a scientistic ideology. This powerful confluence of forces led to the nonvoluntary euthanasia of tens of thousands of lives deemed not worth living.

The accomplishments of medical science are breathtaking, improving the lives of millions of patients. But scientism in medicine needs to be balanced by knowledge and wisdom from many other disciplines, as pointed out more than a century ago by Drs. William Osler and Francis Peabody, two oft-quoted physicians, in their objections to the 1910 Flexner report that "Germanized" American medical education (Flexner 1910). They feared that a reliance on scientific medicine would lead to grave errors because, as Osler stated, Flexner was "a man who knows the profession from the outside only" (Osler 1962; Peabody 1927, 9–10). Or, as we are told in *Pirkei Avot* (Ethics of the Fathers) by Ben Zoma, "Who is wise? He who learns from all men, as it is written (Psalm 119:99) 'I have gained understanding from all my teachers'" (4:1). Medicine has learned from philosophers, filmmakers, bioethicists, and lawyers, but it has failed to learn from Sinai, Hippocrates, Osler, Peabody, and from the study of Nazi medical ethics and medicine.

Today, culture and government are strong, and medicine is weak. Patient autonomy and rights, such as the right to die, are promoted by both the culture and government. By abdicating its moral authority and abandoning its professional responsibilities, medicine has merely accepted the mores of the dominant culture and submitted to the dictates of government. One result has been the reintroduction of the historically discredited practices of physician-assisted suicide in the United States and euthanasia in several European countries, Canada, and Australia.

Film was one of the National Socialist government's most effective propagandistic media. Contemporary cinema, likewise, is a powerful cultural medium that encourages simple solutions to complex and emotional end-of-life dilemmas and has promoted assisted suicide and euthanasia in many films including six Oscar winners.

Western culture and governments are well along in the process of discarding three millennia of traditional Judeo-Christian medical ethics and two millennia of Hippocratism. Films both reflect the culture and help to shape it. Contemporary films regarding PAS and euthanasia, like their progenitors in the Nazi era, dismiss traditional medical ethics and, using strikingly similar arguments, present a new ethic. One result of this change in ethics is that today, as in mid-century Germany, we are witnessing a not-so-subtle "shift in emphasis in the basic attitude of the physicians" (Alexander 1949, 44). These changes are generating an ever-increasing demand for and supply of physician-assisted suicide and euthanasia.

We conclude by encouraging physicians to seriously engage with the questions raised by the striking similarity between Nazi and contemporary cinematic portrayals of physician-assisted suicide and euthanasia. This similarity is not a coincidence. It is not an accident. It should be a warning to all of Western society and a call for physicians to take a stand and speak up for the benefit of the medical ethos, the medical profession, and, vitally, all their patients.

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Filmography

A 41/2-Year-Old Patient with Microcephaly (German 1937): A Nazi propaganda film featuring Valentina Z designed to demonstrate the low developmental level of a mentally challenged child submitted to cruel experiments and examinations, a child considered a "life not worth living."

Alles Leben ist Kampf (*All Life is a Struggle*) (German 1937): A 16 mm, silent, black and white propaganda film promoting compulsory sterilization for those with allegedly inferior genes and prolific reproduction.

Amour (*Love*) (French 2012): Portrays in painful detail the ravages of dementia on a cultured music teacher and her music teacher husband. She makes him promise not to hospitalize her or send her to a nursing home, appears to attempt suicide, and lets him know that she doesn't want to go on living.

Barbarian Invasions, The (Canadian, French 2003): A son returns to care for his terminally ill father who is hospitalized in an overcrowded Canadian hospital with inadequate palliative care. The son uses his wealth to secure better accommodations, staff, and illegal heroin for pain relief. His father is euthanized at a country home in the presence of his family.

Black Stork, The (American 1915): A controversial silent film about a physician mercifully withholding life-saving medical care from an infant born with multiple non-lethal congenital anomalies.

Dasein ohne Leben (*Existence without Life*) (German 1941): Nazi propaganda documentary, not released to the public, about the extermination of people with presumed inherited disabilities who were considered a threat to society.

Doctor Neighbor (American 1915): A silent film that explores whether a doctor and his nurse should euthanize a distraught patient with a severe spinal injury.

Dr. Cook's Garden (American 1971): A young doctor returns to his New England hometown to work with an older doctor who helped him after his abusive alcoholic father died. As it turns out, the doctor has been weeding both his garden and the town of "life not worth living."

Drei Menschen (*Three People*) (German 1941): The first of three Nazi feature films, as opposed to documentaries, made to pave the way for an anticipated euthanasia or "mercy killing" law and to cloak the euthanasia of disabled patients in a cloud of sentimentality.

English Patient, The (British 1996): A severely burned, dying man, "The English Patient," is cared for by a nurse at a monastery. After he finishes telling his story to her and two other guests at the monastery, he asks her to euthanize him.

Erbkrank (*The Hereditarily Ill*) (German 1936): A 16 mm, silent, black and white propaganda film using patients from neuropsychiatric institutions to promote both the social Darwinist struggle for survival in society and eugenics.

Foreman, The (German 1941): The second of three Nazi feature films, as opposed to documentaries, made to pave the way for an anticipated euthanasia or "mercy killing" law and to cloak the euthanasia of disabled patients in a cloud of sentimentality.

Geisteskrank (Mentally Ill) (German 1942): A Nazi propaganda film, with one version for lay audience and another for academic audiences, that stresses the cost of treatment of incurable psychiatric patients, highlights the prowess of German psychiatry, and argues against medical ethics that binds a doctor to preserve every patient's life.

Good Will Hunting (American 1997): A romantic drama about the maturation of a young janitor and criminal who gets a deferred prosecution at the request of a renowned professor who recognizes the youth's mathematical genius and refers him to a psychologist who was once the professor's rival.

Has Man the Right to Kill? (American 1915): A silent film in which a terminally ill patient requests and receives a fatal dose of medication from a doctor who the governor then pardons on the grounds that the drug was intended to relieve pain, not to kill.

Hereditary and Acquired Epilepsy (German 1935): A Nazi propaganda film made to promote the legal compulsory sterilization of "hereditary epilepsy," one of the conditions included in the 1933 Sterilization Law.

How to Die in Oregon (American 2011): A documentary about Oregon's Death with Dignity Act, the first American legislation permitting physician-assisted suicide.

Ich klage an (*I Accuse*) (German 1941): The third of three Nazi feature films, as opposed to documentaries, intended to pave the way for an anticipated euthanasia or "mercy killing" law and to cloak the euthanasia of disabled patients in a cloud of sentimentality. Two doctors love a woman, she marries one of them, and then falls ill with multiple sclerosis. She asks one of them to kill her, he turns her down, then she asks the other, who does her bidding. A trial results, in which the case is discussed.

Intouchables, The (French 2011): This film is based on the true story of a wealthy quadriplegic man who hires an unlikely live-in companion, an unmotivated thief who, rather than pity his employer, brings joy to his life. The men form a strong and long friendship, teaching each other many important lessons about life along the way.

Just Like Heaven (American 2005): A recently widowed man is haunted by the spirit of a young emergency room physician seriously injured in a car accident. Aided by a psychic, the spirit discovers who she is and that, rather than being dead, she is in a coma at a nearby hospital where her doctors plan on honoring her living will by letting her die. The man kisses the dying asystolic woman, and she miraculously returns to life, and they live happily ever after.

Kampf dem Fleckfieber (*Struggle Against Typhus*) (German 1941/1942): This military training film was intended to warn German soldiers about the dangers of typhus and to reassure them that German scientists had the disease under control.

Leisure Seeker, The (Italian, French 2017): A older man with dementia and his wife of 50 years with an ill-defined illness escape from their family for one last trip in their beloved Winnebago that ends when she tapes it up and asphyxiates both of them after putting sedatives in their drinks.

Love Story (American 1970): A melodrama written by Erich Segal from his own popular book about a rich Harvard law student who falls in love with a working-class Radcliffe student who dies at a young age from leukemia. One of the highest grossing movies of all time.

Mar adentro (*The Sea Inside*) (Spanish 2004): Based on the true story of a man who became quadriplegic from a diving accident and spent 28 years pursuing the right to an assisted suicide.

Me Before You (British 2016): A wealthy quadriplegic young man with supportive parents and a woman who loves him chooses to end his life because he is not the man he was before his crippling accident.

Miele (*Honey*) (Italian 2013): A young woman nicknamed “Honey’ (*Miele*) provides illegal barbiturates to terminally ill patients but complications ensue when she discovers that her latest client, an older man, is not sick, is tired of living, and simply wants to die.

Million Dollar Baby (American 2004): A poor, adrift, relatively older and stubborn female boxer finally gets a world championship boxing title match with the aid of her trainer. During the fight, an illegal punch drops her head onto her corner’s stool leaving her quadriplegic on a respirator, and she asks her trainer to euthanize her.

Monsieur & Madame Adelman (*Mr. & Mrs. Adelman*) (French 2017): During their 40+ years of marriage, a wife has been the silent brains behind her husband’s successful career as a writer. When he becomes demented, she takes charge of the ending of the final chapter of his life.

One Flew Over the Cuckoo’s Nest (American 1975): McMurphy, a psychotic but lively and entertaining criminal disrupts his psychiatry ward run by the rigid Nurse Ratched, which eventually leads to his frontal lobotomy. His fellow inmate, the silent giant, The Chief, then euthanizes McMurphy.

Opfer der Vergangenheit (*Victim of the Past*) (German 1937): Hitler liked the silent film *Erbrkrank* so much that he ordered both the production of this artful sound film intended to promote social Darwinism and eugenics and its compulsory showing in all German cinemas.

Ordinary People (American 1980): A drama in which a family disintegrates during the psychiatric treatment of one son who attempted suicide after the death of his brother in a boating accident.

Oslerizing Papa (American 1905): A satirical film based upon William Osler’s facetious comments about the solution to the infirmities of old age proposed in Trollope’s tragicomic novel *The Fixed Period.*

Selling Murder: The Secret Propaganda Films of the Third Reich (British 1991): Historian Michael Burleigh’s essential documentary featuring clips from Nazi propaganda films promoting euthanasia.

Short Stay in Switzerland, A (British 2009): Inspired by the true story of a physician who develops a degenerative neurological disease very similar to the one that recently caused her husband’s death. She struggles with her children about her choice to end her life in a Swiss clinic before she becomes incapacitated.

Sterilisation beim Manne durch Vasektomie bzw. Vasoresektion (*Sterilization in the Male by Vasectomy*) (German 1937): A training film for German surgeons intended to educate them about the difference between sterilization by vasectomy and castration and to promote the implementation of the compulsory Sterilization Law.

Suicide Tourist, The (British 2007): A documentary investigating suicide tourism by following a British professor with amyotrophic lateral sclerosis to Switzerland where Dignitas ends his life.

Werke ohne Autor (*Never Look Away*) (German 2018): A portrayal of the heartbreaking Nazi euthanasia of a woman who is the beloved schizophrenic aunt of an artist (inspired by Gerhard Richter) who mourns her death when he is a child and then, as an adult, unwittingly falls in love with and marries the daughter of the man who personally ordered his aunt’s death.

Whose Life Is It Anyway? (American 1981): A sculptor becomes quadriplegic after a car accident and, despite very good hospital care, demands to be discharged from the hospital so he can die. His doctors and the hospital refuse so he pleads his case before a judge at an informal hearing in the hospital.

Wilson-Pseudosklerosis (Wilson’s Pseudo-Sclerosis) (German, 1938): A detailed portrayal of the neurological examination of patient Albert F that stimulated anatomic and clinical research on heredity.

Chapter 11
Godwin's Law and the Limits of Bioethics and Holocaust Studies

Ira Bedzow

Abstract This chapter examines the ways in which Godwin's Law disallows good bioethical discussion on controversial topics in healthcare because of the ways in which it invokes improper Holocaust analogies. However, rather than concluding that contemporary bioethics never use the Holocaust as a point of reference, the chapter suggests productive ways that lessons of the Holocaust can inform moral deliberation in bioethics.

11.1 Introduction

As of the writing of this chapter, medical aid in dying continues to be one of the most controversial topics in healthcare and the one that often invokes Holocaust analogies. However, invocation of the Holocaust when discussing controversial matters in contemporary bioethics, such as medical aid in dying, can achieve the opposite of what the one who draws comparison may want. Rather than providing a convincing moral argument for why a position is not ethically warranted, logically unsound analogies to the Holocaust or juxtaposition of an issue with that of the Nazis turns the discussion into one of farce or fearmongering. The reason for the former is that the other participants in the debate recognize the absurdity of the comparison. Moreover, the result of drawing such an absurd comparison is that the moral line becomes one where, as long as one does not act like a Nazi, one's actions are morally permitted. The reason for the latter is that the other participants in the debate are concerned about even considering the differences between the cases, let alone expressing their positions on the contemporary issue. The line is, therefore, drawn without attention to all aspects of moral concern; only the fear of being portrayed as evil is relevant. In both cases, moral deliberation no longer continues.

There is a famous law that originally applied only to online discussions yet has since permeated social discourse and now threatens academic examination of bioethical topics. Articulated by Michael Godwin in 1990 and formalized in the third

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edition of the *Oxford English Dictionary* in 2012, “Godwin’s law” asserts that “as an online debate increases in length, it becomes inevitable that someone will eventually compare someone or something to Adolf Hitler or the Nazis.” Academic incorporation of Godwin’s law is readily recognized in books and journal articles that opine on the death with dignity movement and legal developments in medical aid in dying legislation, as well as in various academic conferences and university lectures. While Godwin’s law assumes that conversation will proceed for some length of time, the back and forth of debate has become increasingly shortened since the law was first posited. In political debates, for example, mention of the Holocaust, Hitler, or the Nazis has often become the opening line rather than the closer. Godwin’s Law is a more recent take on *Reductio ad Hitlerum*, coined by Leo Strauss, which is the rhetorical strategy of condemning an argument by drawing comparisons to it with Hitler, the Nazi party, or organizations associated with Nazism (Strauss 1953, 42).

Oftentimes when Godwin’s Law is invoked, the one drawing comparison with the Holocaust either has made a logical error or has transgressed the norms of rhetoric. The difference between the two is whether the speaker incorrectly believes the comparison or whether he or she incorrectly believes that others will be persuaded by it. The two most common errors in judgment and/or persuasion are “appeals to fear” (*argumentum in terrorem*) and guilt by association.

11.2 Godwin’s Law and Bad Logic

Arguments that appeal to fear come in several different forms. The most obvious appeal to fear regarding medical aid in dying that relies on Godwin’s Law would be something like the following: “The Holocaust, and the example of medical participation in unethical euthanasia in particular, serves as a clear example of what can happen when the medical profession does not take a strong stance against societal influence in determining what is acceptable medical practice.” This sentence would be used to advocate that physicians should play a role in lobbying against medical aid in dying legislation. The argument draws the reader’s attention to a horrible past and suggests the possibility that such will be the future if the writer’s proposition is not accepted. Basically, if physicians don’t stop society from influencing medical practice, the consequence will be another Holocaust.

Yet, there have been previous examples in the history of medical ethics where the medical profession has not stopped society from influencing medical practice, and their inability—or lack of interest—in stopping society from changing the expectations of what is acceptable medical practice has in fact improved rather than detracted from the ethical practice of medicine. For example, the medical ethics principle of respecting patient autonomy is a societal imposition on medical practice and not a value that developed internally within the medical profession. In fact, globally the impetus for considering the rights of the individual was initially a response to reports of the inhumane treatment of Holocaust victims who were subjected involuntarily to medical experimentation, even if in the United States the principle of respecting patient autonomy grew in priority because of other societal factors.

In the United States, patient autonomy, and its corollary of informed consent to medical treatment, began as a legal principle, derived from common law notions of battery, to mean that individuals have a right to refuse invasion of their bodily integrity (*Union Pacific Railway Co. v. Botsford* 1891; S*chloendorff v. Society of New York Hospital* 1914). It developed into the full principle that it is today by virtue of legal development and societal pressure on reforming medical practice and physician autonomy. From the time of Hippocrates until the mid-1950s, medicine was paternalistic, where physicians upheld values of beneficence and non-maleficence towards their patients but did not consider their wishes or goals for care. Thomas Nys, Yvonne Denier, and Toom Vandevelde (2007, 3) explain, "Traditional medicine was paternalistic through-and-through: its goal was to restore or promote the patient's well-being where the doctor's expertise made him [*sic.*] the best judge regarding this conception of well-being. He [*sic.*] knew what it took to make the patient better." While confidentiality was a Hippocratic value and seeking consent was part of medical practice, neither of these were out of respect for patient autonomy. Confidentiality was a matter of protecting trade secrets of the esoteric profession and maintaining control over new initiates as much as it was concerned with patients' welfare (Thompson, 1979). Similarly, seeking consent entailed providing patients with information on the nature of the proposed procedure and the option for the patient to refuse it (Silverman 1989). The 1957 court case, *Salgo v. Leland Stanford Jr. University Board of Trustees*, invented the term "informed consent" and determined the practical requirements for physicians to fulfill this legally established duty to patients. This duty included the requirement to provide patients with all relevant information about available treatment alternatives so that patients, rather than their physicians, could decide how to balance various risks and benefits in making their decision.

The increase in priority of patient autonomy in the United States continued throughout the 1960s and 1970s through court cases and society viewing patient rights as an extension of consumer rights (Scher and Kozlowska 2018). In Europe, the inclusion of respect for patient autonomy developed within its own contexts, though it was also influenced by American bioethics (Baker 2013, 278). Yet, in each environment, the idea that the medical profession should respect patient autonomy and engage in shared decision-making whereby the goals and values of the patient are taken into consideration was an adoption by the medical profession of ideas originally foreign to it. As Tom L. Beauchamp (1990, 145) writes,

> This challenge has jolted medicine from its traditional preoccupation with a beneficence-based model of medical ethics in the direction of an autonomy model. Rather than perceiving the physician-patient relationship in terms of the patient's submission to the physician's professional forms of care, the autonomy model views the relationship within a wider social framework, emphasizing that patients have decision making rights and should be enabled to define the boundaries of the patient-physician relationship to fit their own ends.

What is now a core principle of medical ethics was a product of the medical profession not being able to take a strong stance against societal influence in determining what is acceptable medical practice. The concerns for which society fought through various legal cases and social movements in the 1960s and 1970s changed the standard of ethical practice when they were applied to health care. As such, the statement "The Holocaust, and the example of medical participation in unethical euthanasia in particular, serves as a clear example of what can happen when the medical profession does not take a strong stance against societal influence in determining what is acceptable medical practice," is a red herring since societal demands to change the status quo of medical practice does not always lead to the Holocaust.

Appeals to fear can come in an alternative form, which makes the juxtaposition between today and a scary tomorrow a little more distant. The slippery slope argument is not as strong as the traditional appeal to fear, but it implies the same conclusion. The argument goes something like the following: "If we allow for medical aid in dying today, we will eventually allow for passive and then active euthanasia of both competent and incompetent individuals. Eventually, we will permit the reinstatement of the Aktion T4 program, which called for the killing of those deemed mentally unfit or people who could not contribute to society in a meaningful way." Euthanasia has become legal in many countries across the world, and, for just one example, the Canadian government has recently expanded access to medical aid in dying to include people with disabilities based on the ruling in *Truchon v. Attorney General of Canada* ((AG), 2019 QCCS 3792). This would lend credence to the idea that allowing for limited legislation would inevitably lead to its expansion past the originally intended scope. However, the slippery slope argument that puts contemporary euthanasia on a slope leading to the Nazi Aktion T4 program and the Final Solution misses the essential element that pushed Nazi genocide forward, which is not present in today's public debate over euthanasia. Hitler's plan was always based in the eventual eradication of undesirables for the sake of Aryan purity and the future of the German *Volk*. In *Mein Kampf*, he writes how Germany "must take care that only the healthy beget children; that there shall be but one thing shameful: to be sick and ailing, and nevertheless to bring children into the world" (https://archive.org/stream/mk1merged/MK1-merged_djvu.txt). As Robertson et al. (2019, 175) explain, "The perpetrators of *Krankenmorde* [the murder of the sick] sought to legitimate and later defend their crimes by defining their actions in terms of 'mercy death', 'medical futility' and 'relief of suffering'. While these arguments remain the basis of the present-day case for legislating assisted dying, in the setting of the *Krankenmorde* they were a significant component of deceit utilized in a state-controlled program of mass murder of parts of its own population." Hitler's plan, therefore, was not a slippery slope but rather a multi-staged process. The Third Reich did not simply fall down the moral hill into committing genocide.

This does not mean that, if one does condone current medical aid in dying legislation, one need not worry about its potential vulnerability to immoral extension. In countries where euthanasia is legally performed on infants and children, as well as those who are deemed incompetent and do not have advanced directives requesting such aid, the moral and legal basis of patient autonomy is either indirect or stretched too thin to be cogent. Moreover, responses to the COVID-19 pandemic, in terms of public health measures and resource allocation protocols, have revealed social bias against people with disabilities as well as structural ableism (Caleb and Gallin 2021, 7). Yet, the potential—and actual—discrimination and harm to vulnerable populations that may lead to an immoral expansion of medical aid in dying result from different social motivations than what occurred in Nazi Germany. They do not stem from government sponsored promotion and marketing like what occurred through the Nazi Propaganda Ministry. To quote Robertson et al. (2019, 176), "[T]o simply accept that the murder of patients in the gas chambers and starvation houses of the *Krankenmorde* is in some way morally equivalent to decisions about end of life treatment by a patient suffering intractable cancer pain is as ignorant and culpable as accepting the 'mercy death' euphemism proffered by the Nazi regime." As such, the inevitability of any state establishing a euthanasia program like that of Aktion T4 is not only farfetched; the idea that medical aid in dying is a subversive steppingstone to Nazi genocide is an appeal to fear rather than logic.

Unlike appeals to fear, guilt by association does not draw any conclusions. It simply dismisses an idea by attributing the same idea to someone abhorrent. The typical Godwin's Law dismissal is as follows: "Do you know who else used euphemisms like 'a good death' when they were promoting a program of State-sponsored medicalized mass murder? The Nazis…" However, the fallacy of this argument reveals itself as soon as one recognizes the difference between the ways in which the Nazi party communicated its idea of why euthanasia constitutes a good death and why advocates of death with dignity communicate that medical aid in dying allows for a good death. Today, medical aid in dying is grounded in the principle of patient autonomy. Advocates of medical aid in dying legislation seek legal recourse for individuals to determine when and how terminally ill patients will die. A good death for those terminally ill patients is defined by the values and choices of the patient. While in certain countries, applicability of medical aid in dying has expanded to include people who are not terminally ill, the inclusion has still been in the name of respecting patient autonomy. In the Third Reich, euthanasia was a euphemism for state-sponsored ethnic cleansing and racial purification through the elimination of the "unfit" (Grodin et al. 2018, 54). For the Nazi party, the good in such a death was for the sake of the *Volk*. For advocates of death with dignity, the good of medical aid in dying is for the sake of the patient.

One of the most significant moral foundations for the Nazi euthanasia program was the 1920 book, *Die Freigabe der Vernichtung lebensunwerten Lebens: Ihr Mass und ihre Form (Allowing the Destruction of Life Unworthy of Life: Its Measure and Form)*, co-authored by psychiatrist Alfred Hoche and attorney Karl Binding. This book sought to justify on both legal and medical ethical grounds euthanizing handicapped and impaired people. Because he was a leader in the medical field, and because the German medical profession could no longer stand against the political and social ethos of the time, Hoche's reflections on euthanasia made it possible for German physicians to extend their understanding of their role to ease so that it could rationalize Nazi proposals for racial hygiene and mass murder. This became a starting point for German medical-political views on the acceptability of physician's participating in Nazi euthanasia programs.

Hoche wrote that though the standing duty of a physician is to heal the sick, to eliminate or alleviate pain, to retain and, as much as possible, prolong life, "the doctor has no absolute, but rather only a relative connection with the fundamentally recognized task of preserving other people's lives under all circumstances; a connection, which changes under new circumstances and needs to be newly reevaluated (Binding and Hoche 2012)". The implication of this statement is not that physicians must at times recognize the futility of ineffective care or the rights of patients to refuse treatment. Rather, the implication is that it is cruel both to the individual patient and to the general population to preserve the lives of handicapped individuals who are unproductive to the state. He writes regarding those with a certain level of mental handicap, "If we consider a median lifespan of 50 years for the single case, then it is easy to comprehend what an enormous capital—in terms of nourishing means, clothing and heating—is diverted from the national assets toward an unproductive purpose (Binding and Hoche 2012)".

Advocates of death with dignity legislation do not speak of the benefits to the general population as a reason for permitting medical aid in dying. Nor do they describe those who utilize medical aid in dying as unproductive or diverting society's assets. Rather, they seek legislation as a means for people to exercise a right to determine their own life—and its conclusion—rather than be subject to the whims of illness or medical technology. Unlike the Nazi promotion of a good death, which is imposed upon others, the good death sought by those who favor medical aid in dying is one that is imbued with personal autonomy.

The disanalogy between Nazi euthanasia programs and medical aid in dying can be seen in a statement the judges in the Doctors' Trial made in their verdict. They wrote, "Whether or not a state may validly enact legislation which imposes euthanasia upon certain classes of its citizens is a question which does not enter into the issues. Assuming that it may do so, the Family of Nations is not obligated to give recognition to such legislation when it manifestly gives legality to plain murder and torture of defenseless and powerless human beings of other nations" (Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10). The point of this statement is not to justify euthanasia morally or legally. It is to recognize that deliberation on the moral and legal soundness of euthanasia—and medical aid in dying—must take the issue on its own accord. Its morality and legality should not be determined through simple analogy or juxtaposition to the Holocaust and Nazi genocide.

Because the comparisons to the Holocaust are often absurd or logically fallacious, Godwin's law is typically accompanied by the following corollary: When a Hitler comparison is made, conversation ends and the one who draws the comparison loses the debate (The Daily Telegraph 2009). What is most dangerous about these absurd and fallacious arguments is that once they are recognized for what they are, they have also stopped any fruitful or thoughtful discussion on the ethical validity of the topic previously under examination. We should not set the bar of moral permissibility just above "not equivalent to the Holocaust." Medical aid in dying is not the same as

Nazi euthanasia, but that does not mean that it is a morally permissible position for society or the medical profession to uphold. The arguments that support the moral permissibility of medical aid in dying need to stand on their own accord and not in contradistinction to the Holocaust.

Yet, it is not the case that the Holocaust should never be a point of reference. As Godwin himself points out, his namesake law "is about remembering history well enough to draw parallels—sometimes with Hitler or with Nazis, sure—that are deeply considered. That matter. Sometimes those comparisons are going to be appropriate, and on those occasions GL [Godwin's Law] should function less as a conversation ender and more as a conversation starter (LA Times 2018)".

11.3 Godwin's Law, Ethics, and Historical Reflection

Bioethicists, like those in many other normative fields, have difficulty resting their arguments on the fact that something has previously occurred. The logical fallacies brought above reveal a greater difficulty for scholars of bioethics and the Holocaust, namely that study of history and of morality have very different foci. History is a descriptive field, while ethics is prescriptive, and philosophers are keen to point out the naturalistic fallacy, i.e. that one cannot learn an "ought" from an "is". However, Godwin is correct that the Holocaust and the political and medico-scientific discourse that preceded it should be a conversation starter. As Holland M. Kaplan correctly writes, "[T]he Nazi analogy does not aptly apply to PAD [physician aid in dying] in the United States today. But it does draw upon historically situated sources of fear that should inform how PAD legalization and implementation efforts account for health equity and social determinants of patients' vulnerabilities to discrimination (Kaplan 2021)". In other words, there is something to learn from the ways in which Nazi totalitarianism subsumed German society and in how the medical profession became "Nazified more thoroughly and much sooner than any other profession, and as Nazis they did more in service of the nefarious regime than any of their extraprofessional peers (Kater 2000)". The key is not to allow for study of the past to lead to bad arguments regarding decisions about the present and future. Essential to the study of the Holocaust for the sake of bioethical deliberation is to learn how and why certain arguments were persuasive then, even when they were bad arguments to begin with. When viewed in this manner, we follow what "Thucydides appears to assert when he says history is philosophy learned from examples" (Dionysius of Heraclea, *Ars Rhetorica*).

