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Susan Maria Miller, Stacy Gallin

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An Analysis of Physician Behaviors During the Holocaust: Modern Day Relevances

Susan Maria Miller¹ and Stacy Gallin²

¹*Houston Methodist Research Institute, USA*

E-mail address: smmiller@houstonmethodist.org

ORCID ID: <https://orcid.org/0000-0002-5519-3255>

²*Maimonides Institute for Medicine, Ethics and the Holocaust; Misericordia University, USA*

E-mail address: sgallin@mimeh.org

ORCID ID: <https://orcid.org/0000-0001-6076-8773>

Abstract

Even with the passage of time, the misguided motivations of highly educated, physician-participants in the genocide known as the Holocaust remain inexplicable and opaque. Typically, the physician-patient relationship inherent within the practice of medicine, has been rooted in the partnership between individuals. However, under the Third Reich, this covenant between a physician and patient was displaced by a public health agenda that was grounded in the scientific theory of eugenics and which served the needs of a polarized political system that relied on this hypothesis to justify society's racial hygiene laws. As part of the National Socialist propaganda, Adolf Hitler ominously argued that the cultural decline of Germany after World War I could largely be based on interbreeding and a "resultant drop in the racial level." This foundational premise defined those who could be ostracized, labeled and persecuted by society, including those who were assimilated. The indoctrination and implementation of this distorted social policy required the early and sustained cooperation and leadership of the medical profession. Because National Socialism promised it could restore Germany's power, honor and dignity, physicians embraced their special role in the repair of the state. This article will explore the imperative role, moral risks and deliberate actions of physicians who participated in the amplification process from "euthanasia" to systemic murder to medically-sanctioned genocide. A goal of this analysis will be to explore what perils today's physicians would face if they were to experience the transitional and collective behaviors of a corrupted medical profession, or if they would, instead, have the fortitude and courage necessary to protect themselves against this collaboration. Our premise is that an awareness of history can serve as a safeguard to the conceit of political ascendancy and discrimination.

Key-words: Holocaust; National Socialism; medical ethics; physician behavior; physician-patient relationship

I. Background

Prior to World War II, German medicine had a stellar international reputation.¹ Germany's universities and hospitals were pre-eminent and sophisticated locations for medical education and research training.² Research experimentation was highly regarded, and ambitious physicians traveled to German laboratories and clinical facilities to learn the most up-to-date medical techniques within venues which aggregated state-of-the-art knowledge. In addition, Germany had more Nobel laureates than any other country.³ In fact, as early as 1900, Germany was an early adopter of research ethics and provided guidance on research practices which explicitly forbade research on children and other vulnerable populations.⁴ By 1931, Germany issued the *Regulations on New Therapy and Human Experimentation*. These guidelines were established by the governmental Reich Health Council preceding the rise of the Third Reich and were stricter and more formalistic than the Nuremberg Code subsequently published at the conclusion of the Nuremberg Medical Trial (i.e., "Doctor's Trial;" *United States of America v. Karl Brandt, et al.*). Specifically, the Reich Circular guidelines explicitly stated the physician [was] "responsible for the well-being of the patient or subjects."⁵ Of note, one of the physician contributors to these 1931 guidelines, Dr. Julius Moses, died in the Theresienstadt concentration camp in 1942.⁶

II. Formalized Ethics Training

Although the regulations were not legally formalized,⁷ mandatory didactic ethics lectures were incorporated into the medical curriculum beginning in 1939.⁸ Notably, the standardized textbook on medical ethics was written

¹ Francisco López-Muñoz, et al., "Psychiatry and Political Institutional Abuse from the Historical Perspective: The Ethical Lessons of the Nuremberg Trial on Their 60th Anniversary," *Progress in Neuro-Psychopharmacology and Biological Psychiatry* 31 (2007): 792.

² Jeremiah A. Barondess, "Medicine against Society: Lessons from the Third Reich," *Journal of the American Medical Association* 276 (1996): 1657.

³ "All Nobel Prizes," The Nobel Prize, accessed December 2, 2019, <https://www.nobelprize.org/prizes/lists/all-nobel-prizes>.

⁴ Michael Grodin, "Historical Origins of the Nuremberg Code," in *The Nazi Doctors and the Nuremberg Code*, eds. George Annas, and Michael Grodin, 121-144 (New York: Oxford University Press, 1992), 127.

⁵ *Ibid.*, 129-130.

⁶ Vivien Spitz, *Doctors from Hell: The Horrific Account of Nazi Experiments on Humans* (Boulder, Colorado: Sentient Publications, 2009).

⁷ Grodin, "Historical Origins of the Nuremberg Code," 129.

⁸ Florian Bruns, and Tessa Chelouche, "Lectures on Inhumanity: Teaching Medical Ethics in

by Rudolf Ramm, whose educational influence extended through his role as editor-in-chief for the German Medical Association journal, *Deutsches Arzteblatt*.⁹

On the other hand, the psychiatric and neurologic communities were further influenced by the textbook, *Human Heredity and Racial Hygiene*, based on the teachings of three prominent geneticists, Erwin Bauer, Eugen Fischer, and Fritz Lenz, who described and promoted the “scientific” rationale for medically-sanctioned, eugenic sterilization programs to protect the racial hygiene of society. A further example of indoctrination included the appointments by the Ministry of Science of avowed National Socialist non-academics as university physician-lecturers.¹⁰ This curriculum was intended to implement the Nazi biomedical vision of restoring racial purity and heredity health to the nation of Germany¹¹ through educational reform. The medical school lessons argued against diversity, viewing it as *contamination*, and described the unequal worth of human beings. These lectures proposed the authoritarian role of the physician permitted the (s)elective application of ethical principles applied only to “Aryan patients.”¹² Hence, “(R)ace was the criterion of value.”¹³

On reflection, the consequences of these educational programs created a preparatory mechanism to psychologically dehumanize extant members of the population based on their demarcated value to society. The slippery slope towards dehumanization doesn’t typically happen overnight. Labeling, classification and persecution are required antecedent steps towards debasement. Physicians were the only individuals with the moral imperative and medical authority to preserve the purity of the Aryan people through sterilizations based on the perceived empirical, non-capriciousness of eugenics and eugenic cleansing. In addition to their central role performing procedural medical processes, their political participation was also essential. This led to the confluence of medicine and politics as demonstrated by one of Hitler’s quotes which buttressed the pre-eminent role of physicians: “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.”¹⁴

German Medical Schools Under Nazism,” *Annals of Internal Medicine* 166, no. 8 (2017): 1-17.

⁹ Ibid., 7.

¹⁰ Ibid., 5.

¹¹ Ibid., 5, 8.

¹² Ibid., 8.

¹³ Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 1986): 24.

¹⁴ Robert Proctor, *Racial Hygiene: Medicine Under the Nazis* (Cambridge, MA: Harvard University Press, 1988), 64.

III. Patient-Physician Relationship

Although other countries, including the United States, were enamored with the promising, new scientific theory of eugenics, in Germany the concept was radicalized into a more narrowly focused theory of racial hygiene (*Rassenhygiene*), which became the new Holy Grail. Utilizing the underlying classification and innate biases within eugenics, German medical training shifted away from historical professional ideals which emphasized the physician's moral responsibility to their patients towards the now redefined preventive and public health practices inherent in the physician-society relationship. "No longer was the sole interest of doctors the health of their patients [...] they were legally obliged to ignore their patient's objections [...] because the [...] prime consideration for doctors should be the wellbeing of the nation."¹⁵ The concept of *Volk* represented a mystical group of native people with a shared cultural heritage and language.¹⁶ A