When drawing comparisons between the present and the past, scholars must be careful to recognize the differences between conceiving of the past through the lenses of history and through that of tradition. The former in essence tells a story of the past. The latter introduces the past as a prelude to the present. This distinction is especially important when looking to the Holocaust as a conversation starter on topics that speak to one's current goals and markers of identity.

The historian, regardless of which historiography she uses, tries to take herself outside of the lived experience to explain a sequence of events as an observer of a chain of causation. The historian looks backward to explain how something occurred. If the historian ventures into questions of why something occurred, she acts more as a philosopher than a historian, since she begins to look for purpose rather than process. Despite the absence of telos, however, the historian nevertheless feigns a deterministic philosophy, as the historian provides the explanation for what has occurred. She tells of the cause for the effect under study.

Determinism's grip in the historian's explanation of the past, however, does not have the same grip on the present or the future. Knowledge of the past allows one to avoid its repetition—as long as the explanation is correct and exclusionary. The normative implication for having the Holocaust be a conversation starter of contemporary topics in bioethics through a historian's lens is that society must avoid going down the same road for a second time. Not wanting to become Nazis or bring about another Holocaust, the historian warns that current laws or medical positions are too similar to those of pre-Holocaust Germany, such that they set society on course to repeat itself. When using the history of the Holocaust to tell a story that warns us that we are setting out on a road that we should avoid at all costs, risk of Godwin's law and its corollary arises. Rather than consider how our contemporary lived experience is different than pre-Weimar Germany, such warnings from history may unduly highlight the similarities—or false similarities—between today and the Holocaust so as to argue that we must change course.

The lens of tradition is not simply a premodern or a religious viewing of how the past has inroads into the present. Many medical and other professions conceive of their identities as emerging through the collective experience of generations who have shared the same professional goals and values. Similarly, patients' goals, their reservations about their care, and their apprehensions over giving too much power to medical professionals, stem from their experiences—both direct and vicarious through their parents and grandparents—and the history of the Holocaust and other violations of ethics and human rights. Both sides of the patient-physician relationship view their current roles and future possibilities through the lens of the past, even when looking to the future. This is especially the case with vulnerable or marginalized and minoritized populations. Moreover, social and political discourse continues to speak in terms of an arc of history and political trajectories. There are seldom successful hard stops and pivots in social life. We are products of our past as much as shapers of our future.

When the past is viewed through the frame of tradition, it serves to provide comprehensibility to the practices of contemporary citizens and professional practitioners. It explains why people engage in the practices they do and hold the beliefs that they have come to possess. Within the frame of tradition, the past neither determines the present, even if it influences it, nor is one entirely free from it, even if certain practices and beliefs fall out of favor and others are adopted. The thread that holds the past to the present is the overarching commonality either of purpose or of inertia.

Understanding what has occurred in the past will inform decisions that contemporary citizens and professionals make, but not in the same way as for the historian.

For the historian, history repeats itself by virtue of the laws of cause and effect. For the reflective citizen and for the informed professional, the lessons of the past can allow one to share the goals and values that one continues to share with previous generations yet avoid the pitfalls that caused previous generations to stumble. The past provides practical experience on a grand scale. Just as a person learns how she should behave by reflecting on her experiences, so can a people reflect on how best to move forward by considering how previous generations have conducted themselves.

The lessons of the Holocaust can supplement bioethical discourse on controversial topics, not only by serving to call out when ideas or policies are too close to Nazi ideas, but also by providing practical cases for how ideas become normalized and implemented. Study of the Holocaust and its aftermath provides examples for how individuals and society at large can become persuaded by unethical framing of arguments and how to prevent such lapses in judgment in the future. These lessons need not solely be learned because they are extreme, nor do they apply only in extreme circumstances. Conversation over how medical professionals and others were subsumed within the Nazi medico-political machine can lead to discussion on everyday practices and instances of preserving the dignity of human beings.

Society and the health professions cannot place upon individuals the onus of making value-laden medico-political decisions without providing them with the necessary tools and opportunities to learn how to weigh the different priorities and arguments that underlie these decisions. Learning about the history of the medical profession's views on euthanasia and how Nazi propaganda subverted medical authority is one way to achieve this goal. A historical account that includes Binding's and Hoche's work, for example, would allow medical professionals not only to understand the values at stake when deliberating on the different positions regarding medical aid in dying as they apply to the practice of medicine and the goals or ends of the medical profession. It would also provide real examples for how different positions of leading professionals on the topic can influence social and medical practice. Strengthening public discourse and the ethics of the medical profession depends on our ability to understand the past and integrate those lessons into current practice and policy debates.

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Chapter 12
From the Nuremberg "Doctors' Trial" to the "Nuremberg Code"

Paul Weindling

Abstract Guidelines on permissible clinical experiments were pronounced by the judges on August 19, 1947 at the close of the Nuremberg Medical Trial (NMT). Yet these guidelines were called the "Nuremberg Code" only starting in 1963, implying that only then were the guidelines invested with status as a fundamental bioethics document on proper research procedure. The aim of this chapter is to correct some misconceptions concerning the origins and implications of these guidelines. The first misconception is that the Code arose solely from courtroom proceedings. This misconception overlooks how during the post-war Allied liberation of Europe, victims of research and liberated prisoner doctors made a profound impression on Allied scientific intelligence officers. The second misconception is that the Code introduced the term "informed consent." However, although the judges stressed the autonomy of the research subject and the obligation to inform subjects about potential risks, the term did not appear in the guidelines of 1947. The third misconception is that the Code was not widely known until 1963. Yet, the principles promulgated by the judges received extensive publicity even before the guideline's official naming as the "Nuremberg Code."

Keywords Informed consent · Nuremberg trials · Nazi coerced experiments · Nuremberg code

12.1 Introduction

The origins of modern ethics codes on clinical research and practice were long seen as an achievement of jurists responding to legally presented evidence of medical atrocities in the Holocaust. However, deeper probing of surviving victims and prisoner doctors presented evidence of medical atrocities in court as framing the need to prevent coerced experimentation.

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Historical study of Nazi experiments on prisoners uncovers protest, sabotage and evasion both by victims and prisoner doctors against the experiments as illegitimate and unethical. This contradicts the assumption that prisoners were passive, silent victims and that it was only in the courtroom of the Nuremberg Palace of Justice that ethical principles were first debated and determined.

Prisoners had a strong sense that their rights were violated. For example, the self-styled Polish "Rabbits" (*króliki*) protested against experiments that deliberately made them disabled by deeply and painfully wounding their legs. Even some German doctors attempted to protest unethical experimentation, though many young researchers exploited prisoners in concentration camps justifying their actions on Germany's highly scientized system of medical education. For example, the assistant surgeon Fritz Fischer initially carried out experiments, yet eventually extricated himself by transferring to military duties on the Eastern Front.

Auschwitz became in a short time the location with the highest number of experiment victims and the location where Nazi doctors selected groups for further experimentation elsewhere. A definitive database provides a means for comparative evaluations. The declaration, "The Prisoner Doctors of Auschwitz to the International Public," issued on March 4, 1945, stated that prisoners had been treated as experimental animals, that the Allies and neutral states should bring to trial those responsible, and that prosecuting perpetrators would prevent coerced human experiments and medical atrocities in the future (The National Archives 1945). There were comparable efforts by liberated prisoner doctors to document Nazi medical experiments at the concentration camps of Buchenwald and Dachau. At the concentration camp of Bergen-Belsen, survivors of the death march from Auschwitz alerted British liberators to the widespread conduct of medical experiments. As a result efforts were made by scientific intelligence officers to collaborate with war crimes investigation teams to systematically document all experiments, not just those with surviving victims.

At a crucial meeting at the Pasteur institute in Paris from July 31 to August 1, 1946, the US physiologist Andrew Ivy formulated a code requiring participant consent in research. Telford Taylor decided that evidence for a medical trial was ready to go. Ivy was determined that any such trial should result in a regulative code fort human experiments.

The Nuremberg Medical Trial, held from December 5, 1946 until judgement on August 19, 1947, should be seen primarily as a trial revolving round the criminality of coerced experiments as well as an ethics tribunal. At times, the judges interrupted the criminal proceedings to ask for the ethical opinions of the defendants. Here, the judges appear to have been interested in the ethical mindset of defendants and not in proving their guilt. The trial differed from subsequent Nuremberg trials in that it concluded with a declaration of ethical principles by the judges. The trial included a large number of witnesses who were either subjects of Nazi research or witnesses to such experiments. This is unique in that other trials of Nazi criminals were primarily document based.

At the close of the Nuremberg Medical Trial (NMT) on August 19, 1947, the judges pronounced their guidelines on ethically permissible clinical experiments. From around 1963, these guidelines were called the "Nuremberg Code," thereby investing them with status as a fundamental document on proper research procedure. The status as part of a judgement at an international court set a precedent in adjudicating landmark cases of murderous and maiming conduct arising from coercive research.

12.2 Misconceptions

The aim of this chapter is to correct certain misconceptions concerning the origins and implications of these guidelines. The first misconception is that the Guidelines/Code arose solely from courtroom proceedings. This overlooks a prior agenda set upon the liberation of concentration camps, which was to secure a set of regulations to protect research subjects. In short, victims of unethical experimentation actively protested against, resisted and sabotaged these coerced experiments. Moreover, they also spoke out as witnesses at the NMT. Victims of research and liberated prisoner doctors had made a profound impression on Allied scientific intelligence officers, who then laid the ethical foundations for the NMT. Secondly, although the judges stressed the autonomy of research subjects and the obligation to inform subjects about potential risks, the key term "informed consent" did not appear in the guidelines of 1947. Thirdly, it is a misapprehension that the principles promulgated by the judges received neither publicity nor recognition.

12.3 The Nuremberg Medical Trial Agenda to Create a Code of Ethics

Prisoner documentation came to the attention of Allied scientific intelligence officers, notably the neurophysiologists Leo Alexander, a US military officer, and John Thompson, head of the British branch of the FIAT scientific intelligence organization (Weindling 2010). In 1945 Thompson interrogated Belsen doctor Fritz Klein, who had conducted experiments with mescaline and on the drug Rutenol in Auschwitz (The National Archives 1945). Concerned about the criminality of German wartime research, Thompson first identified the experiments as "Medical War Crimes" in November 1945. This specific form of medical criminality required scientific intelligence and war crimes investigation teams to collaborate. To attract attention to the problem of coerced experimentation, Thompson stated that 90% of German wartime medical research by leading scientists and clinicians was criminal (Weindling 2010, 137–148). Thompson organized a meeting on medical war crimes at the Pasteur Institute in Paris from July 31 to August 1, 1946.

Another key expert drawn to the Nuremberg Medical Trial was Andrew Ivy (1893–1975), a Chicago-based physiologist who had conducted war-time research on water desalination for the US Navy. Some servicemen had opted out during these experiments, and Ivy recognized their full autonomy to do so. Ivy was nominated by the American Medical Association for an appointment as Special Consultant (on Nazi medical research) for the U.S. Secretary of War in 1946. During this time, Ivy outlined a set of principles on medical research. Ivy's "OUTLINE OF PRINCIPLES AND RULES OF EXERIMENTATION ON HUMAN SUBJECTS" stated that:

I. Consent of the subject is required; i.e. only volunteers should be used.
   (a) The volunteers, before giving their consent, should be told of the hazards, if any.
   (b) Insurance against an accident should be provided, if it is possible to secure it.

II. The experiment to be performed should be so designed and based on the results of animal experimentation, that the anticipated results will justify the performance of the experiment; that is, the experiment must be useful and be as such to yield results for the good of society.
III. The experiment should be conducted
   (a) so as to avoid unnecessary physical and mental suffering and injury, and
   (b) by scientifically qualified persons
   (c) The experiment should not be conducted if there is a prior reason to believe that death or disabling injury will occur (Weindling 2004, 261–265).

This long-overlooked draft code was drawn up a year before the Guidelines of August 1947. It was the basis for mounting the NMT as well as a series of revisions in the suggested code. Thompson's investigations of medical crimes provided a basis for prosecution. The decision by Chief Prosecutor Telford Taylor to hold the NMT was made shortly after the Pasteur Institute meeting in August 1946 (Weindling 2004, 265).

The US Secretary of War then appointed Ivy to be an expert witness to the court at the NMT. Ivy had been nominated for this role by the American Medical Association. He had a strong sense of the need for medical research to be conducted on a Hippocratic basis in that the experimenter should do no harm and protect the welfare of the research subject. He was also in favor of prior animal experiments. He reflected, "I accepted the invitation to serve at the Nurenberg [sic] Trials only because I had in mind the objective of placing human beings in an international judicial decision the conditions under which human beings may serve as subjects in a medical experiment, so that these conditions would become the international common law on the subject" (Wellcome Library PP/MHP/C5 Ivy to Pappworth 6 April 1966; Gaw 2014). This confirms Ivy's agenda for becoming expert witness to the court.

The relations with the 1931 Reich circular on human experiments was to be an issue for the NMT defense and prosecution because its existence implied a prior code of ethics regulating German medical experimentation. That the Reich guidelines of 1931 retained validity has been confirmed (Weindling 2004). However, that all German research abided by the Reich directive was a misleading claim by a defensive German medical establishment and defendants (Weindling 2004).

Ivy saw the matter of the doctors' criminality in terms of their violation of the Hippocratic Oath. On December 28, 1946, the journal of the American Medical Association (JAMA) published recommendations for an abbreviated Code. Among the requirements: "The voluntary consent of the individual on whom the experiment must be performed must be obtained. The danger of each experiment must be previously investigated by animal experimentation. The experiment must be performed under proper medical protection and management" (AMA Judicial Council 1946, 35). During the NMT, Ivy assessed German/Austrian medical research. He astutely observed that the defendant Wilhelm Beiglböck altered records of the Dachau experiment on making seawater drinkable, so as to conceal the effects of the different types of desalinated seawater on victims. The judges consequently increased the sentence (Weindling 2017).

Ivy's main achievement was to drive forward the agenda of creating an international code of ethics for medical experimentation. As Ivy reflected in 1964, "The judges and I were determined that something of a preventative nature had to come out of the "Trial of the Medical Atrocities" (Ivy in Ladimar I, Newman, R eds, Clinical Investigation in Medicine: Legal, Medical and Moral Aspects, Law-Medicine Research Institute Boston University, 1963, 116 "The Nuremberg Code"; University of Wyoming Ivy Papers, Ivy to Ladimar, 23 March 1964. His sense of mission is confirmed by a Special Press Release of January 22, 1947: "Dr Ivy … left Nuremberg with the recommendation that an international legalised code of ethics should be published on the use of human beings as experimental subjects."(Archives de France, BB/33/260, folder 4c Special Release no. 104, 23 January 1947, OCCWC). Ivy shows a clear conviction that the NMT should conclude with a set of ethical principles, and he successfully persuaded the judges in making such a declaration as a preliminary finding to their judgement.

12.4 The Victim's Voice

The Nuremberg Medical Trial was distinctive in that victims had a key role as witnesses. The NMT relied more on victim testimony than either the four-power International Military Tribunal or the later American military-administered trials. The prosecutors made radio appeals in German, Czech, and Polish for witnesses and victims of medical experiments. Letters from experiment and sterilization victims provided significant testimony. Victims' organizations, such as *Opfer des Faschismus* (Victims of Fascism) and the *Betreuungsstelle für Sonderfälle* (Care Office for Special Cases) also sent evidence to the Nuremberg prosecution (Archives de France BB/35/268 documentation relative aux expériences médicales, no year). The victims' voice was important in shaping views on the need for consent (Shuster 1997, 1998).

One victim of X-ray sterilization stated that he had come forward as a result of the radio call for witnesses. Leo Alexander, a US military physician with duties in aviation medicine and originally a graduate of Vienna University, was appointed expert witness for the prosecution. He wrote about the victim of X-ray sterilization experiments at Auschwitz:

> When he heard over the radio that the people responsible for the German medical atrocities are going to be tried, he decided that it was his duty to come here and to testify although he is afraid that, especially if his name is printed in newspapers, his sisters might find out about his condition that way. However, he feels that it is his duty to be helpful in bringing those responsible for the atrocities, to which he and others have been subjected, to justice.
>
> It appears that he is one of 100 young Jewish boys who were castrated for no reason other than to confirm the fact that they had been sterilised by sufficient Xray radiation as if Xray burns which resulted from a fifteen minute exposure were not enough to prove that point (Archives de France BB/35/260 Folder: Sterilisations. Interrogations et comptes-rendus d'interrogatoire: Alexander 22 November 1946).

Victims took the initiative in alerting the police about medical criminals. In February 1946, Dachau survivors alerted the Austrian state police that the Vienna specialist in internal medicine Wilhelm Beiglböck had conducted a painful experiment in Dachau by testing the salt water solutions derived from different methods of desalination of salt water on patients over a number of days. The investigations uncovered the involvement of the celebrated internist Hans Eppinger of the Vienna Medical Faculty, and led to the arrest of Beiglböck in Lienz in the British zone of occupation. Beiglböck was transferred to Nuremberg by the British in September 1946. He was the one Austrian defendant at the Medical Trial (Weindling 2017). Beiglböck was a member of the SA, and not one of the seven SS doctors on trial. Yet he was drafted in to Dachau concentration camp to direct these experiments.

There were three non-medical defendants, all SS members: Viktor Brack of the Chancellery of the Führer, responsible for euthanasia and Xray sterilization experiments, Rudolf Brandt, Himmler's Secretary involved in arrangements for experiments on concentration camp prisoners, and Wolfram Sievers, manager of the SS Ahnenerbe research organization.

In the case against Beiglböck, the Sinto ("gypsy") witness Karl Höllenrainer punched Beiglböck when asked to identify him in court. Höllenrainer's testimony stressed mistreatment and coercion. Beiglböck was accused of drawing a pistol to force a Sinto, who had already survived the freezing water and malaria infection experiments at Dachau, to submit to the desalination experiment. However, the prosecution failed to prove any fatalities from the experiment. Although one research subject died before liberation, the connection with the experiment is unclear (Dörner et al. 1999; Spitz 2005, 151, 163).

On July 17, 1947, the defense lawyer Gustav Steinbauer gave an eloquent and revealing final plea for Beiglböck, imploring that deaths should be accepted as a necessary cost of medical progress:

> Over the entrance gate of the General Hospital in Vienna we read the words "Saluti et solatio aegrorum-Dedicated to the health and consolation of the sick." These words not only demand the highest accomplishment of the doctor's duties but are the motive for the most

> successful work in the large field of medical research. Theory and practice joined together in order to become a piece of living humanity. I would go beyond the limits of my task if I mentioned all the names that spread the glory of Vienna University throughout the world. But their penetration into the world of the unknown was always a hazardous enterprise which demanded courage and sacrifice.
>
> I want to quote the words of one of the great doctors, Professor Wagner-Jauregg, who says in his book "Fever and Infection Therapy,", "The vaccination against malaria was certainly a risk, the outcome of which could not be foreseen. It was dangerous for the patient himself and this to a much higher degree than the treatment with tuberculin and other vaccines, and it also was a danger for the surroundings and even for the community."
>
> And, on page 136, it states "Three patients died after having been vaccinated with blood infected with malaria tropica and not with malaria tertian;" and "The tragic outcome of this experiment was discouraging, and only a year later could the author decide to proceed with the malaria vaccinations…" Nobody talks of these victims today, but Wagner-Jauregg's revolutionary discovery is known and adopted throughout the world and has become the common property of all peoples for the benefit of suffering mankind…. (Steinbauer 1947 Nuremberg Medical Trial, p. 6412)

The judges' concluding principles sought to refute such dangerous arguments made by a series of defendants that injury and death of human subjects are necessary for medical progress.

With this aim in mind, US and British scientific intelligence officers Leo Alexander, Keith Mant, and John Thompson collected evidence from victims. The Court proceedings ran on two levels. It was an international trial to determine culpability for the consequences of aggressive war resulting in crimes against humanity, but it was also an ethics tribunal concerned with the medical validity of the research and consent of the research subject. The conduct of the trial involved periodic ethical discussions. The judges asked defendants for their opinions. Kurt Blome and Karl Brandt gave their opinions on clinical experiments. Blome's statement that prisoners should always be volunteers and receive a reduction of sentence or an amnesty showed criticism of the concentration camp experiments. The defendants were permitted to cross-examine expert witnesses (Nuremberg Medical Trial Transcripts 1947, p 11,302 for 17 July 1947 http://Nuremberg.law.harvard.edu/transcripts/1-transcript-for-nmt-1-medical-case?seq=11450&q=+type:transcripts.). At one stage, Ivy was cross-examined by the defendants Ruff, Rose and Beiglböck. The Trial had a dual character as a criminal court and as an ethics debating chamber.

12.5 From Ethical Debate to the Final Declaration

On December 7, 1946, just after commencement of the NMT, Alexander noted that he had finished his own written guidelines for ethical and unethical human experimentation. This text outlined the conditions for "permissible experimentation by a doctor" (Alexander 1976). As in Ivy's draft guidelines of August 1, 1946, Alexander required consent—meaning the full understanding of the issues being investigated, and voluntary participation of the experimental subject. While Ivy required the experiment to be useful, Alexander preferred a more generalized viewpoint, requiring only that the experiment should not be unnecessary. Both, however, concurred that results should be for the good of society. This overlap suggests that Alexander took Ivy's report as a basis for his views. Alexander nevertheless amplified the concept of consent, such that it would be based on a proven understanding of the exact nature and consequences of the experiment. He considered that a doctor or medical student was most likely to have the knowledge base and capability for full understanding. The degree of risk was justified by the importance of the experiment and the readiness of the experimenter to risk his own life. Overall, Alexander produced a more rigorous set of requirements than either Ivy or the minimalist AMA code.

Rather than informed consent, the expression of choice at the trial was of a "Voluntary Consent," which includes disclosure of risks. Alexander also noted the intention of the judges to rule on issues of experimentation at the end of the NMT: "As we have anticipated all along the defense is making a concerted effort to introduce a great deal of literature on human experimentation in other countries. So far we have been successful in keeping out most of the proof, but the Tribunal has stated that it will rule on this question at the conclusion of the case" (Archives de France 1947, BB/35/260 Folder 4c, 4 May 1947). The judges provided a distillation of the Alexander and Ivy drafts along with stress on the autonomy of the research subject. Voluntary consent meant that "the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision…" (Trials of War Criminals before the Nuremberg Military Tribunals, vol. 2. Washington DC: US Government Printing Office 1949, 181–183).

12.6 Publicizing the Guidelines

The declaration on permissible experiments provided criteria for judgment of the 23 defendants. Yet, it was also intended to have wider circulation, thereby fulfilling Ivy's hope of entering the international common law on medical experiments. Telford Taylor had been meticulous in allowing press access and inviting international jurists to be present at the trial as observers. The presence of the German medical delegation throughout the trial was remarkable, because Taylor wished to show impartiality of the court to the German medical profession. The judgement was publicized in German by Alexander Mitscherlich and Fred Mielke in their NMT overview *Wissenschaft ohne Menschlichkeit* (Mitscherlich and Mielke 1949a), and in French by François Bayle, the French military observer in his study of the Trial (Bayle 1950, 1493, 1495). Importantly, in 1949 Telford Taylor published the guidelines on "Permissible Medical Experiments" in his contribution to *Doctors of Infamy*, which was based on the interim publication by Mitscherlich and Mielke, with additional contributions by Taylor, Ivy and Alexander (Mitscherlich and Mielke 1949b). The volume included a draft apology, which the German delegation declined to make at the first World Medical Association (WMA) meeting, and a concise version of the WMA's revised version of the Hippocratic oath, which was oriented to apply to practitioners. Commentators have suggested the impact of the Nuremberg Medical Trial on various international conventions and agencies, notably the WMA and ultimately the Helsinki Declaration for medical research involving human subjects. The WMA and WHO closely engaged with each other on the issue of war crimes committed by the medical profession and issued a preliminary report on "War Crimes and Medicine. The German Betrayal and a Restatement of the Ethics of Medicine" in 1948 (World Medical Association 1947). US military and official agencies took note of the NMT judicial guidelines (Advisory Committee on Human Radiation Experiments 1995).

The judges' guidelines on permissible experiments were a distillation of a wider post-WW II discourse in which victims played a crucial role. Each version of the guidelines needs to be contextualized so as to understand the agendas of the various participants. For example, the expert witness Ivy had a firm agenda, which he impressed on the judges, prompting their guidelines on permissible experiments. Ivy's original principles of August 1946 served as a starting point, which was then elaborated on by Alexander before the NMT judges finally added the additional principle of the autonomy of the research subject. The guidelines were accepted and publicized and made readily available as a reference document in English, French and German in the period after the NMT. This explains the widespread acceptance of these guidelines in medical jurisprudence in the early 1960s as the definitive "Nuremberg Code".

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Chapter 13
The Holocaust as an Inflection Point in the Development of Research Ethics

Stacy Gallin and Ira Bedzow

Abstract Modern research ethics arose as a response to the scientific and medical communities' participation in the Holocaust. The Holocaust remains the only example of medically sanctioned genocide and thus can provide critical lessons regarding the importance of valuing basic ethical principles ahead of the potential for scientific progress in the contemporary context of research ethics. This chapter will explore the trajectory of research ethics using the Holocaust as an inflection point. It will briefly describe the difference between medical and research ethics before and after the Holocaust, and then show how the lessons of the Holocaust not only influenced the creation of the Nuremberg Code but also the subsequent development of the Declaration of Helsinki, the Belmont Report, the Federal Policy for the Protection of Human Subjects (The Common Rule) and the International Ethical Guidelines for Biomedical Research Involving Human Subjects.

13.1 Introduction

The Holocaust is a unique event, both in the history of genocide and in the history of professional ethics. As an incidence of mass murder, the Holocaust is the only instance of medically sanctioned genocide, where mass murder was framed as an issue of public health and implementation of the state's ethnic cleansing was overseen by the medical community through systematic labeling, persecution, forced sterilization and eventual killing of those deemed "unfit" or racially inferior. In the history of professional ethics, the Holocaust serves as a unique inflection point, where ethical standards in medicine and research went from being a priority internal to the medical profession to one that became subject to the oversight of society at large. The worldwide shock of hearing about the abrogation of ethics on the part of the

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medical and scientific communities during the Doctors' Trial at Nuremberg became the impetus for the Nuremberg Code, which is widely accepted as the "constitution" of bioethics and research ethics (Caplan 2010). Exploring the genesis of the Nuremberg Code and its impact on subsequent codes of ethics is essential to understanding the development of modern research ethics.

Bioethics consists both of medical ethics and research ethics, which are distinct fields with their own practical applications. The former consists of regulating the ethical relationship between patients and physicians, while the latter regulates the relationship between subject and researcher. These two relationships are not exactly the same, since the goals of medicine and the goals of research differ. However both subfields of bioethics are each founded on the same moral principles: i.e. respect for autonomy, nonmaleficence, beneficence, and justice (Beauchamp and Childress 1979). While entire books have been written offering definitions for these terms, for the purpose of this chapter they will be defined as follows: Respect for autonomy is the principle that recognizes the right of individuals to make informed decisions and the need for health care professionals to respect those decisions. Nonmaleficence and beneficence are complementary ethical principles; the former refers to the duty of researchers and medical providers to avoid harming patients and minimize potential risk to them, and the latter refers to the duty of maximizing benefit either to the subject/patient and/or the larger community. Justice takes two forms, procedural justice is the principle which implies the duty to treat "like cases alike," in other words, to provide fair and equal treatment of humans; substantive justice demands an equal distribution of the benefits and burdens of research so that the burden of research does not fall on any individual or particular population (Beauchamp and Childress 1979). These principles existed as part of the ethics of medicine and research dating back to the beginning of the nineteenth century even before the Nuremberg Trial; however, these principles were only formally incorporated as the foundation of bioethics and research ethics in the 1970s. Only after the Holocaust were these principles given priority. Moreover, only after the Holocaust did society at large take an active role in attempting to emphasize and hold physicians and researchers accountable for them, especially the principle of respect for autonomy, even if each of these four principles is a fundamental element of current research ethics.

When physicians who took an oath to heal were put on trial at Nuremberg for unspeakable crimes against humanity including torturous experiments performed on prisoners of war who did not—and could not—consent, both the prosecution and the defense were immediately tasked with seeking out historical examples of research ethics to bolster their arguments. A review of the history of international research ethics and those specific to Germany were necessary.

This chapter will provide a brief history of research ethics, noting the change in priority after the verdict and the publication of the Nuremberg Code. The influence of the Nuremberg Code on the development of subsequent codes of ethics, including the Declaration of Helsinki, the Belmont Report, the Federal Policy for the Protection of Human Subjects, and the International Ethical Guidelines for Biomedical Research Involving Human Subjects will be examined. The latter portion of the chapter will shift focus to address significant issues that have arisen from the codification of research ethics, such as the necessity of informed consent and the practical difficulties caused by a lack of adequate definitions for key terms within the codes. The current debate regarding what constitutes a vulnerable population and what types of special protection should be offered to these groups of people will be considered. The rapid pace at which medical science continues to advance necessitates a thorough reevaluation of the current state of research ethics in order to ensure the protection of human dignity regardless of the possibility of scientific or societal advancement. Finally, the chapter will end with the suggestion of a paradigm shift away from the rigid protectionism that has resulted from the codification of ethics towards a moral professionalism that uses the Holocaust as the historical framework for developing a personal and professional code of ethics that guides future generations of researchers. While the Holocaust served as an important inflection point in research ethics, since it was the impetus for developing formalized regulations that were created and enforced by entities external to the medical profession, a consequence of this has been a reduction in the internal moral motivations of professionals to demand ethical integrity of the profession, as was found in pre-Holocaust medical ethics. Finding a balance between internal and external ethical requires synthesizing the ideological goals of traditional medical ethics with the practical needs of modern research ethics in order to encompass the benefits of both.

13.2 History of Research Ethics Pre-World War II

While the explicit purpose of the Doctors' Trial at Nuremberg was not to explore the concept of research ethics, the nature and magnitude of the trial led to the recognition of the need for a universal set of standards established by a governing body to ensure ethical human subject experimentation rather than continued reliance on ethical compliance that was internally motivated (Grodin 1992). This recognition stemmed from the strategies of both the prosecution and the defense in the trial, which utilized the (brief) history of research ethics as part of their legal strategies to show how research ethics should be understood as an affair internal to the medical profession. The prosecution based their historical arguments on the work of Hippocrates, Thomas Percival, William Beaumont, and Claude Bernard, while the defense argued that in order to appropriately contextualize the behavior of German physicians operating under National Socialist rule, German codes of ethics must be used as the benchmark.

The Hippocratic Oath is perhaps the most well-known and influential example of an explicit ethical standard to which physicians committed themselves. It was written between 470 and 360 B.C.E. and unequivocally states that the physician's foremost responsibility is to act in the best interest of the patient: "I will follow that system of regimes which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous" (Grodin 1992, p. 123). While the Hippocratic Oath was written well before the introduction of the four principles upon which modern bioethics and research ethics are founded, Hippocrates' writings emphasize the necessity of beneficence and nonmaleficence in the care of the patient, despite never specifically referencing any type of human experimentation.

In 1803, an English physician named Thomas Percival wrote what is believed to be one of the earliest codes of medical ethics, where he mentioned research ethics explicitly. Although Percival's code focused mostly on clinical practice, he included a section expressly dealing with human experimentation:

> Whenever cases occur, attended with circumstances not heretofore observed, or in which the ordinary modes of practice have been attempted without success, it is for the public good, and in especial degree advantageous to the poor (who, being the most numerous class of this society, are the greatest beneficiaries of the healing art) that new remedies *and new methods of chirurgical treatment* should be devised but, in the accomplishment of the salutary purpose, the gentlemen of the faculty should be *scrupulously and conscientiously governed by sound reason, just analogy, or well-authenticated facts.* And no such trials should be instituted without a previous consultation of the physicians or surgeons according to the nature of the case (Grodin 1992, p. 124).

William Beaumont's 1833 code of ethics expanded upon Percival's work and included a directive regarding the absolute necessity of voluntary consent. Beaumont wrote, "The voluntary consent of the subject is necessary…The experiment is to be discontinued when it causes distress to the subject" (Grodin 1992, p. 125). Beaumont's work is significant in that it is the first documented code that includes the concept of informed consent, or what Beauchamp and Childress would later refer to as respect for persons/autonomy. Informed consent became the cornerstone upon which the Nuremberg Code was founded and, to this day, continues to be a source of great debate within the field.

In 1865, French physiologist Claude Bernard published his seminal work, *An Introduction to the Study of Experimental Medicine*, in which he proposed his own principles of ethical human experimentation:

> It is our duty and our right to perform an experiment on man whenever it can save his life, cure him or gain him some personal *benefit*. The principle of medical and surgical morality, therefore, consists in never performing on man an experiment which might be harmful to him in any extent, even though the result might be highly advantageous to science, i.e., to the health of others…Christian moral ethics forbid only one thing, doing ill to one's neighbor. So, among the experiments that might be tried on man, those that can only *harm* are forbidden. Those that are innocent are permissible, and those that may do good are obligatory (Grodin 1992, pp. 125–126).

While Bernard's code does not deal with informed consent, it does reference beneficence and nonmaleficence. It also touches upon the concept of justice by explicitly prohibiting human experimentation solely for utilitarian purposes.

The prosecution used each of these codes to argue that the history of research ethics mandates that the physician act in the best interest of the patient. The experimentation that had taken place during World War II were clearly not examples of physicians acting in the best interests of their patients. However, the defense argued that the experiments performed by National Socialist physicians under the Third Reich could only understood in context of German standards. Thus, they aimed to provide a brief history of German medical ethics pre-World War II.

13.2.1 German Research Ethics

Much like German medicine and science, German research ethics at the beginning of the twentieth century was much more advanced than the rest of the world. On December 29, 1900, the Prussian Minister of Religious, Educational and Medical Affairs published a statement regarding human experimentation (Grodin 1992). It is important to note that this document was issued by an official government organization, as opposed to the academic codes of ethics written by Hippocrates, Percival, Beaumont, and Bernard. This document is also unique in that it specifically references both the needs of vulnerable populations and the necessity of informed consent. Not only does this document set forth theoretical principles, it also enumerates the exact methodology for conducting ethical experimentation with human subjects (Grodin 1992). On February 28, 1931, the German Ministry of the Interior published a Reich circular entitled, "Regulations on New Therapy and Human Experimentation," which included the majority of the tenets later cited in the Nuremberg Code (Grodin 1992). Again, it is crucial to understand that these regulations did not arise from within the medical community, but rather from the government (Bruns and Chelouche 2017). This document, published not long before the Third Reich formally rose to power, was considered to be far superior to any guidelines that had come before it and, ironically, even to many that came afterwards, specifically the Nuremberg Code and the Declaration of Helsinki (Grodin 1992). However, these documents did not invest authority to international or other regulating bodies to hold researchers accountable for unethical conduct, leading medical researchers to justify their actions as ethical when they complied with the politics of the Third Reich.

As World War II was officially beginning, Germany was advancing medical ethics for physicians, yet in truth was politicizing medicine and medical research. The Nazis created an entirely new field within medical education called Medical Law and Professional Studies. The goal of this field was to merge medicine and politics by inculcating a new generation of doctors with the ideological goals of the Nazi party, including "the unequal worth of human beings, the moral imperative of preserving a pure Aryan people, the authoritarian role of the physician, the individual's obligation to stay healthy, and the priority of public health over individual-patient care" (Bruns and Chelouche 2017, p. 591). The paradigm shift that took place between the ethical codes issued by the government in 1900 and even in 1931 and the new curriculum that took hold in 1939 is significant. The new code of ethics under the Nazis abandoned the traditional ideals of respecting the person and acting in the patient's best interest in favor of an ethos that valued the health of society and viewed the patient as a utilitarian means to an end who was useful only so far as he or she could benefit the greater good. It was this *transformation* of ethics, rather than what has traditionally been seen as a lack of ethics, that the defendants used to argue their case at the Doctors' Trial.

13.3 Doctors' Trial and the Publication of the Nuremberg Code

On December 9, 1946, Chief Prosecutor Telford Taylor argued in his opening statement, "[T]he defendants in this case are charged with murders, tortures, and other atrocities committed in the name of medical science" (1992, p. 67). He continued:

> Whatever book or treatise on medical ethics we may examine, and whatever expert on forensic medicine we may question, will say that it is a fundamental and inescapable obligation of every physician under any known system of law not to perform a dangerous experiment without the subject's consent. In the tyranny that was Nazi Germany, no one could give such consent to the medical agents of the States; everyone lived in fear and acted under duress" (1992, p. 89).

His opening statement included descriptions and accusations of the horrific acts of the physicians, however it also served as a call to action regarding the broader topic of appropriate guidelines for human experimentation. As a result, while the main focus of the tribunal was on the behavior of the physicians on trial, questions about the lack of guidelines regulating human experimentation persisted throughout the tribunal.

The conclusion of the trial followed the same pattern. On August 20, 1947, 16 of the 23 physicians were convicted of war crimes and crimes against humanity and 7 were sentenced to death (Judgment and Aftermath 1992). However, just as Telford Taylor advocated for a larger ethical accounting to the medical profession writ large than simply charging the defendants with murder and torture, the judgment at Nuremberg likewise did not stop with giving its verdict on the individuals on trial. Fully cognizant of the significance of the testimony and documentation before them, the court established universal guiding principles to govern human subject experimentation. The Nuremberg Code set forth ten principles for the ethical conduct of human experimentation, beginning with "The voluntary consent of the human subject is absolutely essential" (Nuremberg Military Tribunal 1947). The purpose of the code was to:

> set the general agenda for all future ethical and legal questions pertaining to the conduct of human experimentation. What are the individual and societal values that justify science and technology? What are the source and the imperative of the quest for knowledge? Who decides on the limits of scientific endeavors? Who determines the benefits and who sets the research agenda? ... How willing are we to risk human life to serve individual or societal ends? ..." (Annas and Grodin 1992a, b, p. 6).

The publication of the Nuremberg Code was a pivotal moment within the history of research ethics. The creation of a universal standard for the ethical approach to human subject experimentation was revolutionary: however, the difficulty in translating the ideological goals of the Nuremberg Code into practical application soon became apparent.

13.4 Codification of Ethics Post Nuremberg

The Nuremberg Code was created in response to unspeakable abuses of human dignity and ethical misconduct within the medical profession. While the creation of the Nuremberg Code was a necessary step in the codification of research ethics and the development of accountability within the field, its unwavering focus on informed consent ultimately proved to be problematic for those attempting to conduct research with populations incapable of meeting the very strict requirements for informed consent laid out by the Nuremberg Code. Over the next few decades, several other codes of ethics were created in response to similar scandals. Each code attempted to fix perceived inadequacies found in earlier codes and respond to the violations of ethics brought to light by the most recent scandal.

13.4.1 Declaration of Helsinki

The Nuremberg Code was published in 1947 and mandated the absolute necessity of obtaining voluntary informed consent. Coming at the end of a trial in which the lack of voluntary informed consent became a focal point of the prosecution's argument, informed consent seemed to be a necessary prerequisite for any meaningful code of ethics. The closing arguments for the United States at the Doctors' Trial included a statement by James McHaney, the Chief Prosecutor for the Medical Case, in which he maintained:

> There are, indeed, other prerequisites to a permissible medical experiment on human beings…*important as these other considerations are, it is the most fundamental tenet of medical ethics and human decency that the subjects volunteer for the experiment after being informed of its nature and hazards. This is the clear dividing line between the criminal and what may be noncriminal. If the experimental subjects cannot be said to have volunteered, then the inquiry need proceed no further. Such is the simplicity of this case* (Grodin 1992, p. 137).

However, as research ethics developed as a field, the idea of voluntary informed consent began to come into question. From a theoretical perspective, it made sense that a researcher would always attempt to secure informed consent from a subject. However, this requirement precluded the possibility of engaging in potentially valuable research involving children or the mentally ill, who cannot give voluntary informed consent. This perceived obstacle established by the Nuremberg Code to protect vulnerable populations seemed to be preventing them from receiving possible advantages that could be gained through productive medical research.

In response to this challenge, *The Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects* was published by the World Medical Association in 1964. Providing a mechanism for allowing research on populations who could not provide voluntary informed consent that conformed to the strict guidelines laid out in the Nuremberg Code appeared to be a primary factor in the decision to draft this document (Emanuel 2003a, b). The Declaration of Helsinki offered provisions for the consent of a legal guardian when the voluntary informed consent of the subject could not be obtained, thus meeting the practical challenges associated with conducting clinical research in the 1960s.

13.4.2 Belmont Report

When the Nuremberg Code was first published, medical researchers in the United States did not immediately see the relevance between what took place in Nazi Germany and research that was being done stateside. Dr. William Silverman described the experience of American physicians as part of the Advisory Committee on Human Radiation Experiments' Ethics Oral History Project as follows: "There was a disconnect…The interpretation of these Codes was that they were necessary for barbarians but [not for] fine upstanding people" (Faden et al. 2003, p. 8). However, after Beecher's (1966) article in the New England Journal of Medicine exposed 22 research violations conducted by leaders in the field at major research institutions throughout the country, the ethics of human experimentation began to receive more attention. Only after the details of the Tuskegee Syphilis Study were made public was the National Research Act was passed into law in 1974 and the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created (Emanuel 2003a, b).

One of the most important tasks of the National Commission was to produce a statement of ethical principles that would govern research with human subjects and prevent ethical transgressions like Tuskegee from recurring. On April 18, 1979, the *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was published (Emanuel 2003a, b). This document was founded on three principles that were "generally accepted in our cultural tradition: "respect for persons, beneficence and justice" (Emanuel 2003a, b, p. 26). The Belmont Report also attempted to delineate boundaries between practice and research and provide clear definitions for terms so as to avoid issues in a practical setting.

13.4.3 Federal Policy for the Protection of Human Subjects

Despite the previous international and national codes, the United States recognized the need for administrative law that could implement practical guidelines for ethical research and delineate particular norms that could be followed in practice. The US Department of Health and Human Services, National Institutes of Health, and Office for Human Research Protections published the Federal Policy for the Protection of Human Subjects, also referred to as The Common Rule, in 1991. The Common

Rule was heavily influenced by both the Declaration of Helsinki and the Belmont Report, however it differs in certain significant ways. First, the Common Rule established guidelines that were mandatory for institutions receiving financial support from the federal government. It also created a method for overseeing these experiments in the form of Institutional Review Boards, or committees that review research methodology to ensure the ethical nature of the experiment at various points within the process. The Common Rule also extends special protections to experiments pertaining to vulnerable populations: pregnant women, human fetuses, neonates, prisoners, and children. Within the United States government, there are currently 20 agencies that have signed on to follow the revised version of the Common Rule that went into effect in July 2018 (https://www.hhs.gov/ohrp/regulations-and-policy/regulations/common-rule/index.html). The fact that these regulations are compulsory for institutions receiving federal support and that the document established a means by which to enforce these guidelines makes the Common Rule unique among ethical codes.

13.4.4 International Ethical Guidelines for Biomedical Research Involving Human Subjects

In 1982 the Council for International Organizations of Medical Sciences (CIOMS) in collaboration with the World Health Organization (WHO) established a set of International Ethical Guidelines for Biomedical Research Involving Human Subjects. A major impetus for the development of this document was the rapid growth of international human subject research, particularly between developed and developing nations looking for a solution to the HIV/AIDS crisis (Emanuel et al. 2000). The need to balance research and protect human subjects is reflected in the opening of the CIOMS guidelines:

> The ethical justification of biomedical research involving human subjects is the prospect of discovering new ways of benefiting people's health. Such research can be ethically justifiable only if it is carried out in ways that respect and protect, and are fair to, the subjects of that research and are morally acceptable within the communities in which the research is carried out (CIOMS 2002).

The CIOMS guidelines incorporate the principle of justice and aim to ensure that those who are exposed to the risks of research also benefit from potential rewards, which had been a concern raised by the advent of clinical trials for HIV/AIDS drugs conducted by pharmaceutical companies in developing countries.

13.5 Key Issues

13.5.1 Informed Consent

The goal of the Nuremberg Code was to create a set of moral principles that would guide international research involving human subjects in the wake of the ultimate example of what can happen without any type of ethical regulations. However, due to the unique circumstances in which the code was developed, special emphasis was placed on the need for voluntary informed consent. The prosecution at the Doctors' Trial "did not rest their case on the distastefulness of the purposes of the researchers or on the epistemological style or value of the research design or even on the pain and suffering experienced by the human subjects" (Feldman 2014, p. 303). Rather, the prosecution chose to focus their argument specifically "on the failure of the researchers to treat those they experimented with as autonomous individuals capable of giving or declining consent to participate" (Feldman 2014, p. 303). Seen from this perspective, the emphasis on informed consent aligns with the bioethical principle of respecting the person and treating him or her as an autonomous agent. The lack of respect for the individual's ability to make autonomous decisions is a key component of the dehumanization that was so crucial to the systematic mass murder of millions of people deemed "unfit" or "racially inferior."

Feldman argues:

> the point of making autonomy central to human subjects research regulation is to ensure that potential subjects understand such risks, and then choose for themselves whether to participate in research. The significance of autonomy does not vary according to the type of possible injury, although risks of different kinds of injury may require different techniques for ensuring autonomous participating in human subjects research (Feldman 2014, p. 310).

Those who take this view contend that autonomy is the key component not only to the Nuremberg Code, but to any meaningful code of ethics. It is the autonomy of the individual that is paramount, not the level of risk or the methodology by which one obtains consent.

Autonomy and respect for persons has always been a central tenet in bioethics and research ethics, however its practical application and regulatory oversight has proven to be problematic in many cases. This was the primary motivating factor behind the development of the Declaration of Helsinki and subsequent legislation. Removing the strict requirements for voluntary informed consent was seen as a way to make it easier to include a broader audience of research participants, thus fulfilling other bioethical principles such as justice due to fair subject selection, and later laws like the Common Rule made sure that researchers would comply with these rules in order to secure their funding.

The argument against the standards of informed consent set forth in the Nuremberg Code is that not all human subject experimentation poses the same amount of risks, therefore not all experiments should be subjected to the same strict regulations. Rhodes argues that:

> the Nuremberg Code, the original 1964 version of the Declaration of Helsinki, and the Common Rule all explicitly endorse a view that research risks should be balanced against societal benefits that the project promises. Nevertheless, implementation of the current rules often seems to ignore the importance of adopting a balanced approach (2014, pp. 37–38).

Seen from this perspective, mandating voluntary informed consent negates potential societal benefits that could be gained from experiments that pose extremely minimal risks to the subject. Rhodes contends that the strict regulations make it impossible to conduct what she terms "*de minimis* risk" experiments, i.e.: those "involving only negligible physical, social, or psychological risk where nothing inherently dangerous, such as using identifiable leftover blood sample, is done to the body" (2014, p. 37). She states that there should be no requirement to obtain informed consent for studies that pose *de minimis* risk, and that attempts to protect individuals from any and all potential risks are hindering scientific advancement. "Policies that consider only the risk, and deliberately ignore the possible social benefits that research could provide," Rhodes asserts, "express a distorted view of what ethics entails and therefore produce regulations that are ethically flawed" (2014, p. 38). The concept of informed consent that was at core of the Doctors' Trial at Nuremberg remains the focus of much debate within modern research ethics.

13.5.2 Lack of Adequate Definitions

In addition to the problems surrounding the term "informed consent," the lack of adequate definitions for key terms within subsequent documents have continued to cause ambiguity and controversy for the field. Designating where research ends and therapeutic treatment begins, in particular, has generated much contention. The American Medical Association was concerned that the Belmont Report would intrude upon the "ordinary practice of medicine," and thus ensured that the final document would contain a section delineating the "boundaries between biomedical or behavioral research involving human subjects and the accepted and routine practice of medicine." (Schrag 2014, pp. 288–289). Ultimately, after confusion about phrases such as "social research" and "generalizable knowledge," the Belmont Report defined practice as referring to "interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success. The purpose of medical or behavioral practice is to provide diagnosis, preventative treatment, or therapy to particular individuals" (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979). Research is defined as "an activity designed to test an hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements or relationship). Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective" (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979).

While the National Commission and the American Medical Association worked in tandem to create definitions that would be mutually beneficial to professional organizations and associations working in both the fields of medicine and research, scholars have noted that in practice, it is extremely difficult to differentiate between clinical research and medical practice, when patients are recruited for clinical trials. Chalmers stated, “Because episodes of illness and individual people are so variable, every physician is carrying out a small research project when he diagnoses and treats a patient” (Levine 2003, p. 103). Annas and Grodin assert, “It is probably fair to say that modern physicians believe that *anything* they do to one of their patients is, by definition, treatment. This, of course, is consistent with the Hippocratic ethic of acting only for the benefit of one’s patient” (1992, p. 308).

Even in instances that are purely research-based, the history of the doctor-patient relationship can unwittingly cause issues. While their intentions may be good, researchers who stand in front of their subjects wearing a white coat may automatically bring about images of the doctor-patient relationship which can complicate the researcher-subject relationship. Experiments that take place in hospitals can further confuse subjects who are conditioned to thinking of hospitals as a place to go for treatment (Katz 2003). In order to effectively distinguish research from the practice of medicine, bioethicist Edmund Pellegrino argues that definitions alone are not enough. The process of informed consent must include a conversation in which the separation between physician-scientist and physician-healer is made abundantly clear. He states that “[t]he physician can easily obtain consent to an experimental protocol simply by emphasizing the hope of cure and downplaying the risk and the experimental nature of the treatment” (Katz 2003, p. 211). Conflating the relationship between clinical research and medical practice clearly poses potential risks to patient-subjects.

13.6 Current Debate

13.6.1 What Makes Human Subject Research Ethical?

It has been over 70 years since the publication of the Nuremberg Code, yet society continues to struggle with the same question: “what makes human subject research ethical?” The codification of ethics rests on the four basic principles of bioethics: autonomy, beneficence, non-maleficence, and justice. Yet despite the theoretical similarities within the codes, each of these principles is reflected differently in various documents and their practical applications remain problematic.

Different codes of ethics were created in response to different scandals within different countries within different historical eras. As a result, the codes lack a universal applicability making them difficult to employ in a real-world setting. Without any type of unifying, cohesive ethical framework, everyone involved in the process is left without an answer to what most would argue is the single most important question in the field, “what makes human subject research ethical?”.

Emanuel, Wendler, and Grady attempted to answer that question by outlining seven requirements for ethical research involving human subjects. They devised these guidelines after analyzing key research and literature in the field, including the Nuremberg Code, the Declaration of Helsinki, the Belmont Report, and the CIOMS guidelines. First, they addressed the goals, definitions, and theoretical foundations of these requirements by stating:

> The overarching objective of clinical research is to develop generalizable knowledge to improve health and/of increase understanding of human biology; subjects who participate are the means to securing such knowledge. By placing some people at risk of harm for the good of others, clinical research has the potential for exploitation of human subjects. Ethical requirements for clinical research aim to maximize the possibility of exploitation by ensuring that research subjects are not merely used but are treated with respect while they contribute to the social good (Emanuel et al. 2000, p. 2701).

The article then contends that while there are no guidelines currently in existence that include all seven requirements, each condition was chosen because it represents a “fundamental protection” that exists at the foundation of every document that was synthesized as part of the creation of these guidelines. In addition, these requirements were created to be universally applicable, although their specific use may entail adapting the document to the needs of a particular culture. The seven requirements proposed by Emanuel and his colleagues include: social or scientific value, scientific validity, fair subject selection, favorable risk–benefit ratio, independent review, informed consent, and respect for potential and enrolled subjects (Emanuel et al. 2000).

Judging the seven requirements against the four moral principles on which modern bioethics and research ethics were founded, it is obvious that there is much overlap. Emanuel and his colleagues began with the foundation of research ethics, reviewed and synthesized various codes of ethics, and then essentially developed an updated list of principles that are easier to utilize in practical settings and more relevant to a global audience. In the seemingly unending quest to answer the question, “What makes human subject research ethical?” these seven requirements are a seemingly logical next step in the trajectory of research ethics.

13.6.2 Reevaluation of Research Ethics: How Can Codes of Ethics Be Standardized and Enforced?

Ethical guidelines for human subject research continue to be reevaluated in order to better protect the dignity of the individual while still allowing for the advancement of medical science. The history of the codification of research ethics has proven that despite the theoretical and foundational similarities, there is a lack of standardization and cohesiveness among ethical guidelines. Differing opinions regarding the definitions of key terms and an absence of a centralized governing body to enforce these guidelines further complicate their use. These issues were clear to the judges during the Doctors' Trial at Nuremberg and have been cited as one of the reasons behind the including the Nuremberg Code as part of the legal judgment that was delivered at the tribunal. Their strategy was to incorporate the Nuremberg Code into international criminal law, thereby ensuring that its repercussions would be felt throughout the world for generations to come. In addition, the judges recognized that while the legal validity of ethical codes was uncertain, violating international law would have definitive harsh penalties (Grodin 1992). However, because the judges did not offer a concrete method for enforcing the Nuremberg Code it was impossible to practically implement (Emanuel 2003a, b). The history of research ethics has proven that "although a code is necessary, it is insufficient to safeguard human rights in human experimentation…The courts of individual countries, including the United States, have consistently proven incapable of either punishing those engaged in unlawful and unethical experimentation or compensating the victims of such experimentation" (Annas and Grodin 1992a, b, p. 309).

As each new code of ethics was introduced in response to a major scandal within the field of research ethics, it became even more apparent that these codes were not preventing legal or ethical abuses within human subject research. Since the publication of the Nuremberg Code, examples of unethical instances of human subject research abound: the Willowbrook Study, the Brooklyn Jewish Chronic Disease Hospital, the Tuskegee Syphillis Study, drug trials in developing countries are just a few of the instances that triggered revisions in pre-existing codes of ethics. As medical technology has continued to advance, criticism about the usefulness of ethical regulations within the current research environment are growing. There are increasing concerns regarding "new medical devices, genomics, the Internet, mobile technologies, and stem cell research—all of which have revolutionized how and by whom research is conducted" (Davis and Hurley 2014, p. 12). The rapid pace of medical and scientific advancement is going to create new challenges for the development of ethical guidelines for human subject research.

In his groundbreaking work, *The Structure of Scientific Revolutions,* Thomas Kuhn presented a theory explaining the cycle of progress within scientific fields. Very simply put, Kuhn asserted that change does not result from the accumulation of an abundance of new knowledge. Rather, scientific knowledge advances when the old way of thinking about a topic no longer works and a new model must arise to take its place. In this situation, a paradigm shift occurs. The old model is no longer able to sufficiently serve as a reliable guide for solving problems, and a new model emerges that is better equipped to handle the challenges of the field (Kuhn 1962). While this model crisis first occurred after the Nuremberg Trial, it is occurring again today. Rather than continuously revising codes of ethics, it is necessary to reevaluate the entire approach to research ethics and create a paradigm shift. This does not mean abandoning the values that became dominant as a result of the Nuremberg Trial; rather, it means that new regulations and ethics codes must incorporate those values in a way that allows them to remain consistently prioritized in our changing world of medical research.

13.7 From Codification to Moral Professionalism: Teaching Bioethics and the Holocaust

The Nuremberg Code was written in response to the medical community's blatant and egregious disregard for the dignity of human beings that took place during the Holocaust. This unique example of medically sanctioned genocide led to a codification of ethics that has become increasingly incompatible with the current research environment. Cohen and Lynch argue:

> [T]he fundamental issues at stake are the same as they have always been—balancing protectiveness against autonomy, risks against benefits, efficiency against deontological concerns. But several decades after the current human subjects regulatory framework was first adopted…it is not well suited for the reality of much of the research that will emerge in the twenty-first century and the institutions that will be conducting it (2014, p. 6).

Modern research ethics must redefine itself in a way that will both protect the rights and dignity of individuals while also meeting the demands of an ever-changing scientific world whose goal is to improve the welfare of society.

The system in use is failing both researchers, subjects and society. Instead of constantly attempting to revise ethical guidelines, as has been the case since the inception of the Nuremberg Code over 70 years ago, a new paradigm must be established that emphasizes the responsibility of the researcher to prioritize the well-being of the subject first and foremost. Even before Beecher's landmark 1966 article exposing research violations in major US institutions, he had already expressed doubts about the efficacy of using guidelines to regulate ethical human subject research in his response to the publication of the Nuremberg Code: "It is not my view that many rules can be laid down to govern experimentation in man. In most cases, these are more likely to do harm than good. Rules are not going to curb the unscrupulous. Such abuses as have occurred are usually due to ignorance and inexperience" (Advisory Committee on Human Radiation Experiments 1996, p. 90). Instilling a moral ethos within the profession will ensure that researchers are treating individuals with dignity and respect not because a code of ethics tells them to, but because it is the right thing to do. This is a synthesis between the priority of maintaining an internal morality of the profession that existed before the Holocaust and the priority of external oversight and regulation that existed after the Holocaust and continues today.

It is a fallacy to believe that Nazi doctors acted without any type of moral motivation. The history of medical ethics in Germany up to and including World War II has proven that there was, in fact, a very advanced formalized system of ethics being taught and instilled into physicians. Rather, their ethics were corrupted by a National Socialist political ideal that stressed the worth of certain individuals over others based on their value to the nation (Proctor 1992). Thus, it is important to understand that medical and research ethics do not exist independent of society, yet physicians and researchers must also have the ability and integrity to go against society's mores when they become corrupted. As Bruns and Chelouche have argued, "[t]he prevailing medical ethos can be strongly determined by politics and the zeitgeist and therefore has to be repeatedly negotiated" (2017, p. 591). We have seen that ethical guidelines are often created in response to events within a culture or within a historical time period. As a result, these guidelines are equally likely to be influenced by the prevailing cultural or political zeitgeist. This is why they have been—and continue to be—repeatedly negotiated.

Recognizing that the Holocaust served as a historical inflection point in the history of developing medical and research ethics can allow us, as a society and a community of bioethicists, to develop a personal and professional ethos that values the dignity of the individual in a new paradigm, one that also emphasizes moral professionalism. While regulatory systems like peer review and informed consent can certainly help prevent ethical abuses from occurring, ultimately moral professionalism argues that a person's moral compass will always be a better guide than an ever-changing series of documents. Teaching about the ways in which the moral compass of the Nazi doctors was corrupted by forces from outside the medical profession is important. Understanding how these physicians abandoned their Hippocratic Oath and transformed from healers to killers demonstrates the "ease with which a contemporary ideology—one that promises a better future for our country—can undermine ordinary, "good" doctors' core ethical obligations to the primacy of patients' interest" (Cohen 2010, p. 205). External codes of ethics have proven time and again to be a double-edged sword, regulating professionals while also being subject to the pitfalls of politicization. Shifting away from the failing paradigm of codification towards one that also consists of moral professionalism will allow future generations of researchers to develop an internal motivation to act ethically that will guide them to do the right thing, not because they are required to do so, but because they truly believe it is the ethically sound decision.

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Chapter 14
The Rights and Responsibilities of the Physician to Uphold Bioethical Values in Society

Ashley K. Fernandes

Abstract In this chapter, I will reflect on medical ethics after the Holocaust by focusing on the rights and responsibilities of the physician to uphold bioethical values in society—which must transcend cultural, professional, and institutional mores. Physicians can do so only if: (a) They are called back to the value of the human person and the physician's primary duty to uphold his or her good. (b) They acknowledge the hierarchical structure of medical education and resist reflexively the temptation to succumb to its moral dictates. (c) They promote a vigorous right of conscientious objection (CO), so that, if the time comes, they can defend their call to heal even against external pressures from the state, scientific establishment, and/or culture. (d) Finally, they remember those who suffered in the Holocaust both to honor them, and to remind physicians of what the power of medicine has done to degrade dignity, and what it has the potential to do to advance the dignity of all human persons.

14.1 Introduction: Are Bioethical Values "In Society" or "Of Society?"

When this volume is published, it will have been nearly seventy-five years since the Nuremberg "Doctors' Trial" began, marking a formal end to an era where medicine—by commission and omission—sanctioned the murder of the "outsider." Medicalized genocide, which was sifted and rarefied through centuries-old cultural antisemitism and prejudice, a dogmatic and purely materialist anthropology, and a medical and scientific establishment that prized efficiency and racial purity above all else (Proctor 1988; Lifton 1986; Burleigh 1994; Fernandes 2020), caused the death of at least 150,000–200,000 human persons between 1939 and 1945 (Foth 2014). But the trials also mark the beginning for the medical profession of a *moral* reckoning for the medical profession which must continue. These moral lessons of the Holocaust must

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be seen as dynamic, nimble, adaptable—guiding us at once to navigate the future of medical ethics, and also to reflect and recommit to medicine's authentic foundations.

In this chapter, as the title suggests, I hope to explicate the rights and responsibilities of physicians to "uphold bioethical values *in* society"—not "*of* society." This one-word difference is significant in that it suggests that (at least some of) the bioethical values of the physician must transcend the culture in which medicine finds itself. On the one hand, most of us take for granted that concepts such as the healing and restoration of the sick person, nonjudgment, inclusion, autonomy, and consent are fundamental concepts in bioethics. Yet, arguably every systematic abuse of these concepts in the past and present has been defended, in part, by a cultural, institutional, or professional *acceptance* of the abuse. The late Edmund Pellegrino noted that "What the Nazi doctors illustrate is that ethical teaching has to be sustained by the ethical values of the larger community. In Germany, this support system was weakened well before the Holocaust and the experiments at Auschwitz" (Pellegrino 1997, p. 307). In order to preserve the integrity and values of medicine, therefore, I will first affirm that physicians must ground what they do in the good of the human person, and unpack both the concept of "person" and "good." Then, I will show that the hierarchical structure of medicine in which the physician finds herself can be at odds both with the values of persons and with the promotion of their good, as it was during the time of the *Shoah.* Next, I will argue that the current attacks on conscientious objection (CO) in bioethics are a threat to physicians promoting bioethical values in society. Finally, I claim that *remembrance* of the Holocaust and the role of medicine in its execution is a powerful tool for repentance, moral responsibility, and advocacy to protect patients in the future.

14.2 The Person and the Goods of Medicine: Definitions

14.2.1 The Person Matters

Arson which destroys a man's home is an evil. The deliberate killing of a neighbor's pet is also an evil. But for most (proponents of animal rights respectfully excepted) neither instance truly compares to the murder of a single human person. Why is this so? One can give rationalist, phenomenological, theological, or other, more "emotive" justification (intuition, experiential) for this belief, but few would dispute the *prima facie* value of the human person. The tragedy of the Holocaust is a tragedy not because 6 million Jews (*en masse*) were murdered, but because 6 million *individual Jewish persons* were murdered. Likewise, a farmer can restore a fallow field; an autobody shop workman can restore a terribly damaged car. Both are also service occupations. But the physician who heals the human person possesses a deeply profound respect which is different in degree. It is worthy of reflection that medicine draws this reverence not from what it can nakedly do *to* a person, but rather from *the person to whom* its healing power is directed.

14.2.2 Philosophical Anthropology: The Ethical Implications of Personalism and Materialism

Philosophical anthropology, which seeks to answer the question, "What is the nature and significance of the human person?" is a foundational subdiscipline of moral philosophy. As I have stated elsewhere, this "anthropological question" is essential to bioethical inquiry, and indeed, is at the heart of many disputes in bioethics (Fernandes 2002, 2017). Before one can truly decide whether this choice or that is good for the patient *as a person*, one must have at least reflected on the nature of personhood itself. While there are many competing anthropologies, a personalist anthropology, following philosophers such as Jacques Maritain, Gabriel Marcel, and Karol Wojtyla, and political leaders such as Mohandas/Mahatma Gandhi and Martin Luther King, Jr., suggests that it is not happiness, or utility, or choice, or even reason that ought to have the highest value in ethical decision-making. Rather, it is the transcendent human person herself. No other good in society can be elevated above the dignity of a single human person. Such a view comports both with reason and our phenomenological experience of the person. (Maritain 1946; Marcel 1963; Wojtyla 1969; Burrow 2006). This chapter is written from the perspective of a personalist anthropology; but certainly, those who disagree with the foundational premises could still agree with the conclusion by defining values through another transcendent philosophical route.

There is one major exception. The personalist view contrasts sharply with a materialist or positivist-empiricist view, in which there is no transcendent value to personhood:

> Extrapolations of science's materialist premises produces a bioethics measured by the good of the body or the species, for that is all there is. Mind, soul, emotion, spirit—all are simply epiphenomena of matter…There is no reality beyond what we can touch, see, feel, or smell. Suffering is pointless. When the machinery of the body is irreversibly damaged, death can, and should be chosen. (Pellegrino 2006, 255)

As Maritain wrote in the post-World War II period in his critique of National Socialism and Marxism—materialist views of personhood dangerously creates permissibility for individuals to be sacrificed for other "goods," such as racial/nationalist health or the State, respectively. It was precisely because National Socialism did not recognize the value of the Jewish person that they were able to eclipse his or her good with other "goods." Threats to bioethical values in society can occur when physicians and other medical leaders supplant the dignity of the highest good with other goods. Such goods need not even appear overtly nefarious, such as "love of country" ~~racism~~. The security of one's country or state (not necessarily a *prima facie* evil) can become dangerous when the value of the person is sacrificed for it—as in repeated cases of medical professionals participating in state-sanctioned torture (Miles 2020). Likewise, without a transcendent, inviolable value placed on human persons, even goods such as "scientific advancement" or "public health" can potentially override the rights and well-being of vulnerable individuals, as historical examples in Tuskegee (Gamble 1997) and sub-Saharan African HIV research (Brewster 2011) have shown us. To ensure against this, the human person is and ought to be the "central unit of value" in bioethical decisions.

14.2.3 Conscience and Moral Decision Making

It should be underscored that both the physician and the patient are invaluable human persons engaged in bioethical decision making. The doctor-patient relationship arises out of this covenant—where one person, i.e., the doctor, who has knowledge and technical skill, is at the service of another person, i.e., the patient, who is vulnerable and seeks help in the context of illness (Pellegrino 1994). The word "covenant" has an important, deliberate usage—to distinguish the physician–patient relationship from (for example a business) "contract," which is more symmetrical. The covenantal relationship suggests a power imbalance borne out the nature of the relationship itself, while simultaneously conveying the trust of the more vulnerable party in that of the more powerful. Daniel P. Sulmasy puts it succinctly: "Physicians thus receive *authority* from patients to use the *power* of medical knowledge to exercise *control* over their patients' bodies" (Sulmasy 2020, 304). When rights and responsibilities are weighed in these decisions, however, each person's moral obligations arise first out of the fact that they are persons—it is not simply a matter of their roles as doctors or patients. Medicine is by definition, a "phenomenon of healing" as both a moral and an ontological process. It is a moral phenomenon in that physical healing is done for the good of the patient, a "good" that transcends mere biology in the experience; the physician and patient together must decide an ethically right course of action. Medicine is also ontological in that these morally laden decisions lead to the transformation of the being herself. When a physician acts for the patient's good, he or she becomes, through the experience of that action, a different, better person. The tool that enables us to make decisions about right or wrong—indeed to recognize right from wrong—is conscience. As philosopher Kenneth Schmitz notes, conscience is a "bridge within consciousness" connecting the experience of freedom to the object presented through cognition. (Schmitz 1993).

Hence all humans require the free exercise of conscience in order to live out their moral lives as persons and to connect their freedom with rational truths extracted from experience. When Gisela Perl, a Jewish obstetrician, made the heart-wrenching decision to perform abortions, and even infanticide, on children born in Auschwitz in order to save their mothers, her conscience still operated even within the confines of a prison camp (Perl 1948). When *Sonderkommando* and physician Miklós Nyiszli aided the SS in prisoner selection in Auschwitz, his tortured memoirs and legacy reveal the conflict within his own conscience—and what might happen when coercion overlays its free exercise (Turda 2014; Nyiszli 1960). Conscience, therefore, is both a critical tool of moral reason and is crucial to the dignity of the person, for both physician and patient. It also represents a potential bulwark against external forces that holds men and women accountable to their moral responsibilities.

14.2.4 Rights, Responsibilities, and the Goods of Medicine

In ethics, if someone has an entitlement right to something, there is always a corollary duty attached. These rights and duties can be "negative," such as free expression (a person has a right to speak and others have a duty not to interfere with that right); or, as in the case of the doctor-patient relationship, rights and responsibilities can be "positive" (a person has a right to seek healing and restoration, and the physician promises to actively work to help them achieve this right). Given the nature of the physician–patient relationship (covenantal, rather than contractual) and the power ceded to the doctor in that fiduciary bond borne out of illness, the protection of the vulnerable patient is the principal responsibility of the physician. But it also must be balanced against other equal (even temporally antecedent) rights and duties. For example, if society needs physicians to exercise integrity to care for their patients, it must also acknowledge the rights of physicians and health care professionals to exercise their moral conscience vis-à-vis the very same patients they have promised to help (Pellegrino 1994).

Thus, the bioethical values of the medical profession are sustained within the physician–patient relationship, with the doctor morally bound to act for the good of the patient. But what does this "good" actually mean? Edmund Pellegrino outlined four historic goods the physician should strive for: (a) the good as the patient sees it (autonomy); (b) the biomedical (physiologic) good; (c) the good for the person *qua* person (human flourishing); (d) the spiritual good of the person (Pellegrino 2001). While there has been a tendency to focus on (a) and (b) in medical education and practice, to the near-exclusion of all others, attention to all four goods are critical to the moral practice of medicine. It should be noted that "the good of society" or "*the goods as perceived by medical societies*," while they might coincide with any of the four goods are not synonymous with them. Indeed, it is obvious that such other goods may also conflict with the physician's responsibilities to pursue the good of his or her patient exclusively.

This is not an innocuous fact. Physicians have an ethical responsibility to uphold the rights of the vulnerable patients perhaps *especially* when threatened by the priorities of health systems, cultures, and political entities. As Daniel Sulmasy has convincingly elucidated, medicine is a power, a power with authority, and a power that seeks—by its nature—to control the human body. Power is also a profound temptation. Thus, Sulmasy highlights the significance of the motto of Viktor Brack, the administrator of the *Akiton* T4 euthanasia program that murdered hundreds of thousands of disabled persons: "*The syringe belongs in the hands of the physician*" (Sulmasy 2020, 299–306). This chilling phrase suggests that the Nazis knew full well of the innate power of medicine and that what they viewed as racial cleansing became the responsibility of the physician, and the physician alone. How did it come to this?

14.3 Professional Hierarchies: Then and Now

Elsewhere, Dr. DiAnn Ecret and I have described the role the "medical hierarchy" played in moral silence both in Nazi Germany and today (Fernandes and Ecret 2020). In this section, I will summarize key elements that highlight how such hierarchies in medical and clinical education can threaten the physician's ability to do the right thing or exercise her conscience for the good of the patient. Holocaust scholars rightly have identified the hierarchical nature of the medical profession as a "risk factor for abuse of power" (Reis et al. 2019).

14.3.1 Hierarchy in Healthcare

Hierarchies in the training of physicians and nurses are embedded in a professional culture. Sometimes, such hierarchies promote the good of the patient; for example, when during a cardiac arrest a physician leader assigns roles and directs resuscitation. However, oftentimes hierarchies that exist due to inherent power imbalances within structural or practical interactions of the system can put persons at risk of real harm and ultimately affect patient outcomes (Gergerich et al. 2019; DiPalma 2004). The silencing of nurses in contemporary cases of costly medical error, for example (Brown 2013), faintly, but disturbingly, calls to mind the pressure of secrecy placed on nurses who worked in Nazi concentration camps by their "superiors." Nurses working in the camps were forced to sign "nondisclosure agreements" so that, even if they felt an action was wrong in their conscience, they could tell no one (Benedict 2006).

The effect the hierarchy can have on moral conscience and the promotion of silence is profound, as medical education today normalizes humiliation, fear of retaliation, institutional tolerance and apathy among subordinates, thereby leading ultimately to "empathy erosion" (Crowe et al. 2017; Vidal et al. 2005; Neumann et al. 2011). Empathy erosion and medical hierarchies taken together can reinforce a negative impact on conscience or, what one researcher called "moral judgment competence" (Neumann et al. 2011). Simon Baron-Cohen takes this erosion of empathy to be the root of evil behavior, and makes the direct connection between a loss of empathy, the dulling of the human conscience, the "turning of people into objects," and the ability to inflict the unimaginable cruelty of the Holocaust (Baron-Cohen 2017).

14.3.2 National Socialism and the Medical Hierarchy

Nazi physicians worked under a malignant hierarchical system that had its roots in three separate but overlapping loci: educational/cultural, moral, and legal (Fernandes and Ecret 2020). Medical education was impacted directly by a cultural education that taught that Jews, the disabled, and other "undesirables" were inferior to the Aryan person. Even textbooks reflected this extreme social bias (Bruns and Chelouche 2017). Hence, medical students learned—within the already rigid "strongman" culture of National Socialism where obedience to a professor's authority was rewarded—that science *itself* was a biological dictator of how one should act. Given that the Nazi medical professional societies and the larger culture together advocated for a duty to rid the German "body" of "racial disease" (a metaphor they embraced as objectively true), the very notion of medical ethics (or for our purposes, "bioethical values") became inseparable from the values of a corrupt and brutal society.

Hierarchical systems also affected the ability of health professionals to exercise their moral conscience. Andrew McKie has suggested that Nazi nurses were able to justify torture and murder because it was their "duty" to carry out typical nursing duties of executing orders with precision and confidentiality about their work (McKie 2004). Michael von Cranach, in a discussion of the murder of 200,000 psychiatric patients by Nazi doctors, notes that in a hierarchical structure, conscience and responsibility can be blunted when an individual transfers responsibilities of his or her duties to those who hold authority over them (von Cranach 2010).

Legal forces also shaped the actions of physicians under Nazi rule. The Nuremberg Laws of 1935 banned marriages and sexual activity between Jews and non-Jews, and they explicitly tied legal regulations and penalties, as well as the resultant social stigma, to the medical "science" being advocated by doctors, researchers, and scientists throughout academia and clinical practices. Doctors who contributed to the unjust laws could now fall back on the very same law—as so often happens today—as a justification for their actions, and as a compass for *future* actions. It is no surprise that many medical students I teach today, when asked what the ethical thing to do is, first ask what the law says they are *permitted* to do—as if the answers to both questions were the same.

Blind obedience to the law is a tempting but wayward moral strategy.

The banning of Jews from the practice of medicine, the decimation of their rightly-earned professorships and status in medical universities and hospitals, the prohibition of Jewish doctors from calling themselves "physicians" provided powerful incentives for non-Jewish medical professionals to actively cooperate and to not exercise their conscience when it was needed most (Proctor 1988, 131–176). The stigma of the minority physician within the Nazi medical hierarchy directly benefited the majority and kept them silent.

14.4 Conscience, Conscientious Objection (CO), and Ethical Diversity

In 12.2, we briefly discussed both the crucial importance of the person in bioethics, as well as the role of conscience as emanating from the person herself and forming the core of ethical life. In the moral lapses of physicians and health care professionals during the Third Reich, we can see how a sharp conscience—both to not cooperate with evil and, where possible, to speak up against patient harm or unethical science should have been indispensable. Yet, it is also clear that the hierarchical nature of medical culture negatively shaped consciences and even suppressed them. This is not to say that these physicians "had no choice." All of them did. Alessandra Colaianni reminds us that:

> …many studies have concluded that, 'after almost 50 years of postwar proceedings, proof has not been provided in a single case that someone who refused to participate in killing operations was shot, incarcerated, or penalised in any way.' Furthermore, a few doctors did refuse to participate and far from being killed for their actions, they were tolerated and even, in some cases, respected for their decisions. (Colaianni 2012, 435)

Thus, it is possible, even under extreme conditions, for physicians to fall back on the only thing which is truly theirs—the one thing that stands between a patient's healing and their harm—their own conscience. However, there is a strong contemporary movement—perhaps among a "majority" of progressive academic bioethicists—that argues the right of physicians to conscientiously object to practices they deem unethical should now be rescinded. Typically, the "practices" in question revolve around abortion, euthanasia, contraception, gender transformation therapy, and other controversial procedures for which there is still much societal debate and rancor. Some bioethicists such as Julian Salvulescu and Udo Schuklenk claim for example that:

> Doctors must put patients' interests ahead of their own integrity…If this leads to feelings of guilty remorse or them dropping out of the profession, so be it…There is an oversupply of people wishing to be doctors. The place to debate issues of contraception, abortion and euthanasia is at the societal level, not the bedside, once these procedures are legal and a part of medical practice. (Salvulescu and Schuklenk 2017, 164).

Another line of attack on CO can be found in an argument by Ronit Stahl and Ezekiel Emmanuel, who maintain that since medical boards and regulatory agencies license physicians, these individuals ought to be willing to do those things permitted by the licensing boards (Stahl and Emmanuel 2017). Both arguments against CO call for the removal or exclusion (involuntarily or voluntarily, respectively) of physicians who hold moral viewpoints that are currently in the minority.

Many readers may sympathize with the argument against CO because they are supportive of abortion rights, euthanasia and the like, however taking this stance misses the essential nature of the debate. It is not about the topics being considered (i.e., whether or not one believes in abortion rights or medical aid in dying) but rather the right of the medical professional to utilize that most fundamental tool within the doctor-patient relationship: conscience itself. Contemporary attacks on CO are a dangerous assault on the freedom and autonomy of medical professionals. Overlaying these same contemporaneous arguments against CO to the physicians' choices in Nazi Germany is instructive. Is it really true—then or now—that "doctors must put patients' interests ahead of their own integrity?" One could easily ask, "Should *any good* (e.g., the state's interest, the German *volk*) really *be put in front of*" a doctor's own integrity? Such a view negates the four-pillared goods of the patient that the physician takes an oath to protect (autonomy, biomedical, human flourishing, and spiritual, see 11.2.4) and insists that only the patient's own will matters.

Furthermore, arguments such as Stahl and Emmanuel's willingly cede the power of individual conscience to other authorities (e.g., medical licensing bodies or professional groups), much like physicians did in the time of National Socialism. Physicians must be empowered to speak out against injustice, even if such injustices are permitted, tolerated, or even advanced by these bodies.

Yet, calls to exclude or ostracize physicians with minority ethical views (Salvulescu and Schuklenk 2017; Stahl and Emmanuel 2017; Fiala and Arthur 2014) should alarm us, irrespective of whether we agree or disagree with those views. The exclusion and oppression of Jewish physicians by medical societies, hospitals, and legal entities within the Third Reich had an incalculable moral, medical, and economic cost, since it malevolently excluded and oppressed some of the brightest, most accomplished, and ethically committed doctors. Likewise, as I wrote with Christopher M. Radlicz:

> So, while opponents of conscientious objection define the problem as a simple one—get rid of the "problematic, religious physician" and the problem is solved—in fact doing so weakens the moral nature of the profession as a whole, by removing those very persons who are most committed to integrity (Radlicz and Fernandes 2019, 140–141).

Suppressing CO also hurts physicians as persons, if indeed conscience is crucial to human dignity and the moral life as I have asserted. To uphold bioethical values in society, physicians and those in the healing professions must be "fully armed" with the ethical tools available to every human being—precisely because they are at the service of the most vulnerable human beings.

A full accounting of the debate over CO is beyond the scope of this chapter. What I would like to impart is that, at face value, the ability to stand up and speak out against wrongs within the medical profession—should they arise—cannot be done without the ability of physicians of good will having the freedom to disagree, debate, and work to change how medicine is practiced. Had physicians done so with greater courage in Nazi Germany, the history of medicine and the world might have been different. While physicians with minority ethical views may remain just that—a minority—broadening *ethical diversity* by having these voices heard can be both a benefit to patients who agree with these views and choose these physicians, and to the profession as a whole, by acting as a persistent challenge to the prevailing mindset that reinforces the current moral standard or encourages change.

14.5 Remembrance as Both Atonement and Advocacy

I will end this chapter with a more personal reflection. I am a practicing Roman Catholic who married a religious Hindu. Both traditions—East and West—utilize hagiography for spiritual and moral inspiration. In these traditions, the lives of the Saints are read, reflected upon, and utilized as an example for how it is possible for real people to follow a transcendent path. Remembering suffering, courage, and martyrdom is not static. It points backwards and forwards simultaneously. It both deepens our appreciation for what was, and what *ought to be*.

I would like to suggest that those interested in the Holocaust and its moral impact in medicine adopt this approach to remembrance. Remembrance is vital to honor the victims and survivors of medical experimentation and genocide, to "re-personalize," to restore forever the recognition of inherent dignity that was transiently but seriously eclipsed. A visitor to the US Holocaust Memorial Museum in Washington DC receives a "passport" as they begin to walk through, which briefly tells the story of a victim of the *Shoah* and includes the person's picture. The resonance of this visual and historical remembrance cannot be understated. To be clear, I am not making the case for "canonization" or "veneration" of those who suffered at the hands of physicians in the Holocaust; instead, remembrance of this sort can be viewed as moral imperative of accountability that also teaches us, and in the process, *changes us*.

But for those like me also involved in clinical care, *remembrance must also point forward*. In medical education, we are fond of promoting the notion of building the clinical "life-long learner," but much rarer is this concept applied to moral learning. The farther we move in history away from physician atrocities in the Holocaust, and as the last survivors pass into history, the more apt we are to forget them, or worse, to *want* to forget them. In one recent survey of adults under forty years old, 63% did not know that 6 million Jews perished in the Holocaust, and nearly half did not know the name of a single concentration camp (Ramgopal 2020). Elsewhere, I have called for universal, required Holocaust education in every medical school (Fernandes 2017). Reading and teaching the narratives of men and women who suffered at the hands of physicians can remind us of what our authentic responsibilities are. It will also remind us that power is not abstract and that a sharpened and free conscience can move us ever forward to what medicine ought to be.

Power cuts both ways. As we have seen, physicians can tragically and easily demean and destroy, and when this happens, it has an amplified effect precisely because of the societal reverence for the profession. And yet, the physician also has the ability to perform "outsized good" through humility, kindness, patience, integrity, and generosity of spirit. For this reason, the rights and responsibilities of physicians to uphold the bioethical values *in* society—rather than *of* society—should be reaffirmed with intention. For the values of the profession, just like the nature of the human person, is indeed transcendent. They are both aspirational and inspirational. My hope is that the education in medical ethics after the Holocaust will be our moral aid in truly advocating for the rights and dignity of patients, particularly those deemed vulnerable or even "disposable" in society today. Perpetual remembrance of our profession's role in the *Shoah* is the atonement that we must make to preserve and advocate for all bioethical values in the future.

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Chapter 15
Bioethics and the Holocaust in a Multicultural Context

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Abstract This chapter explores the importance of diversity and interfaith initiatives in human rights and bioethics education, by showing its relevance in the study of the Holocaust. In the first section, a concise reference is made to those political and religious events that created the basic state and theological groundwork, respectively, which in turn led to the early formation of human rights and the confessional dialogue. The second section emphasizes contemporary actions and writings that contributed to the denial of freedom and of self-determination, including anti-Judaic sermons and their perversion into anti-Semitic ones. The third section discusses the creation after the Holocaust of global organizations and institutions, their international impact and modern developments in interfaith interaction focusing on human rights and bioethics. The fourth section presents educational, multicultural, and inter-religious initiatives that contribute decisively to the increase of awareness and awakening of learners, so that the field of education is transformed into a multidimensional place that generates world citizens.

15.1 Introduction

Within the field of education, the Holocaust is often documented as a topic that concerns exclusively modern Jewish and European political history. It is precisely this concentrated political position, which is itself a notable boundary that reduces the pedagogical significance of the study of this dark chapter of human existence and ultimately diminishes it in the eyes of both educators and pupils by including it in curricula as simply another historical event among many (Gallin and Bedzow 2019). Yet, this need not be the case. Study of the Holocaust may also include investigation of its impact on an interreligious and intercultural level. The emergence of this aspect within education is a particularly important development, because, on the one

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hand, it concerns the institutional dialogue between countries and the theoretical dialogue between religions around the world and, on the other hand, it determines and influences the internal dialogue of the citizens regarding their participation in increasingly multicultural modern societies.

15.2 Diversity and Interfaith Interaction Before the Holocaust

15.2.1 Diversity as a Human Right

Central Europe in the sixteenth and seventeenth centuries experienced its greatest religious controversy: in the aftermath of the massacre of St. Bartholomew's night in Paris in 1592—an event that directly challenged the monarchy as a justifiable form of government justification for the first time—the theological confrontations of the reformation[1] and counter-reformation[2] of the sixteenth century ended with the Thirty Years' War (1618–1648). The site of the hostility was the region of present-day southern Germany and its environs. Conflicting political demands in an unstable environment with an ever-evolving political map created vast reallocations of lands and peoples. It was characteristic of that time that local rulers, depending on their aspirations, would direct or appropriate large groups of Christian believers, who, divided by the new ecclesiastical fissures, either remained faithful to the prevailing Roman Catholic teaching or opposed it by supporting what they deemed a superior or remonstrating doctrine (Sutherland 1992).

The ideas of the Enlightenment that were gaining ground in Europe ushered in a novel naturalistic and humanitarian philosophy, with wider socio-political implications (Gauthier 2015). Correspondingly, there arose a tendency to demarcate purely nationalistic states using a new governmental model (Chengdan 2010). Due to the emerging social conditions, parliamentary government began to emerge in lieu of monarchism. These new regimes were now based on the principle of separation of powers. In these administrations, an elected parliamentary body assumed the legislative authority of the monarch. In keeping with the ideals of inalienable and natural human rights that were born from Enlightenment philosophy, certain rights would now be guaranteed either by a social contract or constitutionally. These were the rights to life, property, equality before the law, unfettered economic activity, unrestricted freedom of thought and expression, freedom of religion, and the pursuance of one's education.

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[1] The milestone in the context of the Reformation and the creation of the Protestant Protest is the sealing of 95 theses by Luther on the door of the All Saints' Church in Wittenberg, on October 31, 1517.

[2] Recently, a group of theologians has preferred to replace the term Counter-Reformation with that of the Roman Catholic Reformation. The importance of this change is mainly focused on releasing the fact from its genesis, as a reaction to the Reformation.

These Enlightenment principles were the basis of The Declaration of Independence of the United States, ratified on July 4, 1776, and affirmed in its Constitution and Bill of Rights, which guaranteed protection of *human rights* (Banchetti 2012). Its direct effect prompted the respective adoption and enshrinement of human rights by almost every new state in the Western world. The United States had taken these first steps, acting legislatively, and implementing the earlier Enlightenment notions that for decades were cultivated on the opposite side of the Atlantic. Owing to the pluralistic structure of their state's organization, which did not recognize a long-standing ethnos or ethnic nationality as the dominant societal factor, the United States were a model for other nations to prioritize diversity over entrenched national, racial, and religious unilateralism. Specifically, the establishment of the United States presented a tangible impetus to the consolidation of human rights, to interfaith interaction, and to the inclusion of all people (with glaring exceptions). As a state with such qualitative demographic characteristics and guaranteed rights, among other values, it provided coexistence—and therefore interaction—of the heterogeneous population, freedom—and thus diversity—of faith.

The promotion and recognition of the right to diversity and of freedom of belief—despite its acceptability in today's context—does not indicate that, in practice, the circumstances, traditional morals, and prejudices exceeded their times. The degradation and enslavement of the Black community (Hall 1988), the murder of Native Americans, the denial of women's rights, and the prevalence of puritanism within society are examples of the perceptive narrow-mindedness of those whose freedom society was prepared to accept. However, from an historical perspective, it was the first decisive step that inspired the gradual recognition of additional rights, at least more than was previously accepted and expected.

Consequently, a unique multicultural event occurred about a century after the safeguarding of human rights in the country. The *World's Columbian Exposition*, held in 1893 in Chicago on the occasion of the 400th anniversary of the discovery of America, was hosted by the *World's Parliament of Religions*, to which many representatives of different religions of the country were invited. Although it was a local event and did not correspond to what we now call *interfaith dialogue*, it contained strong elements of diversity and intercultural communication and responded to American society's texture, which was representatively reflected (Buonomo 2014). This, one could say, was the first sign that a different, novel reality had already begun to take shape,[3] one that defined new occurrences of multicultural reconstruction and unprecedented composition of the society that birthed it.

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[3] It is very characteristic of what Edmund Burke expressed in the Britain parliament observing the unicity of the new American Society: "A great revolution was happened—a revolution made, not by chopping and changing of power in any of the existing states, but by the appearance of a new state, of a new species, in a new part of the world. It has made as great as change in all the relations and balances and gravitations of power as the appearance of a new planet would in the system of the solar world" (Johnson 1897, 304–305).

15.2.2 The Beginnings of Modern Interfaith Interaction

Within the Eastern Orthodox Christian world, upon those lands under the spiritual custody of the Ecumenical Patriarchate of Constantinople in Eastern and Southern Europe, extreme nationalism was prevalent in the nineteenth century. Influenced by earlier Enlightenment thinking and the political developments of the 1800s, a tendency toward separatist division and self-government of peers arose, derived from claims of ethnic difference. Responding to this tendency of isolationism and discrimination by racial and linguistic criteria, the Ecumenical Patriarchate convened the *Synod of Constantinople* in 1872. With this Synod, the Orthodox Church became the first Christian Church that officially and unequivocally condemned the phenomenon of *Phyletism*, i.e., the conflation between church and nation. Its verdicts condemned the divisive and essentially prejudicial tendency to accept only those of similar ethnic background as spiritual kin and, using that flawed criterion, to demand the formation of an ethnically-linked religious hierarchy and church structure, thereby excluding from it those of distinctive ethnicities, even if they were members of the same faith.[4]

This pronouncement bore the characteristics (within the scope of that time period) of an innovative leap for the now multinational and renewed ecumenical restoration of the inner unity of faith that must, and does, distinguish the members of a religious community, regardless of their ethnic origin. The Eastern Orthodox Church officially stressed that a distinctive human ethnicity is by no means a trait capable of isolating or separating another bonding dimension: the spiritual unity of all people. If this presently comprises a pioneering transcendence, it proved all-the-more so during the era of the creation of purely homogeneous nation states that identified with a particular culture, language, and religion. The obstacles to racial, ethnic, and linguistic differentiation were now subject to the universality of the unity of faith[5] "on the basis of the spiritual content of (one) Baptism," as was inimitably interpreted by Ecumenical Patriarch Bartholomew.[6] The result was to ensure an overarching unity that abolished national borders and concurrently surpassed the disruptive and divisive consequences that ethnic nationalism was attempting to provoke.

If the U.S. Constitution was the principal *Temporal* motivator, which constitutionally guaranteed human rights for its citizens and recognized their right to diversity and free religious expression based on political and philosophical grounds, then the decisions of the Synod of 1872 that took place in Constantinople constituted the first canonically articulated synodical and ecclesiastical *Spiritual* resolution based on theological grounds. The decision removed the phenomenon of the then-emerging racial and intercultural discrimination and condemnation from its faithful.

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[4] For aspects of nationalism in the Orthodox Church and a deeper understanding of its current structure see Kitromilides (2014, 19–20).

[5] See Official Documents of the Holy and Great Council of the Orthodox Church, Encyclical of the Holy and Great Council of the Orthodox Church, Crete 2016, § I.3, https://www.holycouncil.org/-/encyclical-holy-council?_101_INSTANCE_VA0WE2pZ4Y0I_languageId=en_US. Accessed December 10, 2020.

[6] Speech of His All Holiness towards the Ukrainian people, July 26, 2008.

Thirty-eight years following the decisions made in Constantinople, the *Christian Ecumenical Movement* took place in 1910 in Protestant England, which was considered by many scholars to be a forerunner of the creation of the *Faith and Order* movement. Its aim was to achieve convergence in matters related to order and faith. The movement's first international conference took place in Lausanne on August 3, 1927 (Hietamäki 2015), with the participation of 108 Protestant and Orthodox Churches.[7]

Correspondingly, a similar movement had already begun to take shape within the wider Protestant Churches. During the World War I, the Churches, being unable to act and express their positions rationally and unilaterally, realized that they were unlikely to be able to wait for the first achievement of a bilateral unity of faith through the *Faith and Order* movement (Rowdon 1967). Thus, as a result of the war, the *World Alliance of Churches for Promoting International Friendship* of the Protestant Churches in 1914 proved the precursor and ideological foundation of the later established *Movement for Life and Work* in Stockholm on August 19, 1925 (Smit 2003), again with Protestants and Orthodox participation. This new move allowed the Churches to act jointly and to take a stand on practical social issues without the need for prior theological convergence. After successive meetings of their members in Oxford and Edinburgh, these two movements (*Faith and Order* and *Life and Work*) decided to merge into a single body in 1937, the *World Council of Churches*, and to schedule its first international conference in 1941. However, due to World War II, this conference was not realized until 1948 in Amsterdam (World Council of Churches 2013).

The interactive model of the new, single body revolved around three recognized directions: understanding the meaning of life (Dialogue of the Head), empathy of the spirit and expression of the other (Dialogue of the Heart), and participatory action intended to make the earth a better place to live (Dialogue of the Hands) (Swidler 2013). Hence, by effectively disconnecting the concept of joint actions from the prevalent form of theological agreement and unity, a new way of coexistence, filled with life and movement, was founded, and based especially on the more appropriate and feasible application of common values.[8]

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[7] The Roman-Catholic Church was also invited but was not present. It expressed negativity towards the Ecumenical movement, as it is written in the Papal Encyclical Mortalium animos of 1928.

[8] Ethics was not a stable codex of spiritual values that needed a theoretical agreement in order to be achieved, but, with the meaning that Ira Bedzow gives, was a commonly accepted value that we gain, which has to be praxis in order to achieve its goal: "intellectual virtues are not solely 'states by virtue of which the soul possesses truth by way of affirmation or denial'; they also include how the knower relates to knowledge in terms of shaping his or her worldview and how that knowledge manifests in action […] the process of thinking, which could mean either accepting beliefs or transforming beliefs into knowledge, is similar to acting" (Bedzow 2014, 172).

15.3 The Rejection of Multiculturalism Under the Nazi Regime

15.3.1 The Exploitation of Apologetic Sermons

Preceding the Holocaust, various anti-Zionist hate-speeches led by religious leaders were circulated at the local level within Germany (Sanzenbacher 2010). The negative perception and targeting of the Jews, including the pronouncement of Jews as undesirable and harmful to the interests of society did not originate exclusively from the lips and pen of Nazis but also from leading Christian circles with singular standing and influence. Nazi propaganda has roots in the writings and reception of *Von den Juden und ihren Lügen (On the Jews and their lies)* by the pioneer of the Reformation, Martin Luther (Nicolaides 2018). The text, written in 1543, illuminates the prevalent hostility towards Jews which was ultimately one of the factors that led to the Holocaust.[9] Luther's outlandish characterizations of the Jews includes statements such as, "[…] we do not know to the present day which devil brought them into our country," and "[p]roof for this is found in the fact that they have often been expelled forcibly from a country, far from being held captive in it" (Luther 2009, 74 and 75). He also accused them of creating the financial difficulties and the general hardship experienced by the local communities in Germany.

Equally characteristic is the anti-Semitic sentiment held by the region's Roman Catholics in the decades before the Holocaust. This can be found both in the statements of Roman Catholic leaders and the famous "silence" of Pope Pius XII during the Nazi uprising (Ericksen 2013), in which he neither explicitly condemned nor publicly censured Nazi practices but reportedly tolerated the active participation of his Cardinals implicated in similar atrocities, such as in Croatia (Shelton 1983–84). Consistently, there are many such cases of "complicity" within the clerical and theological ranks, whose attitudes encouraged the policies of the Nazi regime.[10]

Clearly, silence and historic polemical religious apologetics, having deviated from their theological core, caused social polarization and controversy, and tarnished the conscience of the faithful. This religious perversion and its exploitation by Nazi propaganda demonstrate how dangerous politicized religious discourse can be to the body politic.

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[9] In the Middle Ages, when these extreme anti-Jewish views were expressed, they had a greater weight than that given to them after the Nazi regime. However, they also had a lasting impact that has perpetuated anti-Semitism even to the present day.

[10] See, for instance, the statement issued by the Bavarian Protestant Church in 1933 (Ericksen 2013, 4).

15.4 Rights and Interfaith Interaction After the Holocaust

15.4.1 Post-Holocaust Human Rights and Bioethics

The post-World War II world, shocked by the atrocities it had experienced, became determined to learn from the recent tragedy and prevent the recurrence of such a phenomenon. After it had once again been demonstrated within a short time frame that a local war can take on global dimensions, the necessity of instituting collective guidelines for preemptive deterrence became evident. This, of course, required the creation of a new code of ethics: a commonly accepted human rights charter that could inhibit the repetition of another world war and another Holocaust (Araujo 2000).

The result of this international recognition for a new ethical order was the founding of the United Nations. In 1945, in San Francisco, the first General Assembly issued the Universal Declaration of Human Rights, declaring that respect for human rights and human freedom "… is the cornerstone of freedom, justice, peace and dignity in the world" (UN General Assembly 1948). It was the first time in history that the international community adopted a text with universally recognized value. The first two articles of the Universal Declaration unambiguously declare the recognition of equal dignity and rights for all, without any discrimination based on race, color, sex, language, religion, or any other criterion. Such protections were born from the atrocities of the war and the need to protect the rights of everyone. This is indicative of the consciousness of the international community following World War II, a recognition that the devastation which had just occurred was not merely a war of expanding national interest, but it was also an intercultural war, born of a "spiritual racism" (Evola, qtd. in Staudenmaier 2020, n. 15) in which self-appointed Aryans, attributing superiority to their genetic characteristics, attempted to undermine general human value and individuality. This supremacist ethos culminated in the genocide of the Jewish population at the hands of the Nazi Party. A new global conscience was aroused following this unparalleled abuse of human beings, leading to a collective urgency to define the rights of every individual human.

The pivotal Nuremberg trials followed the war's end, which sought to bring justice and punish the perpetrators of the war crimes. Unique among them was the Doctors' Trial (*United States of America v. Karl Brandt, et al., 1946).* In this trial, the main categories of crimes against humanity were defined as "the conducting of medical experiments, without the consent of the subject, to prisoners of war, citizens of occupied countries with disabilities and participation in the mass murder of prisoners held in concentration camps" (Moll et al. 2012, 79). The role of doctors, medical staff, and medical science had been transformed from having as its purpose the care of patients to becoming a machine of involuntary death.[11] Many of the victims were exploited like guinea pigs in medical laboratories run by the Nazi regime,

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[11] As noted by Fackenheim (1978, 246): "The murder camp was not an accidental byproduct of the Nazi empire. It was its essence".

where, abusively and against any accepted notions of medical ethics, they forced their prisoners to be part of painful, torturous and horrific involuntary experiments, including historically known forms of torture and forced labor (Grodin and Annas 2007).[12] Moreover, an estimated 200,000 inmates endured the abominable *Aktion* T-4 eugenics program, a model and precursor to the mass killings in the concentration camps. The pretext for the program was to preserve Germany's so-called *genetic purity*. As a result of the *Law for the Prevention of Hereditarily Diseased Descendants* (*Gesetz zur Verhütung erbkranken Nachwuchses*), "[m]any doctors envisioned this as an opportunity to influence the 'regeneration' of the German nation by eradicating those with 'biologically inferior hereditary traits' in order to 'cleanse the genetic pool of the German race'" (Chelouche and Brahmer 2013, 26). This included the "undesirable" elements of the population living in Germany, including the disabled and the mentally ill, who, in many cases, had undergone compulsory sterilization.

Following the war, a question thus arose as to whether only politicians who recruited and issued orders were to be held accountable, or if the doctors and nurses who carried out these actions in complete disregard of the Hippocratic Oath were equally responsible for causing irreparable harm and even death to those who were deemed unfit according (Miller and Gallin 2019). As a result, the *Nuremberg Code* was created to develop a more conscious ethical approach as to how clinical research should be executed. In it were introduced unique fundamental bioethical principles, such as the necessity of informing and securing the patient's consent, considering the possibility of death or injury as a deterrent to any experiment, enabling the patient to discontinue the experiment at any stage if they wish, and the requirement for doctors to act conscientiously. The goal of the Nuremberg Code, much like the Universal Declaration of Human Rights, was to protect the rights of the individual and to ensure that the abuse of power and the violations of human rights perpetrated by the Nazis was never repeated.

15.4.2 Holocaust and the Modern Way of Interfaith Interaction and Dialogue

The current organization of religious dialogue has undoubtedly been prompted by the bloody events of the two world wars. There is, though, a delicate parameter, a differentiation stemming from the woes of the World War II in particular. Succeeding the new approach launched by the United Nations and following the Second Vatican Council (Nov. 1962 to Aug. 1965), the Roman Catholic Church, through the famous *Nostra* Aetate (1965), officially expressed a positive attitude towards Orthodox-Protestant dialogue, from which it had so far abstained and called for its extension into interfaith

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[12] Such experiments included exposure to toxic substances, deadly diseases, high altitudes, and extreme temperatures. See *Trials of war criminals before the Nuremberg Military Tribunals under control Council Law* (Oct. 1946-Apr. 1949), *1*(10), 92–896. https://www.loc.gov/rr/frd/Military_Law/pdf/NT_war-criminals_Vol-I.pdf. Accessed 12 December 2020.

dialogue. The first non-Christian religion invited to dialogue in 1964 was Judaism, and its response was immediate and positive (Swidler 2013). Immediately, Protestants and Orthodox leaders, and almost the entire Christian world, applauded the initiative. The Christian world equally began to cultivate relations with Judaism within the new, revised framework, which it had also applied within its own dialogues. The rapprochement with Islam, Hinduism, and Buddhism followed. Through the acceptance and meeting of these distinct religions, modern global interfaith dialogue was inaugurated for the first time in the post-war era by religious leaders. Historically, this peaceful meeting of Christianity and Judaism proved to be a milestone of the foundation and establishment of all subsequent interfaith groups and forms of dialogue on issues of understanding, joint action, and respect (Head-Hands-Heart Dialogues).

What, one may ask, led the Roman Catholic Church toward Judaism in their appeal for interfaith dialogue? The officially recognized reason—a shared religious ancestry—has many elements of truth, of course, but it may not be sufficient. One could contrast the equally valid shared tradition of Christianity and Islam, whose lands were also targeted by Nazis and moreover, still held the cradle of Christianity, Jerusalem. As analyzed above, both the Roman Catholic and Protestant worlds were stigmatized by the prevalent cultivation of anti-Judaism and antisemitism, which was masterfully employed by the Nazi propaganda and was corrupted and catastrophically realized within German-occupied Europe (American Jewish Committee 1965). Previous anti-Judaic rhetoric and the present silence during the war took on such a dimension that it led to the greatest selective genocide, not of a state against another hostile state, but of a state against an internal group of its citizens (which were not a foreign ethnic remnant of a hostile state, had no absolute aspirations toward the detriment of national sovereignty, and boasted an historical presence well before the establishment of the post-World War I German state).

Though others recognized and enjoyed their self-evident rights, an opposing self-consciousness, differing faith, and non-renunciation of the right to self-determination of Jews were the very grounds of the Jews' condemnation. Thus, what followed was the pursuit of their total disappearance, culminating in the Holocaust (Maroudas 2019). Anti-Semitic sermons existed prior to the Holocaust, yet their content remained unaltered throughout the next centuries. World War I, which geographically occurred on almost the same battlefield as the succeeding World War, did not alter the subsequent attitude of the Churches of Western Europe towards the pre-cultivated, intolerant rhetoric against Jews. Thus, the generative cause of *Inter-religious Dialogue* was not the product of a new consciousness that emerged as an historical necessity from the outbreak of a global war, in which states collided with states. Christian religious leaders united their voices only after the fact.

From a theological perspective, World War I had no religious veneer of justification. World War II, however, donned a religious character. Absent the Churches, the political decisions of a fascist ideology sought to cause division: the non-conforming and dissimilar Jews had to disappear from Christian lands once and for all. As a result, the decisive generative cause of modern interfaith dialogue was both the guilt[13] and the debt of post-war Christian Europe for allowing the Holocaust.[14] The awareness of the heinous injustices committed and the burden of knowing that religious words instigated the catastrophe, the inaction and indirect participation in their targeting, and the alibis created by the previously polarized relations and the social marginalization based on their perception as enemies of the prevailing faith—in short, the realization that Christian dogma and tradition fell prey to the Nazi propaganda machine caused Christian leaders to see the great need for engagement with Jews to prevent theologically grounded division and dehumanization from ever occurring again (Nicolaides 2018).

The Holocaust was the catalyst for a new interfaith spiritual movement that brought together the alienated and entrenched religions, which had previously been content with their dogmatic autonomy (Nicolaides 2018). The resulting interfaith dialogues developed rapidly.

15.4.3 Holocaust and a New Interfaith Awakening as It Relates to Bioethical Issues

Vatican II both recognized the need for an incorporated interfaith dialogue in its proceedings which shows how impactful the Holocaust was in the change to nterfaith rather than interdenominational Christian dialogue. It informed the common values of ethics, and it also helped to harmonize theology with the pulse and occurrences of the modern world. These are typical topics considered by the Synod for religious dialogue: "The problems that weigh heavily on the hearts of humans are the same today as in ages past. What is man? What is the meaning and purpose of life? What is upright behavior, and what is sinful? Where does suffering originate, and what end does it serve? How can genuine happiness be found? What happens at death? What is judgment? What follows death? And finally, what is the ultimate mystery, beyond human explanation?" (Nostra Aetate 1965). We observe the classical nature of these ethical topics, while reference to the newer bioethical questions is absent.

Paradoxically, in the era that was proposing to build nterfaith dialogue, the traditional topics of bioethics seemed not be included as part of the discussion or, at least, was not emphatically highlighted, even though many new bioethical questions had arisen. Issues of a bioethical nature always occupied theological thought (abortions, suicide, cremation, euthanasia, killing of people with chronic disabilities, etc.). However, the Holocaust has many bioethical examples that speak to not only medicine and bioethics but humanity itself where individual autonomy was

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[13] For the guilt as it was perceived after the Holocaust, especially from the French Roman-Catholics bishops, see Madigan (2009, 6–7).

[14] According to Ariel (2013, 210): "The memory of the horrors that anti-Jewish incitements brought about in the 1930s and 1940s played an important role in enhancing the dialogue. For a number of Jewish and Christian leaders, reviving or enhancing efforts at dialogue corresponded with attempts at rehabilitating and normalizing Christian-Jewish relations at the wake of the traumas of the Holocaust".

completely disregarded. Another important aspect was the dismissal of one's freedom to accept or reject the treatments and techniques provided for reasons of religious conscience (Kolman and Miller 2018).

The violation of personhood that took place during the Holocaust when Jews were coerced to act contrary to their personal and religious tenets, including the unlawful disposing of one's corpse, highlighted the necessity for discussion prioritizing respect for one's personal religious beliefs and how to respect religious and personal objections when they arise. These religious injustices introduced a myriad of new bioethical considerations for the interreligious community to examine and relay back to the world. The Holocaust demonstrates what can happen when society allows scientific and societal progress to take priority over human dignity. Recognizing not only the atrocities of the Holocaust but the lessons one can learn from it allows religious leaders to be able to continuously adapt eternal religious values to ever-changing challenges derived from increasing technological progress, thus providing necessary guidance to their followers.

15.5 The Importance of Diversity and Interfaith Initiatives in Education

Education can be an effective tool for reducing human suffering stemming from racism, diversity, and social prejudice. In the same courtyards and the same classrooms, utilizing the rich pedagogical means at his disposal and through the various courses she teaches, a teacher can not only bring her students face to face. She can also teach them to behold each other—to appreciate the spiritual stature of the other. Through education, we have the opportunity to identify the tendency for verbal bullying in youth and to prevent its repetition as an act of hatred later on in life.

We are united creatively as global citizens at a time when ideas which incite and stimulate passions are immediately spread through technology. Many terrorist attacks were planned on one continent and carried out on another. To produce ripe fruits for humanity, the effective cultivation of all the aforementioned aspects cannot be limited only to good intentions and occasional symbolic ceremonies but must proceed by utilizing all the tried and tested methodological means, technologies, and techniques of dialogue.

The following are four educational models that contribute to the work of the educator and the aims of an educational policy with a pluralistic orientation. The first is based on the multifaceted nature of the Holocaust as a case study, while the other three are based upon a tested three-pronged model of communication and understanding: Head-Heart-Hand.[15]

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[15] For more about this model of education, see Gazibara (2013). The reason we choose an educational approach based on this triptych is because it is a harmonious and historically consistent approach to the way of communication and coexistence tried in the confessional and interreligious dialogues.

15.5.1 The Holocaust as a Case Study

After the Holocaust, humanitarian values were revised internationally and are now considered self-evident rights. However, it is possible that another destructive genocide may occur Holocaust[16] (Pearce 2020) if we do not educate future generations about past violence or if we ignore current warning signs which show an escalation of violence and discrimination as one can readily witness from watching the news. The importance of developing and fostering a personal ethical code cannot be overstated. As noted by Gallin (2019, 11): "[…] using the Holocaust, the sole example of medically sanctioned genocide, as the historical framework for exploring current issues and anticipating future challenges in ethics offers a valuable educational perspective, one that underscores respect for the dignity of the human being above all else."

The Holocaust provides a unique and timeless opportunity for humanity to learn how to safeguard and ensure a democratic environment of dignity, unconditional acceptance of others, and peaceful coexistence of peoples. However, this has unfortunately been undermined in many ways. Such a form of degradation is hidden in the ignorantly misleading tendency to narrow the spectrum of the Holocaust, describing it as an act exclusively against the Jewish community and its history (Gallin and Bedzow 2019). As remarked by Cohen et al. (2007, 257–258): "Case studies, in not having to seek frequencies of occurrences, can replace quantity […] Significance, rather than frequency, is a hallmark of case studies, offering the researcher an insight into the real dynamics of situations and people." To gain an essential and meaningful perspective, the Holocaust must be studied with the individualized, qualitative methodology approach of a case study. This approach may coincide with the anniversary of an event of historical significance or remembrance (Kristallnacht, World Holocaust Day, etc.), and include survivor testimony (IHRA 2019, 28), a literary text, a film, etc.

The content of the message varies and extends beyond historical references to issues of contemporary relevance such as diversity and respect of all religions. Learners can consider the specific historical-social context in which the examined case occurred and compare it with familiar modern phenomena that tend to contain common features in their form and manifestation (Zapalska and Wingrove-Haugland 2016).

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[16] Cf. Protopapadakis 2019, 15: "bioethics needs to regulate research, safeguard interests, set and prioritize principles, and define boundaries, always keeping one eye fixed on progress, and the other on the lines of Goethe's *Wizard's Apprentice*, so as to eliminate the gloomy possibility of a second Holocaust, or a sequel of Hiroshima.".

15.5.2 The Holocaust and the Head, Heart, Hand Educational Model Part One

The first part of the Head, Hand, Heart model focus on the Head, which references aims to build the whole cognitive background around the event in order to equip learners with all the spiritual tools to allow them to acquire critical thinking, both by learning how to gather and assess information of historical events (Foster 2020) and by recognizing and opposing flawed argumentation when confronted with ideas of a totalitarian or authoritarian nature.

Knowledge of the Holocaust, including the evolution of nationalist ideas, the methods used to degrade the dignity and diversity of the other, and the inescapable guilt that followed, is relevant to understanding the times we live in today. Often many forms of harassment, denigration of one's neighbor, and denunciation or mockery of religious otherness (which may range from the dietary choices imposed by one's religious culture to the use of a headscarf, bearing a cross, a kippa, or other symbol, etc.) begin in an individual or small-scale environment. If, however, society is in the midst of an unfortunate political moment or in the context of an economic or social crisis, these small-scale aggressions have the potential to take on catastrophic proportions (Philpott 2007).

At a secondary level, it is necessary to know the post-Holocaust reaction, because remembering what occurred during the Holocaust can serve the purpose of preventing it from occurring again. When students discuss the purpose of the UN's founding, the decisions of the International Courts, and the creation of the Nuremberg Code of Ethics, and see how those events were influenced by and influenced interfaith communication, it will have a significant effect on the formation of a universal consciousness of acceptance of the other and function as a bulwark against any form of distortion of acquired values.

At a tertiary level, it is important not to exhaust the consolidation of all this knowledge and information within one's educational life by focusing exclusively on relevant courses, but rather one should seek a multifaceted interdisciplinary approach through other courses with similar references, such as political education, sociology, art, literature, history, etc. (Michalski 2005). Also, as learning tends to become a lifelong commitment with many training seminars, it is equally important that all this information is recalled and disseminated from time to time on the occasion of anniversaries or events, either through the media or through information campaigns.

15.5.3 The Holocaust and the Head, Heart, Hand Educational Model Part Two

The purpose of the second portion of the Head, Heart, Hand Educational Model is to achieve empathy (Wood 2019) through the cultivation of reaction, awareness, and non-silence when citizens are faced with any form of violation of the acquired values inherited by the collective memory and evaluation of the Holocaust. Citizens themselves become the direct recipients of any observed deviation in the social, vocational, or even digital environment in which they exist. By expressing opposition and addressing collective bodies, an immediate reaction is effectively achieved before the individual event takes root. There is no more drastic deterrent for defending social justice and promoting social change than by developing alliances and defensive relations between social groups.

The awareness that is achieved through the actions of the educational Head model should not be buried in the inertia of understanding only historical events. Encouraging controversy, a willingness to react immediately and to engage, to express outright disapproval to those distancing themselves or denying any violation of the right to self-determination, otherness or deviation from the acquis of the international code, must be considered obligations to oneself and to the collective whole. Holocaust distortion and denial (Cohen-Almagor 2008), for example, are common practices of people who harbor extremist ideologies. By knowing what lies behind the alteration or apparent rejection of facts, the citizen can now understand how many acquired humanitarian values are at stake. However, understanding alone is not enough. One must also speak. On an individual level, this translates into the skill of being able to deconstruct and oppose prejudices using one's own democratic principles and representative characteristics, the one-sided thinking, selfishness, and intransigence, which are incompatible with respect for, and acceptance of the right to otherness.

In order for citizens to cultivate their courage in expressing their opinion, it is necessary to be introduced to the procedures followed in respective human rights violations either by international or official human rights bodies, by courts or even by individuals, as well as to role models—people who, by raising their stature and raising their voices, broke the silence and the display of tolerance in matters of individual dignity, diversity and human rights. At this point, one understands the importance of having representatives of religions, organizations, and social groups come together to produce joint statements with one voice that address discrimination or human rights violations, regardless of whether the matter at hand directly affects the individuals or groups.[17] The collective sense of responsibility necessitates that when the reputation and dignity of the other is affected, one must take a stand, because the threat of "today he, tomorrow it is my turn" will always hover.

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[17] One more interesting approach is the parallel presentation of facts with similar characteristics that took place in different parts of the world: for example, "through *comparative storytelling* and *comparative spirituality* in response to some of the defining events of the twentieth century – the struggle against colonialism, racism, sexism, terrorism, and the human capacity to inflict mass death revealed at Auschwitz and Hiroshima" (Fasching et al. 2011, 6).

15.5.4 The Holocaust and the Head, Heart, Hand Educational Model Part Three

Knowledge leads to expression, and expression leads to immediate action in this educational model. The goal of the third part of the Head, Heart, Hand model is action. Active mobilization at every level is essential: personal, professional, collective. The aim here is to practically promote the importance of diversity, interreligious communication, and human rights. Here education is called upon to activate alternative approaches, utilizing the combined benefits of so-called informal and non-normal education. With the variety and dynamics provided by this multiple learning strategy, in combination with the previous ones, a multifaceted and multidimensional scheme of transmitting knowledge and experiences is created.

The advantage of this educational approach is that the benefits learners gain have a lasting, life-long positive impact. The success of an educational model is not limited to the narrow duration of the instructor-learner relationship. Real success comes from lasting change that will creatively permeate the learner throughout his life. Such an example is that of the US Holocaust Memorial Museum, which presents “an ‘inclusive’ approach to the Holocaust, an approach that attracts adults and especially young people from a wide variety of (ethnic and religious) backgrounds” (van Driel 2003, 134).

An added benefit of this combined method is the opportunity given to the instructor for self-action, initiative of selection and connection of the educational purpose with the free expression of his or her personal experiences and perceptions, always integrated and focused on the predetermined educational purposes of the event. At the same time, the instructor will be confronted with a non-exclusively educational environment that will challenge him or her to fulfill his or her teaching objectives and achieve a cognitive result in a nontraditional setting.

The activities related to the purposes of the Hand educational model usually have the character of an *extracurricular education* or *techno science education.* Such might be a visit to a Holocaust Museum, a Genocide Memorial, a religious monument, a site where a symbolic work of art has been erected to commemorate the rights of vulnerable social groups or minorities, or a relevant film screening at a cinema.[18] They might not be places of classical, formal education, but they are places of broader education, where the formal teaching is consolidated in a freer environment, thus increasing the chances for learning assimilation of the pertinent subject. At the same time, the organization of artistic, literary, and digital events and teleconferences that have a multicultural and inter-religious character are considered necessary for the consolidation and dissemination of the taught values with clear messages so as to combat prejudices, violence, sexism, and social stigma.

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[18] Other examples include “programs operating in refugee camps, in post-conflict societies, with victims of domestic abuse, and with groups serving the poor” (Tibbitts 2002, 9).

15.6 Outlook

In the case of the Holocaust, one cannot easily isolate which of the two characteristics of the Jewish people—their ethnicity or their faith—was more distressing to the Nazis. It certainly was both, and many events rotated around these foci. Observing the Holocaust as a multifaceted event can also teach us that no progress—no good—comes from anything and anyone who ignores the recognition of personal value and deprives individuals of the right to self-awareness, freedom of belief, and individuality in expression.

The ultimate goal is for the youth, as citizens of tomorrow, to take initiative and be an active part of any event or organization that encourages diversity, intercultural pluralism, and interfaith encounters and interactions. Likewise, educating individuals at an early age about courage of speech will cultivate morally responsible reactions to s violations of rights or values. This will positively impact society and help ensure a future where all people are treated with dignity and respect.

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Chapter 16
Medicine, the Holocaust, and Human Dignity: Lessons from Human Rights

Jason Adam Wasserman and Mark Christopher Navin

Abstract The development of bioethics in the late Twentieth Century parallels the development of human rights discourses. Both intellectual movements have ideological roots in a reckoning with the tragedy of the Holocaust and both invoke conceptions of human dignity that have sometimes been accused of being vague or empty and therefore useless. However, despite its ambiguity, human dignity plays an important role in both discourses. In particular, we argue that bioethics scholars can learn from how advocates of human rights have balanced their idealized and abstract conceptions of dignity (and other values) with a focus on how real-world personal and institutional moral failures can inform efforts to promote human rights. We argue that a reengagement with the horrors of the Holocaust can supplement and motivate a critical, real-world bioethics, one that is responsive to the personal and institutional failures of our time and which provides practical guidance under *non-ideal* conditions.

16.1 Introduction

The Holocaust gave birth to an international human rights agenda and, later and somewhat circuitously, to the bioethics revolution. These are distinct movements: The former expresses the idea that individual persons have fundamental interests that ought to be protected by the state and which are also a matter of international concern and potential intervention. The latter expresses the idea that patients and research subjects are entitled to special protections and that clinicians and researchers need

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to better incorporate the values and preferences of patients and subjects. However, human rights and bioethics movements are similar kinds of *philosophical* projects. They both introduce new moral vocabularies that attempt to build a consensus about what people are owed among diverse peoples within and between societies (Andorno 2009).

In light of the structural similarity between human rights and bioethics discourses, bioethics may have something to learn from critical philosophical work about human rights. In particular, bioethics can benefit from insights about the role that human dignity plays in explaining and justifying human rights claims. We argue that one such insight is that bioethics needs to balance the idealization and abstraction of its theories (e.g., about the basis of 'respect for persons' or what 'autonomy' means) with a focus on real-world personal and institutional moral failures. In the Twentieth Century, experiences of the Holocaust helped the creators of human rights and bioethics to identify *ideals* towards which their theories directed people. In the Twenty-First century, a reengagement with the details of the Holocaust can teach us how to respond to the *nonideal* complex moral challenges and messy contingencies of real life.

In this chapter, we argue that bioethics faces similar philosophical challenges as those that face human rights discourses and that these challenges can be met in a similar way. Appeals to human dignity are prevalent in bioethics, but that concept is just as under-developed in bioethics as it is in the human rights literature. Also, bioethics similarly turns to autonomy as a core value, but it supplements it with other values, including beneficence, justice, and non-maleficence. Yet, these concepts are often too abstract or too idealized to give the kinds of guidance that real-world bioethics requires. What we need is a non-ideal theory of bioethics. The bioethical lessons wrought from the Holocaust about human dignity itself and the challenges involved in specifying that construct can contribute to such a theory.

This chapter explores what the Holocaust can teach medicine and bioethics about human dignity, particularly as a concept that signals more about the moral worth of persons than simply their ability to make choices (autonomy), avoid pain (nonmaleficence), and pursue interests (beneficence). We acknowledge the substantive emptiness of the concept of human dignity, but the combination of its universal appeal and its philosophical ambiguity can generate immediate consensus and motivate ongoing moral investigation. Indeed, the dominant bioethics discourse surrounding 'autonomy' is an example of such an investigation. 'Autonomy', such as it is in bioethics, has been informed by appeals to human dignity, with roots tracing back to the Holocaust and the Doctors' Trials at Nuremberg.[1] Thus, while the notion of autonomy conceives of what it means to be a person in only a partial way, it is nonetheless illustrative as a product of a collective methodology. We will argue that many of the shortcomings of the principles of bioethics can be supplemented by

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[1] As we discuss below, the relationship of the Holocaust to bioethics was not formally engaged to any significant degree until the later advent of bioethics as a professional discipline following additional travesties in research ethics such as Tuskegee.

engaging in similar ongoing discourses, and, in particular, by reorienting to a non-ideal bioethics grounded in the Holocaust. That is, appeals to human dignity, even as a substantively impoverished construct, can generate new moral tools for the kinds of bioethics problems that the principles of bioethics cannot sufficiently address.

16.2 Making Sense of Human Dignity

From its beginning, there has been substantial criticism about the philosophical foundations of human rights and, in particular, the central role played by the idea of human dignity. On one hand, human rights discourse aims to be a universal moral vocabulary, so it should not be expressed in terms of parochial religious or philosophical ideas. On the other hand, there must be some set of moral reasons to care about human rights, or else it is an empty placeholder (Schulman 2008). Depending on how one attempts to resolve this dilemma, they can end up with conceptions of human rights that seem hopelessly vague, inevitably religious, western-centric, or that represent indefensible forms of human exceptionalism (Jacobson 2006; Schmidt 2007).

Many people have attempted to provide more fully theorized accounts of human dignity (Gilaber 2018; Kateb 2011; Rosen 2018), but these efforts consistently meet with skepticism or irresolvable disagreement (Macklin 2003; Sangiovanni 2017). Some suggest that human dignity can be operationalized as autonomy. In turn, the practical work of protecting dignity entails protecting people from coercion and ensuring their ability to make choices (Griffin 2008). Others reply that autonomy does not capture everything that human rights aim to protect or that it does not accord with the variety of justifications people provide for human rights (Beitz 2009). Ultimately, the fundamental problem may concern excessive abstraction and idealization in our theorizing (Farelly 2007; Mills 2005; Sen 2011). What we need, perhaps, is a theory of human rights—and of political philosophy, more generally—that offers guidance in the real, highly imperfect worlds we actually inhabit, and not a perfect abstract philosophical theory. On such a view, we need moral concepts that offer guidance when other people are acting immorally, when the institutions we work within are faltering, and when we aim to *resist* particular injustices, rather than when we are merely *aspiring* for a utopian ideal.

We do not answer these critiques, nor do we provide a robust philosophical defense of human dignity. Instead, we provide a modest defense of dignity, but one which paves the way for future discourse and richer analysis. We agree that the current conception of human dignity ultimately serves as a placeholder for our intuitions about the value of human persons and the duties that are grounded by that value. By itself, ‘dignity’ tells us little about *what* we ought to do, or *why* we ought to do it. Nonetheless, this concept can serve as a touchstone that directs us to answer questions about our moral sentiments, to refine and better articulate a fuller notion of our ethical obligations.

We cannot avoid the centrality of human dignity for the normative foundations of international human rights documents. It is invoked at the beginning of the UN

Charter and of the Universal Declaration of 1948. According to the two major human rights covenants—International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic, Social, and Cultural Rights (ICESCR)—human rights "derive from the inherent dignity of the human person" (International Covenant on Civil and Political Rights 1976; International Covenant on Economic, Social and Cultural Rights 1976). The 1975 Helsinki Final Act states that "all" human rights, including "civil, political, economic, social, cultural and other," "derive from the inherent dignity of the human person" (Conference on Security and Co-Operation in Europe 1975; quoted in Beitz 2013, p. 259). The horrors of the Holocaust, having been put on display at Nuremburg, help explain such rhetoric. However, the correct operationalization of dignity in political action, in establishing exactly what kinds of restrictions particular sovereign states could place on citizens and which could be subject to international condemnation, requires further evidence and argument.

The numerous competing interpretations of the concept render ambiguities pervasive when it comes to elaborating the duties that follow from a commitment to human dignity (Chapman 2010). It is clear to the point of obvious that genocide violates dignity, whatever the details of any theory of dignity. But it is less clear that it violates someone's dignity to fail to provide them with access to the "enjoyment of the highest attainable standard of physical and mental health," as article 12.1 of the ICESCR states. Does dignity require that all people have the best possible medical care, or should this statement be struck from the ICESCR as inappropriate for inclusion in a list of *true* human rights? To answer these kinds of questions we need a robust theory of what 'dignity' requires. We also need a theory underlying the philosophical foundations of human rights, something that international human rights documents currently do not provide (Gostin 2001).

Correspondingly, in the area of medical ethics, we can ask what it means for health care professions to protect and promote the dignity of patients. Here, too, some transgressions are clearly prohibited (e.g., causing harm or unduly undermining patients' choices about their treatments), but many questions are left unanswered. Thus, while rhetorical appeals to respect for persons and dignity are common, what they mean for how we ought to treat patients is often unclear. On this point, Ruth Macklin argues that we should abandon the idea of "dignity" in bioethics and, instead, rely on more substantive moral ideas, like autonomy and nonmaleficence (Macklin 2003). She writes:

> Possibly the most prominent references to dignity appear in the many international human rights instruments, such as the United Nations' universal declaration of human rights. With few exceptions, these conventions do not address medical treatment or research. A leading exception is the Council of Europe's convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine. In this and other documents "dignity" seems to have no meaning beyond what is implied by the principle of medical ethics, respect for persons: the need to obtain voluntary, informed consent; the requirement to protect confidentiality; and the need to avoid discrimination and abusive practices. (Macklin 2003, p. 1419)

Macklin continues, noting the perhaps inevitably religious foundations of human dignity:

> Why, then, do so many articles and reports appeal to human dignity, as if it means something over and above respect for persons or for their autonomy? A possible explanation is the many religious sources that refer to human dignity, especially but not exclusively in Roman Catholic writings. However, this religious source cannot explain how and why dignity has crept into the secular literature in medical ethics. (Macklin 2003, p. 1420)

Noted critic of bioethics, Stephen Pinker, agrees with Macklin:

> Reductions in dignity may harden the perceiver's heart and loosen his inhibitions against mistreating the person. When people are degraded and humiliated, such as Jews in Nazi Germany being forced to wear yellow armbands or dissidents in the Cultural Revolution being forced to wear grotesque haircuts and costumes, onlookers find it easier to despise them. [However,] all these cases involve coercion, so once again they are ruled out by autonomy and respect for persons. So, even when breaches of dignity lead to an identifiable harm, it's ultimately autonomy and respect for persons that gives us the grounds for condemning it. (Pinker 2009, p. 31)

Notice, however, that Pinker implicitly makes something of a concession here by stipulating that many of these cases surely do involve breaches of dignity, even if autonomy and respect for persons do the heavy lifting in terms of justifying actual protections for patients and research participants.

We raise a question that Pinker gets close to asking, but never does: Do these principles of bioethics *always* offer protection against indignities? Do these concepts sufficiently *explain* the wrongs associated with violations of dignity? Do they provide us with sufficient *guidance* about what to do when violations of dignity occur? We think the answer is 'No.' However, a search for a more robust notion of human dignity—one the extends beyond "respect for persons," "autonomy," and "beneficence," etc.—*can* affirmatively answer these demands.

Specifically, we need to reconsider whether the ambiguity of human dignity actually renders it useless. While the substantive emptiness of the construct may mean that it does not do much to direct our actions, it may nonetheless be valuable. We argue that it is precisely because it is both substantively empty and the source of ongoing consensus, that we can return to human dignity with new challenges and questions for bioethics. In much the same way that principles of bioethics were originally derived by evaluation of socio-historical events from the point of view of violations of human dignity,[2] we can continue to generate new moral vocabularies in bioethics by orienting ourselves to real-world violations of dignity (Habermas 2012).

16.3 Human Dignity, Bioethics, and the Holocaust

The principles of bioethics have an ideological lineage rooted in the atrocities of the Holocaust and the Nuremburg codes that followed. However, in the US context, they crystallized around other watershed events such as the Tuskegee Syphilis and

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[2] For a discussion of human dignity as the grounding for deontological norms in biomedical ethics, see Rothhaar (2010).

Willowbrook experiments (in the research context) and cases such as Karen Ann Quinlan and Dax Cowart (in the clinical context) (Hinote and Wasserman 2020). The seeds of medical ethics planted at Nuremburg did not really begin to grow in the United States until the 1970s. For more than two decades following the end of WWII, human research subjects, including children, were subjected to medical experiments without regard for their autonomy or best interest (or where the logic of benefit was contorted beyond recognition) (Beauchamp 2014).

This presents an interesting question. How could the revelation of the horrors of the Holocaust have been met with a comparatively tepid response? Why did it take another 25 years, and many more unethical experiments, to begin serious attempts at an ethical consensus for medical research and (later) clinical practice?

One answer is rooted in the uniqueness of the Holocaust. During the Doctors' Trial at Nuremburg, the U.S. faced the embarrassment that Nazi physicians learned from and emulated American medical research and pro-eugenics laws and policies, including *Buck v. Bell* (Okrent 2019; see also Rubenfeld 2014). The fact that the Holocaust itself—and especially the medical experiments conducted at Auschwitz—were so gruesome and so unprecedented in their scale allowed US medical researchers to imagine that their own practices were not implicated. This kind of "American Exceptionalism," framed the Holocaust generally, and the participation of physicians within it, as an aberration, a breakdown in an otherwise strong professional ethic (Brody 2014). Katz asserts that American medical leaders saw the Nuremburg Code—with its institutionalization of patient and research participants' rights—as "a good code for barbarians but an unnecessary code for ordinary physician-scientists" (Katz 1992). This response ignores deep similarities between American and Nazi German medical research, including the longstanding high regard that U.S. doctors had for their German counterparts in the early decades of the twentieth century through the start of WWII (Duffy 1993). It also supposes that Nazi medicine abandoned the medical ethics of the day, while, in fact, Nazi physicians had developed *their own* theories of bioethics. For example, Rudolf Ramm's 1942 book *Medical Jurisprudence and the Rules of the Medical Profession* explicated a distinctly Nazi medical ethics and was widely distributed in Germany (Ramm 2019).

In this light, we cannot understand contemporary bioethics as the emergence of ethics itself, but rather the postulation of a kind of ethics that responds to, among other historical events, the horrors of the Holocaust. In particular, the Nazi personification of the "social organism" and the related fetishization of "social health," subverted the notion of the individual as a moral entity and projected it onto that of the collective. Notions of individual self-determination or the idea that the right way to define welfare is fundamentally in terms of individual well-being can be read as antithetical to those kinds of extreme collectivism. But while the elaboration of a largely individualist medical ethics feels right, particularly in response to Nazi medical ethics and the atrocities it allowed, it rests on an inevitably ambiguous metaphysics.

The idea of society as an organism has a kind of empirical clarity. Similarly, hedonic versions of individual well-being, which certainly form part of our account of bioethics, rest clearly in human animal's ability to feel pain (and, of course, also raise oft-avoided questions about why this does not accord non-human animals moral standing). But just why human beings are worthy of dignity or respect requires a metaphysics of the human that is difficult to ground empirically. This challenges the ability to produce a secular account of human dignity and a corresponding account of our moral obligations to respect persons. The answer to this challenge in Western bioethics has centered on the reduction of the notion of "respect" to the notion of self-determination through choice-making, rendering it more discrete, observable, and measurable. In turn, the concept is more widely agreeable across groups which may hold radically different metaphysical commitments, but which nonetheless arrive at the same conclusion about the right of individuals to make decisions about their own lives.

The codification of respect for persons into autonomy, however, disregards important qualities of humanism and moral life. Insofar as we can trace the origins of contemporary bioethics to the Holocaust, we can also return to that history to ask what lessons might have been left behind. Take for example this first-hand account of the medical experiments at Auschwitz, written by someone identified by the Claims Conference as Ms. M.:

> I was about five weeks in Auschwitz alone, separated from my family, my parents, two sisters and two brothers when Dr. Mengele pulled me out of a queue as we were on the way from the c-lager [camp] to the gas chamber. I was the only one picked that day personally by Mengele and his assistant. They took me to his [laboratory], where I met other children. They were screaming from pain. Black and blue bodies covered with blood. I collapsed from horror and terror and fainted. A bucket of cold water was thrown on me to revive me. As soon as I stood up, I was whipped with a leather whip which broke my flesh, then I was told the whipping was a sample of what I would receive if I did not follow instructions and orders. I was used as a guinea pig for medical experiments. I was never ever given painkillers or anesthetics. Every day I suffered excruciating pain. I was injected with drugs and chemicals. My body most of the time was connected to tubes which inserted some drugs in to my body. Many days I was tied up for hours. Some days they made cuts in to my body and left the wounds open for them to study. Most of the time there nothing to eat. Every day my body was numb with pain. There was no more skin left on my body for them to put injections or tubes … One day we woke up and the place was empty. We were left with open infected wounds and no food. We all were half dead with no energy or life left in us. [One] day … Russian soldiers tried to shake me to see if I was alone or dead. They felt a tiny beat in my heart and quickly picked me up and took me to a hospital. (Claims Conference 2020)

Certainly, the bioethics principles of autonomy, non-maleficence, and beneficence can make some sense of the moral failings in this account. But at the same time, it feels insufficient to say that what was unethical about the treatment of Ms. M. as a child was only that she was harmed, or that her best interests were not promoted. It would feel equally insufficient to say of an adult experiencing such treatment that the moral failing resided in the fact that she did not provide informed consent for her participation in the experiment. These are all true statements, but they are only partial accounts of what went wrong. The screams of these children, the violation of their innocence, the abject cruelty they experienced orbit other moral notions. There is in this description a kind of sorrow lying beyond the account of morality captured by the principles of bioethics and which those abstract and idealized principles cannot adequately depict.

In the same way that the mid-level principle of autonomy identifies something important about what is wrong in the narrative above, we can return to the amorphous construct of human dignity to ask what else is wrong, beyond the coercion and the harm it recounts. This points to the utility of human dignity as a kind of non-ideal bioethics, one that, while substantively empty, can let us ask real questions about how we ought to act, particularly in an imperfect moral universe where we must actually live our lives. The Holocaust has particular lessons here as well.

16.4 The Holocaust and Non-ideal Theory in Bioethics

One of the core debates in contemporary political philosophy concerns the relationship between two different kinds of approaches to thinking about social justice and the responsibilities that individuals have to promote social justice. Debates about the value of 'ideal theory' versus 'non-ideal theory' take place on three axes that are relevant for thinking about the role of the Holocaust in our thinking about bioethics.[3] In particular, the concept of human dignity is useful for framing a non-ideal theory bioethics, one grounded in the details of real histories, including and perhaps especially the Holocaust and its aftermath. This kind of account is necessary to supplement an ideal theory bioethics that is grounded in the principles of autonomy, beneficence, justice, and non-maleficence.[4]

On the first axis, ideal theory focuses on what we ought to do when most other people are ethical (this is sometimes called 'full compliance theory'), while non-ideal theory focuses on what we ought to do when many or most people are not doing what they should (sometimes called 'partial compliance theory') (Rawls 1999, p. 8, 215; see also Murphy 2000). Some of the rules of full compliance theory bioethics always apply. For example, we always ought to act with beneficence and to respect autonomy. But we need a bigger toolkit for thinking about ethical actions in medicine when we are surrounded by competing obligations, and sometimes even outright moral failures (Levine et al. 2019). For example, are healthcare personnel supposed to be self-sacrificial heroes to make up for the shortcomings of others? When and how do they have the right or the obligation to protect themselves from forms of moral injury or moral distress caused by the failure of others to do what they should? How far do the obligations to treat patients extend? For example, we know that poverty causes illness. What then are the obligations of physicians to address poverty and other kinds of social, structural conditions?

Second, ideal theory tells us what justice and ethics *are*, while non-ideal theory aims to tell us *what to do*. Ideal theory is the realm of pure philosophy, where ethical

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[3] Importantly, "non-ideal theory" is the term that describes a sort of theorizing grounded in the imperfect realities of our world. This is not to suggest that non-ideal theories are suboptimal (i.e., not as good as "ideal" theories), but rather that they are responsive to the non-ideal worlds we actually live in; see Laura Valentini (2012); see also the taxonomy in Robeyns (2008).

[4] For examples of others who have applied the idea of idea/non-ideal theory to bioethics, see Goodin (2012), Kittay (2008), Luna (2015), Sreenivasan (2012).

investigation aims to get us to *true beliefs* about ethics and justice, even if those true beliefs do not tell us how to live our lives. G.A. Cohen famously wrote that the relevant question for theories of justice "is not what we should do but what we should think, even when what we should think makes no practical difference" (Cohen 2008). In contrast, non-ideal theorizing aims to give concrete guidance for our lives today, and that requires us to identify empirically-informed and historically contingent rules of action. While an ideal theory bioethics may do a good job telling us what medicine *ought* to look like, it may not do a good job of telling us *what to do* in our current world. Yes, we want dignity for patients and providers, and yes, we also want to value autonomy and act beneficently. But what should we do when those things are impossible? What should we do when healthcare institutions fall short? What should we do in contexts of scarcity or triage? How should we live in the context of so much injustice? Non-ideal bioethics offers help to answer these kinds of questions.

Third, ideal theory tells us what the perfectly just world looks like; it identifies the goal at which we are aimed. In contrast, non-ideal theoryfocuses on diagnosing existing injustices, and making the world somewhat less horrible. Utopian thinking is, of its nature, a kind of ideal theory, and it has been central to political philosophy, from Plato's *Republic* to Rawls's *Theory of Justice*. But the mere fact that you *have* a goal does not tell you *how* to approach that goal, or even *whether* you ought to aim for that goal in your current circumstances. Attempts at utopian revolution often backfire disastrously. Often, the best thing you can do is make an existing system somewhat less unjust, even if that makes some forms of contemporary injustice even more intransigent (Gaus 2016). Non-ideal theory focuses on these more concrete and transitional projects by orienting us to the evils and injustices that we are motivated to resist, and not only goals we are trying to pursue. Amartya Sen (2011) argues that non-ideal theory correctly notes that our motivations are more often about resisting existing injustices than pursuing justice as an ideal: "What moves us, reasonably enough, is not the realization that the world falls short of being completely just—which few of us expect—but that there are clearly remediable injustices around us which we want to eliminate." In turn, a non-ideal bioethics is always oriented to ongoing injustices, and the histories of oppression and inhumanity that have informed current practices. A non-ideal bioethics aims at a better world, but is always practically engaged in resisting current wrongs, and at avoiding the resurgence of evils that we have previously faced.

A non-ideal bioethics for today's world benefits from deep and sustained engagement with the facts of the Holocaust, and with the impact of the Holocaust on the current practice of medicine and medical research. Take for example, Gisella Perl, the Jewish physician who worked under the supervision of Josef Mengele in the women's hospital at Auschwitz. Because pregnancy was punishable by death, Perl performed not only abortions, but infanticide, in an effort to save the lives of the women prisoners. In this and many other ways, she resisted, where she could, Mengele's dictates, using all sorts of deception. In her book, *I Was a Doctor in Auschwitz*, she offers a painful and honest account of just one such incident:

> The third day, Yolanda's little boy was born. I put her into the hospital, saying that she had pneumonia—an illness not punishable by death—and hid her child for two days, unable to destroy him. Then I could hide him no longer. I knew that if he were discovered, it would mean death to Yolanda, to myself, and to all these pregnant women whom my skill could still save. I took the warm little body in my hands, kissed the smooth face, caressed the long hair—then strangled him and buried his body under a mountain of corpses waiting to be cremated. (Perl 1948, p. 83)

As with the narrative above, the moral anguish captured in this account, both that of Perl herself and our own, as we read and reflect on these unimaginable circumstances, cannot be reduced to ideal-type principles like autonomy and beneficence. Of course, we could say that Perl's actions were in the "best interests" of Yolanda, perhaps neutral with respect to 'harms' to the infant since he was likely to be killed anyway. But such an analysis would be offensive to the richer moral sentiments captured here. There is a sorrow that pervades the account even for many of us who would judge Perl's actions ethical. There are in this account other ethical concepts that are at least as helpful as autonomy and beneficence in terms of making sense of what is right and wrong in this narrative. Notions of cruelty, inhumanity, and desperation surely must inform our ethical analysis of Perl's decisions. These moral sentiments capture the lived experience of the ethical dilemmas she faced in a way that the principles of ethics do not. Indeed, many ideals of ethics ran up against the real-world context in which Perl had to try to live out her profession as a moral actor. We might even say, somewhat ironically, that Perl lied and cheated her way through the Holocaust and that she was right to do it. In light of Perl's story, we can see the clear limits of the concepts of autonomy, non-maleficence, and beneficence, and we must acknowledge the need to look for other moral tools.

A deep study of the Holocaust illuminates our understanding of what is morally required of physicians and other healthcare providers when they *cannot count on other people to do what is right*. There are stories of heroism, especially among the Jewish doctors who continued to care for people in the ghettos and in the camps, often under impossible conditions (Oberman et al. 2010; Reis and Wald 2009; Wasserman and Yoskowitz 2019). There are also the many stories of non-Jewish physicians and healthcare workers who resisted the Nazi regime, often at great risk to their careers and even, at times, their lives. Even amidst tragic circumstances and insurmountable odds, they found ways to assert their humanity and to make even the most horrible of worlds (e.g., the ghettoes and camps) a little less horrible. From the point of ideal theory, it may be easy to condemn the kind of compromises that sometimes had to be made, or at least the way in which we might make sense of them seems like a tortured application of insufficient tools. But a non-ideal orientation points us to much more difficult questions about what we ought to do when people around us are acting badly. While we can reasonably hope that none of today's physicians will face moral failures like the Holocaust, we should recognize that they will often face the moral shortcomings of the other people with whom they work and the larger social systems within which they work.

An engagement with the facts of the Holocaust helps us to construct a non-ideal bioethics that is always *practical* because it is dynamically responsive to the actual situations in which we are trying to decide how to act. We are theorists—in sociology and philosophy—and we appreciate the value of theory for its own sake. But a bioethics theory should always orient us to action and towards resisting injustice. The Holocaust is not a theory. It is not a set of principles. It is an evil that demands a response. To think about and study the Holocaust is to try to answer questions about what we would have done, or what we should have done, in light of our knowledge about the choices that many people actually did make.

Finally, the Holocaust forces us to think about bioethics as less of a journey towards what we believe is good, and more of a fight against what we know is bad. This kind of non-ideal bioethics is not just about striving for a goal of treating patients well. It is not only about building autonomy, nonmaleficence, beneficence, and justice into patient care. It is also always about refusing to become cruel and inhumane. It is about responding to desperate circumstances with courage and compromise, when living up to the ideals of bioethics is not possible.

An orientation to a non-ideal bioethics is also important because we can feel abandoned by ideal-type principles as we try to navigate our imperfect worlds. The history of the Holocaust reminds us that bioethics is a fight against real enemies and dangers. There are forces in contemporary social institutions and in the perennial failures of human character that ensure that the dignity and autonomy of patients are always at risk. Confrontation with the Holocaust helps to ensure that people will feel the full force of what is at stake when we argue for values in medicine.

Bioethics is relatively new and was, forged, in part, from the ashes of the Holocaust.[5] We make a mistake if we think that the fervor of bioethics' early advocates will be automatically inherited by today's students. John Stuart Mill raised this worry when he argued that *fighting for new ideas* cultivates a passionate commitment that may not be adopted by those who are merely *taught those ideas* as part of the received wisdom:

> [W]hen [an idea] has come to be an hereditary creed, and to be received passively, not actively…there is a progressive tendency to forget all of the belief except the formularies, or to give it a dull and torpid assent, as if accepting it on trust dispensed with the necessity of realizing it in consciousness. (Mill 1859, p. 73)

A Holocaust bioethics makes the notion of human dignity more than just an empty creed. It instead fills people with a sense of the great values that are at stake and the great disasters that one must aim to avoid (Lerner and Rothman 1995). In this way, even in its substantive emptiness, the idea of "dignity" holds out a call to action and an opportunity to wrestle with the moral dimensions of the world as it really is. Today, the great challenge for bioethics is that many of its cornerstone ideas risk becoming merely parts of an 'hereditary creed'. However, just as these ideas were derived by reflection on moral atrocities, including the Holocaust, we can return over and over to the history of the Holocaust to ask ourselves what we ought to do, right here and right now.

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[5] This is particularly true with respect to certain key concepts such as voluntary informed consent; see Arthur L. Caplan, "The Meaning of the Holocaust for Bioethics," *The Hastings Center Report*, 19, No. 4. (1989): 2–3.

16.5 The Usefulness of Human Dignity

A non-ideal bioethics, especially one grounded in the realities of the Holocaust, can help us to better understand the meaning of human dignity and to complement the moral vocabulary that constitutes the 'ideal bioethics' (e.g. of 'autonomy' and 'beneficence'). Here too, we can look towards political philosophy to guide such an endeavor. Let us return to Habermas, who argues that attention to human moral failings, institutional limits, and the facts about real-world cruelties and injustices can orient us to a richer sense of what human dignity involves:

> The appeal to human rights feeds off the outrage of the humiliated at the violation of their human dignity. … [C]hanging historical conditions have merely made us aware of something that was inscribed in human rights implicitly from the outset—the normative substance of the equal dignity of every human being that human rights only spell out. (Habermas 2012, p. 66)

The problematical nature of the concept of human dignity has been the source of consternation, but this is also precisely what makes the concept an important source of moral reckoning. As Edmund Pellegrino writes:

> …intelligibility of so elusive a notion as dignity must be grounded in our lived experiences of dignity either personally or collectively or, as the rest of the world experienced the Holocaust and the other horrors of the last century, vicariously. This will require an effort to philosophize about dignity as a concept arising from, and returning to, experience in the real world of everyday life. (Pelligrino 2008, p. 516)

Grappling with the horrors of the Holocaust gave birth to efforts to articulate international consensus on human rights, and later, consensus around core bioethical principles. It is precisely because of its ambiguity that we can return to the concept of human dignity to address the insufficiencies of established mid-level principles like autonomy. It is also its substantive emptiness that makes it useful as a source of critical reflection and a wellspring of new moral ideas, particularly those which can help us navigate the imperfect, real world contexts of medicine today.

In this respect, we can look back to the notion of human dignity and what the history of the Holocaust signals to us about moral action in several key ways.

The first concerns a real-world moral methodology that grounds and humanizes ethics. In particular, violations of human dignity that we can witness in the Holocaust set off alarms in our moral sentiments. As we read these accounts, most of us feel something ranging from anxiety to existential dread and, in turn, we can feel the insufficiency of how abstract bioethics principles attempt to explain them. While such sentiment reflects a beginning rather than an end to the work that needs to be done to explicate actual moral concepts that can guide our decision making, it is a commitment to the notion of human dignity, a recognition that dignity violations are often sensed before they are articulated, that can motivate this work. The lesson here centers on the instrumental value of sentiment and intuition for calling bioethics forward.[6]

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[6] Wink (2006, p. 85) notes something similar about using Holocaust history in the classroom: "For our growth and students' learning, there exists a need to suffer the loss of out-moded thinking and

If we wrestle to explain what is morally wrong in the accounts of Perl or Ms. M., the existing bioethics tools leave us wanting, and, hopefully, compelled to go further. Similarly, in actual clinical interactions, one's sense that something is wrong often motivates further thought, more robust conversation with the patient, or ethics consultations in the hospital. Done well, these efforts should be about articulating the moral content of the situation, rather than the mere application of ideal-type principles (even if those offer helpful guidance). One can imagine for example an instance of treatment over objection of a patient, which may be fully justified on the grounds of best interest, but for which there is a moral residue found in the guilt of the physician, the alienation of the patient, and the distress of the staff (Navin et al. 2019; Wasserman et al. 2019). These concerns are owed the same kind of clarity we now have surrounding the balance of autonomy against beneficence in many clinical scenarios.

Secondly, staring back into the abyss of human dignity, anchored by the history of the Holocaust, helps us reflect on ways to navigate the imperfect and often unethical institutions in which we, as actors, are nonetheless striving to be ethical. This is an ever-present phenomenon, but perhaps most keenly illuminated by the COVID-19 pandemic. For example, appeals to abstract principles of justice and fairness helped elucidate various proposals related to the ethical distribution of scarce resources such as PPE, ventilators, experimental therapies, and vaccines. These schemas fell notably short when confronted with the social histories of socioeconomic and race inequality that became so evident during the pandemic. Black Americans, for example, faced disproportionate burdens during the pandemic, both in terms of prevalence and acuity. Yet protocols for rationing ventilators or vaccine distribution schemas tended to ignore this phenomenon. In fact, given the disproportionate burden of relevant clinical comorbidities among these populations, they are likely to have been disadvantaged in many of these rationing schemas. Certainly, incorporating these types of social factors into those schemas, which are already so complex as to be difficult to implement in real world clinical settings, represent a logistical challenge. But it also represents an insufficiency of the conceptual tools we use to navigate such moral challenges in bioethics in particular, the way in which fairness is operationalized is abstract and not grounded in real histories of racism and marginalization. Other moral tools can be derived and could be further specified, tools such as representation and reparation that are scarcely mentioned in the context of clinical ethics.

Third, and extending along the same lines as the concerns above, appeals to human dignity can help derive new concepts to guide medicine's commitment to humanism and social justice. Appeals to patient- and family-centered care have become canonical in contemporary medicine, but there is an interesting dearth of ethical justification for these. That is, shared decision making and patient-centered communication, are positioned, at best, as adjuncts to clinical ethics. We can see some ways in which shared decision making may help us navigate the tension between

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refine assumptions so that students can, in turn, dismantle their thinking, rise out of apathy and connect to emotion to break the sluggish cycle. Discovering one's feelings and giving language to those feelings is one response to apathy.".

autonomy and beneficence, but there is little by way of grounding these clearly in principles of ethics. Instead, these seemed to be assumed strategies of humanistic patient care, something that we intuitively feel is a good thing, but for which the moral foundations have not been clearly articulated (at least not in the same way that autonomy, non-maleficence, and beneficence have). Explicating precisely why centering patient narratives, not just their specific autonomous treatment preferences, in the context of caregiving represents a moral obligation can benefit by appeals to human dignity and refinement of relevant moral concepts from there. Not to do so risks relegating the various manifestations of patient centered care to merely a clinical strategy, something that serves providers rather than patients (Vinson 2016).

Concerns for social justice and the obligations of medicine to participate in the rectification of health inequalities beyond the clinical interaction may also benefit from appeals to human dignity and the lessons from the Holocaust. The Holocaust was predicated on a severe kind of othering. This same alienation pervades our society in ways that have health consequences for patients. While medicine has something of an arms-length relationship to public health, one that is supportive but understood as an effort distinct from clinical practice, appeals to human dignity may call this way of understanding clinical medicine into question. Sitting across from a homeless patient in a clinical encounter, it is problematic to divest the way that larger social inequalities have been inscribed on the body of that patient. Ethical care of that patient, then, demands a true coming together of those extra-clinical realities and the body in the clinic. Efforts at promoting structural competency in clinical medicine are a start to re-imaging the scope of clinical practice in this way (Metzl and Hansen 2014). However, as with patient centered care, without a strong moral foundation, one that can perhaps be extracted by staring into the emptiness of human dignity, and aided by appeal to various historical narratives, efforts to bring together the micro-level clinical moment with the macro-level social conditions in which patients live may be relegated to something strategic or supererogatory.

Finally, there is in the insufficiency of the dominant conceptual tools of bioethics an important lesson for all students of medicine and bioethics, no matter what their age or stage of career. That is, moral life is always, of necessity, an unfinished project. The moral concepts derived in response to specific historical moments serve particular social functions within medicine. These always will represent a partial address of the moral content of our complex and messy real lives. In this respect, we must always demand to know more, to go further, to turn back toward those histories and to examine what has occurred since to refine our moral sensibilities and our ethical tools. Correspondingly, our own professional identities and the value commitments we personally bring to our professions are always in a similar development. Reflecting on the history of medicine in the Holocaust helps us contribute not only to the collective moral project of bioethics, but also to our personal moral projects of professional identity formation (Reis et al. 2019). The emptiness of the construct of human dignity is precisely what allows it to compel us forward in this way. Its ambiguity is what makes it so useful.

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Chapter 17
The Goals of Medicine in a Post-Holocaust Society

Stacy Gallin

Abstract Determining the goals and purpose of the medical profession has long been a topic of debate among physicians and scholars alike. If medicine is a practice, then it is necessary to define the aim of the practitioner's actions. Regardless of the differing perspectives, there is consensus that the promotion and preservation of individual health and well-being is a primary component of medicine. However, an exploration of the medical community's active participation in the systematic labeling, persecution, forced sterilization, experimentation and eventual mass murder of millions of people deemed inferior or unfit during the Holocaust reveals decidedly different goals. Examining the process by which healers became killers provides an opportunity to hold the profession accountable, take stock of the moral vulnerabilities of physicians and use these lessons to create a post-Holocaust moral ethos that values rehumanization and human dignity.

17.1 Introduction

Defining what it is that physicians ought to do is a question that philosophers and practitioners have long grappled with. Finding a consensus regarding the exact purpose and specific goals of medicine has proven difficult. Is the primary goal of the physician to heal the sick and cure illness, to prevent future disease or premature death, to provide care directed by the wishes of the patient or third-party providers or to serve the best interest of society? Should physicians be categorized as scientists, artists, businesspeople, advocates, administrators, public servants, or some combination of these? What can and should be done when a conflict arises between goals and purposes (Pellegrino 2001)? The answers to these questions, among others, shape the foundations of our healthcare system; thus, it is understandable that they provoke debate.

There are two main perspectives concerning the goals of medicine. The first is the teleological approach, in which medicine is viewed as a practice with intrinsic

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goals, such as relieving suffering or treating illness. The roots of this approach are philosophical in nature and incorporate traditional views about actions, practices, and virtues. All actions and practices must be goal oriented. In this case the goal would be defined as the aim of medicine: namely restoring and maintaining health (Schramme 2015). Medicine is based on the human experience of sickness and healing. It is not socially constructed (Pellegrino 2001). Although it is possible that the purpose of medicine may change depending on the needs of society, the teleological approach necessitates that the goal would still need to remain aligned with the ultimate aim of medicine, which is the health of the patient (Schramme 2015).

The second technique used for defining the goals of medicine is the consensual approach. Published in a report by the Hastings Center in 1996, the purpose of this philosophy is to achieve international agreement regarding the goals of medicine by allowing for historical and social change (Schramme 2015). Daniel Callahan, the Co-Founder of the Hastings Center, lamented that contemporary medicine does not appear interested in any type of systemic inquiry as to the goals of medicine. He questioned:

> Is it no less important to ask whether medicine should have the same goals now as in the Hippocratic era, or in the 19th century? The litany is familiar: our century has seen an enormous increase in average life expectancy, the conquest of most infectious diseases, a huge increase in the cost of health care, the possibility of using genetic medicine to enhance human traits and a public demand for medical care that escalates just as steadily as its costs. (Callahan 1999, 103)

The consensual approach is an attempt to acknowledge that while there may be certain virtues or goods inherent to the practice of medicine, the social and historical environment in which medicine is practiced must also be taken into consideration when goals are determined. This includes scientific and technological advances that have altered the medical profession.

While these two approaches may differ in their methodologies, their outcomes are similar. Both the teleological and the consensual approaches advocate preventing sickness and disease and/or relieving the pain and suffering caused by them and promoting health and wellness. Specific questions as to exactly what constitutes "health" or "disease" and whether the role of medicine should include enhancement as well as curing continue to abound. It is clear there are many challenges associated with the philosophical nature of defining the goals and purpose of medicine and the implications of these issues are far-reaching (MacDougall 2020). However, regardless of any other questions that may arise, the well-being of the individual remains the priority of medicine.

For the purpose of this book and, more specifically, this final chapter focused on the goals of medicine in a post-Holocaust society, why is it important to examine the goals of medicine? If we can agree that the care and well-being of the individual is a priority within the medical profession, then the complete and utter disregard for the individual in Nazi medicine becomes even more stark by comparison. If we know that preventing sickness and disease and/or relieving the pain and suffering caused by them and promoting health and wellness are widely accepted goals of medicine, then the labeling, persecution, forced sterilization and experimentation and eventual mass murder perpetrated by Nazi doctors becomes almost unfathomable. In his article, "Goals of Medicine," Thomas Schramme stated that any "reference to the alleged goals of medicine can often be found in contexts where certain contested ways of using medical means are being discussed" (2020, 5). In the case of the Holocaust, we are trying to understand how the goals of medicine could shift so drastically as to allow healers to transform into killers. To do so, we must recognize how the social, political, and medical atrocities of the Holocaust are important, not simply as history, but because they can inform how we can and should act today to ensure that the goals of medicine in a post-Holocaust society remain true to their Hippocratic pledge to, "First, do no harm."

17.2 The Medical Profession in Nazi Germany

"The individual personality cannot be the final goal of ethics. […] The people (Volk) as an organism is the goal of our ethics […]" – Professor Dr. Fritz Lenz, Holder of the First Chair of Racial Hygiene in Germany (Bruns 2014, 215).

As previously established, the role of physicians in society can take on many forms, but they all must remain consistent with the mission of medicine, succinctly expressed by the maxim, "Cure sometimes, relieve often, and comfort always." However, medicine under the Third Reich bore very little resemblance to this notion. As a consequence of the Doctors' Trial at Nuremberg and the resulting Nuremberg Code, many people are aware of the medical experiments performed by physicians during the Holocaust. However, the abrogation of ethics was not relegated to this one area. The medical profession was actively involved in every aspect of the systematic labeling, persecution, forced eugenic sterilization, and eventual mass murder of millions of people deemed "unfit" in the only example of medically sanctioned genocide in history (Caplan 2010). The role of physicians during the Holocaust included, but was not limited to:

- Providing scientific justification for public policy measures
- Enforcing public policies through hereditary health courts
- Deciding which children would live or die based on nothing but questionnaires
- Injecting lethal doses of medication into disabled children and adults
- Falsifying death certificates
- Selecting who would be sent to an immediate death and who would be forced into labor on the ramps of the concentration camps
- Operating the gas chambers that killed millions of innocent victims (Proctor 1988; Lifton 1986)

Contrary to popular belief, physicians were not forced into these behaviors. Their participation was voluntary. The function of National Socialism in the process was not one of coercion, but rather of cooperation and empowerment (Proctor 1988). There were distinct changes in the moral ethos of the profession that allowed the primary task of the physician to transition from the care and well-being of the individual to the care and well-being of the nation of Germany. This paradigm shift, undertaken in the name of scientific and societal progress, became the foundation on which Nazi medicine was built. A variety of methods were implemented to provide the scientific and medical justification for Nazi political ideology, creating a powerful system that exploited and persecuted anyone considered to be an outsider.

17.2.1 Labeling and Othering

Placing people into social categories is an automatic act that begins in infancy. The process can help aid human development by allowing an individual to quickly assign unfamiliar people to groups to navigate the complexities of the social world we live in (Liberman et al. 2017). However, the process can also lead to stereotyping, discrimination, and dehumanization. While the process of "othering" may be an innate part of human development, its implications extend to the broader community as well. Sigmund Freud posited that one would naturally treat a neighbor differently than a stranger due to the feeling of connection that comes with being part of the same group. The idea of belonging to a shared community creates a moral obligation to care for one another. Those outside the shared community are not entitled to the same protections (Koonz 2003).

When attempting to understand how those who took an oath to care and heal could abandon their moral commitments, it is helpful to refer to a term Claudia Koonz refers to as the "Nazi conscience," which she describes as "a secular ethos that extended reciprocity only to members of the Aryan community, as defined by what racial scientists believed to be the most advanced biological knowledge of the day" (2003, 6). In the quest for societal progress, the people entrusted with creating these classifications and determining who belongs to the community of belonging and protection were the scientists and doctors. Science provided the justification for the creation of a hierarchy of human life in which certain people were seen as being racially, ethnically, or culturally inferior based on biological traits. Creating a rationale for labeling and othering was the first step in the transformation of physicians' moral ethos because it allowed them to alter the makeup of the community for whom they were responsible to care. It also paved the way for societal acceptance of the ostracization and exclusion of entire categories of people who were no longer considered part of the shared community.

Although the Holocaust is the only example of medically sanctioned genocide, the rationale behind scientific racism and discrimination goes back much further. Historically and philosophically, it is important to understand how the concepts of reason and progress were used to marginalize groups of people during the Enlightenment. The division of reason and unreason can be seen as the precursor to the eventual distinction between the mentally fit and the mentally unfit. Those considered to be unreasonable were seen as a threat to society, leading to the introduction of asylums to segregate them from the general population for the good of the community (Proctor 1988). This would allow the reasonable to thrive which would in turn lead to societal progress.

By the end of the eighteenth century, Enlightenment ideas about the power of reason, progress and science had usurped religion as the primary method for explaining social phenomena. Race, in particular, was identified as the driving force behind many of the major power shifts in world history. Arthur de Gobineau's "Essay on the Inequality of the Human Race" (1853–1855) argued that the history of the world could best be defined as a racial struggle and, perhaps more importantly, this racial history should be categorized as science. While the concept of racial prejudice was not invented by Gobineau, his work provided a rationale for ethnic and racial discrimination that was biological, rather than religious (Proctor 1988). The popularity and acceptance of Gobineau's theory demonstrates an important paradigm shift in which science replaced religion as the major explanatory force behind human nature.

As more people looked to science to provide biological explanations for human behavior, actions, and differences among members of humankind, the power of science to determine "the origin of human character and institutions" (Proctor 1988, 12–13) increased and it became "an important part of ideological argumentation and a means of social control" (Proctor 1988, 13). By the middle of the nineteenth century, science was seen as the answer to all of society's problems. While Gobineau's scientific racism was explanatory and theoretical in nature, once the idea grew and expanded it became part of a political ideology meant to support a power dynamic in which Anglo-Saxons remained the dominant culture (Proctor 1988).

By the first half of the twentieth century, Francis Galton's theory of eugenics rose to international popularity, formally codifying the idea that all human behavior-positive or negative- was attributable to biology. Prior to the 1930s, all German citizens belonged to the same shared community and were entitled to the same protections. Eugenic theory broadened the spectrum of who could be excluded from this community, resulting in an increase in discriminatory policies focused on those with disabilities and restrictions on immigration (Robertson et al. 2019). Public policies such as the 1935 Nuremberg Laws were a blatant attempt to change the definition of who was to be considered a German citizen, and thus what rights were to be granted to whom. By 1939, there was a clear distinction between Aryans and non-Aryans, between those who were productive members of the *Volk* and those who were deemed "unfit." These definitions were not arbitrary. They were created based on a combination of scientific theory and Nazi ideology (Koonz 2003). They were accepted by the public because of the leadership and endorsement of the medical community.

Science had provided an explanation for the cause of society's ills; it was now the job of the medical community to take the appropriate action to prevent further degeneration of the state and ensure its strength and vitality for years to come.

17.2.2 Medicalization and Dehumanization

As defined by Peter Breggin, medicalization in Nazi Germany referred to “the application of medical ‘diagnosis’ to psychological, social, spiritual, and political problems. The use of diagnoses establishes a hierarchy of superior (allegedly normal) and inferior (allegedly mentally ill) people. It ‘medicalizes’ human conflict, permitting ‘treatment’ of the victims. This fit Nazi ideology and paved the way for ‘selections’ in extermination centers” (1993, 143). Using this type of biomedical model to explain behavioral or psychological variations aligns with eugenic theory because it assumes that there is an inherited, genetic basis to abnormal behavior which predisposes a person to being biologically inferior. Further, medicalization advocates for the use of healthcare practitioners using biomedical means as the primary methodology for dealing with these problems (Breggin 1993).

Medicine was given a prominent role in Nazi Germany and the power and privilege that accompany this position in society. Adolf Hitler gave a speech to the National Socialist Physicians’ League in which he stated, “You, you National Socialist doctors, I cannot do without you for a single day, not a single hour. If not for you, if you fail me, then all is lost. For what good are our struggles, if the health of our people is in danger?” (Proctor 1988, 64) Physicians in Nazi Germany were tasked with finding and implementing a medical cure for society’s ailments, based on the definition of eugenics: “the science which deals with all influences that improve the inborn qualities of a race; also with those that develop them to the utmost advantage” (Galton 1904, 1). Thus, the role of the physician in Nazi Germany was to label and medicalize the inferior and unfit and then rid the nation of this biological scourge.

Physicians defined the category of “unfit” in a way that aligned with eugenic theory while also benefitting Nazi ideology. Following in the footsteps of Enlightenment philosophers, anyone deemed “mentally unfit” was segregated from the community for the good of society. However, Nazi medicine differed from Enlightenment philosophy in its treatment protocols. Many of these people were forcibly sterilized or killed- not because it was in the best interest of the individual, but because they could not contribute to society and were a biological threat to the health and future of the *Volk*. They were removed from the community of belonging by physicians, and their freedoms, rights, and liberties, including the right to life, were taken from them. The same fate would befall the Jews who were forced into ghettos to segregate them from their Aryan counterparts and ensure that they would not infect the *Volk* before ultimately being sent to their deaths in concentration camps (Proctor 1988).

When combined with Nazi ideology, eugenics morphed into *Rassenhygiene* (Racial Hygiene)—a theory that linked the biological concept of race with the German notion of hygiene as a way to control the spread of disease. Racial Hygiene Theory became a call to action aimed at cleansing the nation of Germany of a deadly inherited disease. This social reform movement advocated for public health measures to rid Germany of its inferior genetic stock and purify the nation. The scientific and medical terminology created an aura of trust that further broadened the purview of medicalization to include social issues such as crime, poverty, alcoholism, and other problems that would now be treated with biomedical means (Proctor 1988).

Caring for society became the ultimate goal. An individual's value was measured by his or her ability to contribute to society. Thus, those who could not contribute to society due to a perceived biological inferiority were seen as expendable and not worthy of the same level of care. The term *Lebensunwertes Leben* (life unworthy of life) was coined by two German scholars, jurist Karl Binding and psychiatrist Alfred Hoche, and came to encompass the category of people considered unfit in Nazi Germany. Included in this group were (among others): those suffering from congenital mental or physical illness, prisoners, degenerates, political dissidents, schizophrenics, epileptics, homosexuals, those suffering from muscular dystrophy or cerebral palsy, the Roma, the deaf and the blind, and Jews (United States Holocaust Memorial Museum 2019; Kershaw 2001; Snyder and Mitchell 2006; Proctor 1988). People belonging to these groups were viewed as biologically inferior to pure German citizens. Stripped of their status as members of the community of human belonging by science and medicine, physicians had no moral obligation to care for them as they would typically care for their patients.

No longer seen as "individuals," the unfit were dehumanized. They were "diseases" that needed to be "cured," for the good of the Volk, and it was the responsibility of physicians to undertake this endeavor. Fritz Klein, a physician in Nazi Germany, declared, "Of course I am a doctor and I want to preserve life. And out of respect for human life, I would remove a gangrenous appendix from a diseased body. The Jew is a gangrenous appendix in the body of mankind" (Lifton 1986, 29). The paradigm shift was complete: the role of the physician was solely to promote the health of the state. Whatever practices supported this objective fell within the purview of the physician, and he was empowered to use whatever means necessary to prevent any threats to achieving this goal. Doctors became involved in every aspect of the persecution and mass murder of millions of people, lending a pretense of trustworthiness to the process. Behaviors that would not otherwise have been legally or ethically acceptable, such as forced sterilization and experimentation, were organized and performed by physicians (Breggin 1993; Colaianni 2012). Diminishing the inherent dignity of the individual person by enacting a system of classification in which people were valued based on their worth to society was a key factor in the process of dehumanization. This allowed physicians to ignore the traditional medical goals of promoting health and well-being and preventing sickness and disease in the individual.

17.2.3 Politicization, Utilitarianism and Caring for the Volk

As we have seen, the role of physicians in Nazi Germany included labeling, othering, medicalizing, dehumanizing, persecuting, and murdering. The sum of these actions was medically sanctioned genocide, a unique occurrence throughout history. This begs the question: what was it about this particular situation that led physicians to willingly accept the unification of medicine and politics as the primary objective of the profession? As Michael Grodin argued, “Joining a political party is one thing; using its ideology to justify the torture and extermination of an entire people is another” (2010, 51). Yet the medical profession played a central role in establishing the *Volk* as the chief object to be cared for and nurtured. Doctors validated the idea that it was the health of the *Volk* that must be protected at all costs, and that any and all threats to the *Volk* must be eliminated (Breggin 1993). This concept—that society was paramount and must be cared for at all costs regardless of what that meant for the individual—represented a confluence of political ideology, scientific theory and medical implementation that resulted in the mass murder of millions deemed unfit.

The political ideals of the Nazi party were to systematically identify, socially isolate and legally persecute the unfit. At the same time, science and medicine were using genetics to better society. The Nazi vision was to use science and medicine to gain total control of the biological process and ultimately ensure the health and strength of the German nation. Incorporating eugenics and race hygiene into National Socialism provided the justification necessary to gain the trust and acceptance of the public. Laws and policies were portrayed as public health measures intended to protect and improve the *Volk*.

Physicians were empowered to take whatever means necessary to protect the *Volk*. Their actions could be defended “on the grounds that the Jew, the homosexual, the congenitally handicapped, and the Slav posed a threat, a biological threat, a genetic threat, to the existence of the future of the Reich” (Caplan 2010, 90). Once identified, threats were to be eliminated. There was no need for lengthy explanations or debates. It was science—value free, objective, and neutral. A physician need not explain his rationale for removing one’s burst appendix (Caplan 2010). Similarly, one did not have to provide a defense for removing a biological threat to the *Volk*.

This justification was offered at the Doctors’ Trial at Nuremberg when physicians were held accountable for their actions as part of an American military tribunal. The neutrality intrinsic to science and medicine was cited as part of the defense: “[I]f the experiment is ordered by the state, this moral responsibility of experimenter toward the experimental subject relates to the way in which the experiment is performed, not the experiment itself” (Nuremberg Trial Transcripts 1946–1947 in Caplan 2010, 88). Using this argument, the physician’s skillset qualified him to perform the actions; however, he did not have the appropriate knowledge regarding moral virtue to determine the ethical validity of the actions themselves. As such, he should not be held accountable for his actions (Caplan 2010). Science and medicine, by definition, must remain objective and impartial.

Diffusion of responsibility was another method used to distance physicians from moral accountability. In concentration camps, such as Auschwitz-Birkenau, responsibilities were often divided up amongst a group of medical personnel. This allowed the individual physician to believe that he was not directly responsible for the atrocities that were taking place (Lifton 1986). Believing that he was a member of a special group entrusted with protecting the *Volk* provided a rationalization for the physician’s actions. This is what Nazi doctors did. Their responsibility was, first and foremost, to care for society using whatever means necessary to rid the state of its diseased and inferior elements.

However, many physicians did not need any coping mechanisms at all to deal with the medicalized persecution and killing. One of the distinguishing characteristics of being a physician is what Alessandra Colaianni calls the License to Sin (2012, 436–437). From early on in their training, medical students are given permission, and even encouraged, to partake in activities that would be considered unethical, immoral, and illegal if performed by non-medical personnel. This is done in the name of science. Physicians are granted permission to perform acts that, in other settings, would be unacceptable at best and criminal at worst. Under the Third Reich, the License to Sin was even more pronounced. Hitler signed an order in October 1939 (backdated to September 1, 1939, to coincide with the start of the war) that stated, "charged with the responsibility of enlarging the authority of certain physicians to be designated by name in such a manner that persons who, according to human judgment, are incurable can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death" (Robertson 2019, 25). This was one of the few orders ever put down in writing by Hitler and provided for the establishment of an organized system for the identification, labeling, segregation, and potential murder of the unfit. Hitler's order was a literal License to Sin that, while never explicitly forcing physicians to do anything against their will, provided them with the power, justification, and defense to choose who would live and who would die. The politicization of medicine allowed those dedicated to healing to kill in the name of the state.

17.3 Medicine in a Post-Holocaust Society

During the Holocaust, the traditional goals of medicine were altered to serve the best interests of National Socialism. Conventional medical ethics was subverted in favor of a professional ethos that ministered to the healthy instead of the sick, the strong instead of the weak, the productive rather than the vulnerable. Medicine during the Holocaust represented the complete abandonment of Hippocratic ethics and the doctor-patient relationship. International outrage surrounded the crimes against humanity perpetrated by those in the medical community. Chief Prosecutor, Brigadier General Telford Taylor in his opening statements at the Doctors' Trial charged the defendants with "murders, tortures, and other atrocities committed in the name of medical science" (Gallin and Bedzow 2020, 8). However, although the Trial resulted in 16 of the 23 physicians being convicted of war crimes and crimes against humanity as well as the publication of the Nuremberg Code, unethical behavior committed in the name of scientific progress continues to abound (Gallin and Bedzow 2020). As the events of the Holocaust continue to fade into memory and the ability to hear first-hand accounts from survivors lessens with each passing year, it becomes increasingly important to explore and understand how the Holocaust continues to shape the ethics of health, medicine, and human rights.

17.3.1 Lessons from the Holocaust

Using the Holocaust as the historical framework for exploring the ramifications of placing scientific and societal progress ahead of the promotion of individual welfare and human dignity is essential to ensure that the lessons of the Holocaust remain relevant for current and future generations. While the Holocaust can serve as an invaluable educational tool, it must be invoked with caution so as not to overuse the Nazi analogy. There are certain unique attributes of the Holocaust that should be recognized as such. Referencing the Holocaust when discussing current debates in bioethics can seem like an unjust comparison. However, to ignore the motivations and rationales of Nazi medicine when analyzing current issues is to turn a blind eye toward a period of time that many people, particularly those in the medical field, may prefer to forget, despite the necessity of examining these critical perspectives and their implications for modern society (Robertson et al. 2019). After all, "If the Holocaust is like nothing else, it is relevant to nothing else" (Neuhaus 1992, 214). As we have seen throughout the course of this book, the lessons of the Holocaust remain increasingly relevant to the fields of medicine, healthcare, public policy, and human rights—to name just a few. It is incumbent upon us to preserve the legacy of those who perished or whose lives were changed irrevocably by Nazi medicine to use these lessons to shape a post-Holocaust society that reflects upon the past to protect current and future generations.

Conversely, balancing the use of the Holocaust for educational purposes with the need to respect the enormity of the event should not be overlooked. When invoking the Holocaust in any situation, it is important to understand the reason for doing so. In trying to determine what the role of medicine is and what it should be, examining the ways in which the foundations of medicine were corrupted in Nazi Germany can provide valuable lessons for today. Studying the changing moral ethos of the medical profession in the Third Reich and how it led to policy decisions is instructive as its ramifications continue to reverberate internationally. The people have changed, the political ideologies are different, the motives are not the same, but the ideas underlying Nazi medicine and its rise to power are still pertinent to our discussions about the role of medicine and the rights of individuals to be treated freely and equally in society. As Richard John Neuhaus argued.

> Of course then is not now, and there is not here, and they are not us…Since those who do it may continue to be in charge, since there may never be the equivalent of the Nuremberg trials, it will be called not Holocaust but Progress. We need never fear the charge of crimes against humanity so long as we hold the power to define who does and who does not belong to "humanity." (1992, 217)

The best way to protect medicine and the people it professes to serve now and in the future is to continuously reassess the core values of the profession and its role in society, always keeping in mind the lessons of the past.

17.3.2 Medicine: Its Power and Privilege

The medical profession has long been granted a special role in society. After the creation of the Code of the Medical Ethics of the American Medical Association (AMA) in 1847, “the social status of physicians was eventually raised to near-stratospheric heights, based in part on this explicit social contract that demanded altruism, civic-mindedness, devotion to scientific ideals, and a promise of competence and quality assurance through self-regulation” (Wynia 2008, 568). In the early part of the twentieth century, Germany’s medical and academic centers were renowned for being the best in the world, and physicians were treated with the commensurate levels of respect and prestige. Part of Hitler’s strategy was to bestow even more power and privilege upon doctors in the Third Reich, as evidenced by the importance of medicine in Nazi ideology and propaganda. Their ability to determine who shall live and who shall die, and to then execute such decisions, is the supreme example of their influence and authority.

Physicians continue to occupy a place of power and privilege in society. While the motivations behind such choices are different, decisions about who shall live and who shall die remain in the hands of the medical profession. Beginning of life care and end of life care are two major areas that face these challenges on a constant basis. Returning to the earlier notion of shared communities, physicians are still being tasked with determining who is part of these communities of belonging and protection and what types of care they are morally entitled to. These decisions result in a system of classification in which some lives are worth more than others based on definitions of personhood or quality of life. Choices regarding treatment or allocation of resources are affected by these determinations.

Time and again we find ourselves dealing with the issue of defining the self in relation to its value to society. The constant mission to achieve societal progress through personal improvement exacerbates pre-existing distinctions and classifications. What is the starting point for a “good” individual, one who is “normal,” or “healthy,” or “fit? Who is determining this? Once this baseline is established, what are the gradations of physical improvement? How are they achieved through medical means and at what financial cost to the individual? How do personal improvements correlate with societal betterment? This process can reinforce stereotypes, further marginalize minoritized or vulnerable cultures and be used to justify the biological superiority of one group over another (Rose 2009). Physicians are at the heart of this never-ending cycle because they are not only the ones who create the standards for normalcy and the benchmarks for progress, they also develop and implement the mechanisms for achieving these goals.

We have also learned that medicine does not exist in a vacuum. The moral ethos of the profession can be manipulated by outside forces: economic, social, political, etc., that can influence decisions about who will be considered as part of the community of belonging. Political and social conditions affect the medical profession, and these circumstances, which are external to the field of medicine, are constantly changing.

Though it may not be ideal, we must recognize this as a fact and cautiously guard against a professional ethics that is overly affected by outside influences (Bruns and Chelouche 2017).

17.3.3 Responsibility of Medicine to Society

Once we accept that medicine exists within a complex system, we must take into consideration the reciprocal relationship between medicine and society. We have established that medicine should be accountable to the individual first and foremost, but what responsibility does medicine have to society as a whole?

Dr. Andrew C. Ivy, medical scientific consultant for the American Medical Association at the Doctors' Trial stated, "Had the medical profession taken a strong stand against the mass killing of sick Germans before the war it is conceivable that the entire idea and technique of death factories for genocide would not have materialized" (Mitscherlich and Mielke 1949, xi). The focus of the Doctors' Trial was largely on the unethical medical experimentation and the crimes against humanity that took place in the concentration camps, yet Ivy goes back much further in his criticism of the medical community and their abrogation of responsibility. Using eugenic theory as the justification to kill the mentally and physically unfit was the precursor to the Holocaust. Ivy's statement places the blame for the decline of moral responsibility and standards of medical practice on the prewar medical community. His comments make clear his belief this was not something that happened overnight. These were not decisions made by a handful of unprincipled representatives of the medical community. This was a failure of the profession to stand up and speak out early on when the foundations of the union between science and politics were being formed and when there was still time to use the power and privilege of the medical profession to put a stop to the atrocities that were to follow.

Hitler knew that to get the public to go along with his plans, the cooperation, endorsement, and leadership of the medical profession were essential. Though there are few examples in modern society of the type of enmeshed relationship between politics and medicine seen in Nazi Germany, the medical community still holds a great deal of influence not only in shaping the perceptions of the general public, but also in shaping public policy and health law. Specifically, regarding controversial issues such as physician-assisted suicide (PAS), there are some who believe that it is the role of the medical profession to actively take a stance as part of their ethical responsibilities. Because physicians are the primary participants involved in the act of physician-assisted suicide, the profession must take a public position on this debate. To choose not to do so relinquishes the moral accountability inherent in the profession (Sulmasy et al. 2018). If those who are most knowledgeable about the action being discussed do not take a stance, this leaves the door open for others who may not have the requisite information regarding the medical aspects of PAS to determine the fate of this contentious issue. In addition, if physicians are ultimately going to have to abide by whatever decision is made, then it would stand to assume that the physicians who make up the professional associations would want to voice their opinions on a topic that will have direct consequences for their practice (Sulmasy et al. 2018).

When exploring the role of medicine in society, another issue that must considered is that of advocacy. Recognizing that medicine does not exist in a vacuum necessitates understanding that the care of patients also takes place within a complex society. While a full examination of the need for advocacy in the medical profession is beyond the scope of this chapter, one cannot ignore the fact that an individual's health and well-being is impacted by his or her ability and capacity to seek care which in turn is affected by social determinants of health. In "The essential role of physician as advocate: how and why we pass it on," LeeAnne M. Luft suggests that a definition of physician advocacy must take into account both individual and societal factors: "Action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise" (2017, e109–e110). Caring for the individual requires an understanding of the relationship between that individual and society and the way in which that relationship influences the individual's health and well-being. While advocacy can be defined in many ways on many levels, in its most basic iteration, a physician has a responsibility to advocate for the best care of the patient. This cannot be done without, at the very least, identifying and acknowledging the aforementioned social, economic, educational, and political barriers to health. Taking steps to help the patient overcome these barriers is often the only way to achieve the goal of health and well-being for the individual.

17.4 Morality and Medicine After the Holocaust

Debate continues regarding the goals and purpose of medicine. However, in a post-Holocaust society, one aspect of medicine that must not be in question is the significance of using the Holocaust as a historical framework for building a moral ethos that will guide the profession now and in the future. Much of Holocaust education has focused on remembering those who died and ensuring that their stories continue to be told to preserve their legacy. This is, of course, a crucial task and one that should be undertaken with the utmost care. However, if we truly want to preserve the legacy of those whose lives were lost, we must not only remember the past, we must also use those lessons to protect the future. As Neuhaus stated, "The Holocaust began in depersonalizing the victims and ended in depersonalizing the perpetrators" (1992, 214). We cannot neglect the essential mission of identifying the process that enabled medically sanctioned genocide to occur so that we can safeguard history from repeating itself. Just as the victims have names and stories, so too do the perpetrators. They must be held accountable for their actions and the rationale given to morally justify their behaviors (Neuhaus 1992).

Physicians are given a special place in society because their profession is unlike any other. Their power stems from the godlike ability of the profession to preserve and take life. Patients literally entrust their lives to physicians, so to look back on the history of Nazi medicine and see the ways in which doctors blatantly abdicated their moral responsibility to patients, to human life, is alarming. Reading transcripts from the Doctors' Trial in which physicians attempt to provide ethical justifications for their behaviors by citing science, medicine, utilitarianism, or the belief that they were "just following orders" calls into question the virtue of the profession. In a post-Holocaust society, how can the medicine redefine itself and regain the trust of those it pledges to serve?

17.4.1 Rehumanizing the Patient

During the Holocaust, we saw the disastrous effects of the process of dehumanization. When an individual is no longer viewed as a human being, but rather as an object without any inherent worth or value, it becomes easier to treat him or her using inhumane methods. The moral rationale for exterminating these groups becomes more acceptable (Breggin 1993; Miller and Gallin 2019). While modern medicine may not be experiencing the same type of blatant discrimination and dehumanization witnessed during Nazi Germany, economic and political pressures along with the rise of medical technology are creating an environment where the centrality of the human person is again at risk. There are debates about the economic cost of keeping alive the elderly or people with disabilities who require long term care and whether that money might be better spent somewhere else. Having the technology to prolong the length of someone's life does not always preserve the quality of a life, and tissues, cells or organs that are kept alive by those machines may be able to help other people (O'Mathúna 2006). The factors being considered when making these decisions and the people in charge of drafting these policies may have goals that are not medical or humanistic in nature directing their choices. Thus, it is not so far-fetched to imagine that society could once again find itself with a healthcare system guided by political or economic forces attempting to do what is in the best interest of society, rather than the individual patient.

As a result, the primary task of medicine in a post-Holocaust society must be to rehumanize the profession. We are living in an unprecedented era of biomedicine in which we increasingly have the ability to alter aspects of the self (Schulman 2008). From personalized genomic medicine to germline genetic intervention, the quest for personal and societal betterment has only increased since the end of WWII as technology has drastically improved. As we continue down this pathway to perfection, we are faced with a challenge: what is the ethical responsibility of the medical profession in protecting the nucleus of humanity? As bioethicist Adam Schulman asked, "Among all the features of human nature susceptible to biotechnological enhancement, modification, or elimination, which ones are so essential to our humanity that they are rightly considered inviolable?" (2008, 16) In order to rehumanize medicine, we must first define what it means to be human.

Like the role of advocacy in medicine, a full examination of what it means to be human is outside the scope of this chapter. However, when attempting to locate the central aspect of humanity, the element that must be respected and protected at all costs, there is one feature that delineates humankind from other species: dignity. Prior to the rise of Social Darwinism, there was a consensus within society that all humans were entitled to certain basic rights based on the religious ideals of the sanctity, dignity, and value of human life. As science began to replace religion as the major explanatory theory of behavior, this view of the inherent dignity of the individual was replaced with the perspective that some lives were worth more than others based on their value to society. This became the foundation for Nazi doctors to persecute and kill those who were not seen as having the necessary value to exist in the Third Reich (O'Mathúna 2006). From an ideological perspective, the link between the inherent dignity of the individual and the rights that are granted as a result was a central characteristic that defined those categorized as part of the community of belonging and protection. Once certain people were stripped of their human dignity, there were also excluded from the community of belonging and protection and vulnerable to the dehumanizing practices of Nazi medicine.

For the purpose of this argument, we can define human dignity as the inherent value of the individual. To further parcel out this definition, "the term 'inherent' means 'involved in the constitution or essential character of something," "intrinsic," "permanent or characteristic attribute of something'" (Adorno 2009, 229). In addition, "The idea expressed in this term, when it is accompanied by the adjective 'human' is that dignity is *inseparable from the human condition.* Thus, dignity is an unconditional worth that everyone has simply by virtue of being human." (Adorno 2009, 229). This definition is the opposite of that used by Nazi doctors. It assumes that the value of a human being is based on their being human, not on the material or functional value he or she may have for society.

Adopting a rehumanized paradigm can enhance the physician–patient relationship at the heart of medicine by reminding the doctor that each patient is an individual human being and should be treated as such. If caring for the individual person is considered to be the aim of medicine, then "no contingent factor—race, religion, economic status, disability, or actions of the past, present or future—can rob a person of the dignity she is owed" (Fernandes and Ecret 2019, 35). Each individual patient is a member of the physician's community of belonging and protection simply because he or she is a human in need of care. The patient is a person—not to be referred to as a diagnosis or a case or a room number—and has the right to be treated with respect and dignity (Adorno 2009). This kind of professional ethos based on human dignity and equality can help prevent the type of abuse of power and moral corruption that took place during the Holocaust.

17.4.2 Rehumanizing the Physician

Michael Grodin stated, "Medicine as a profession contains the rudiments of evil, and some of the most humane acts of medicine are only small steps away from real evil" (2010, 58). Grodin then went on to give the example of amputating a gangrenous limb. Performed in a surgical setting by a licensed physician, this is an act of healing, but in another context it would be considered criminal and, arguably torturous. The distinctive aspects of the medical profession create an environment where medicalization and dehumanization are necessary tools that allow physicians to process the pain and suffering they deal with daily and sometimes must even afflict in order to heal or cure (Grodin 2010). Terminology such as "battling" or "beating" a disease carries this same mentality of attacking and harming. The moral vulnerabilities that allow physicians to engage in this kind of compartmentalization and utilize these coping mechanisms can be dangerous when combined with a political or economic agenda (Annas 2010; Colaianni 2012).

The ability to clinically detach from both the practice and the patients is another skill that must be mastered by physicians not only to successfully do their job but also to avoid burnout (Colaianni 2012). While empathy is a valuable component of medical practice, a physician must keep a level of clinical detachment that permits her to act in the patient's best interest while also protecting her own well-being. Robert Jay Lifton refers to this as the "medical self," which "enables one not only to be relatively inured to death but to function relatively efficiently in relation to the many-sided demands of work (2000, 427). Human emotion should be exhibited when dealing with the patient, but only in the proper amount and when necessary. Likewise, after the interaction with the patient ends, there is an appropriate time, place, and duration for emotion. Too little or too much can throw off the delicate balance of the medical self. The concept of hierarchy is essential to medicine as well, so while one may question the instructions or decisions of an ordering physician, controversial or dissenting opinions are not encouraged (Colaianni 2012).

A post-Holocaust medical morality must focus on rehumanization, not only as it applies to patients but physicians as well. To reiterate Ivy's comments from the Doctors' Trial, had the medical community taken a stand against the status quo of killing the sick, it is likely that the Holocaust would not have happened. However, at the time the culture of the medical profession in prewar Germany made this difficult to do. Scientific and moral justifications were offered for killing the unfit. Medical, academic, and military leaders were advocating for the essential nature of medicine in preserving and protecting the *Volk*. Yet, as Neuhaus warns, to overgeneralize the nature of what took place is dangerous (Neuhaus 1992). To reduce the Holocaust to policies and procedures implemented by nameless, faceless, evil bureaucrats who were just following orders dehumanizes one of the most important events in history, effectively ridding it of its relevance for humanity. The truth is much more nuanced: "It happened one hour at a time, an equivocation at a time, a lie at a time, a decision at a time, a decision evaded at a time" (Neuhaus 1992, 214). Therefore, we must study physician participation in the Holocaust—to understand the moral complexities involved in each step of the process that allowed healers to transform into killers.

Because of the distinct nature of the profession, creating a medical self that allows one to cope with the challenges peculiar to the field is necessary for the well-being of both the physician and his or her patients. The existence of a chain of command, following orders given by superiors and being able to clinically detach from difficult situations can be necessary. However, a rehumanized medical ethos must balance the medical self with a *true* self based on one's own personal moral ethos. It must allow the physician to ask questions if something does not seem right, to respectfully disagree, to stand up and speak out against injustice or discrimination of any kind and in any form without fear of penalty or backlash. Only then will the health and well-being of both the individual and the physician be respected and protected.

17.5 Conclusion

It has been three quarters of a century since the world learned of the atrocities committed by physicians in the name of science at the Nuremberg Doctors' Trial, yet the questions brought to light then still resonate now: What are the goals of medicine? What is the role of medicine in society? Who belongs to the community of belonging and protection? What will physicians do with the great power and privilege that comes with their profession? In a post-Holocaust world in which political, economic, and social forces are increasingly encroaching on moral decision-making within medicine, using the Holocaust as the historical framework to explore the relevance of these questions is essential for building a new paradigm that emphasizes rehumanization and human dignity. Each of us has a responsibility to reflect on the past to protect current and future generations and to ensure that "Never Again" is more than just a rallying cry.

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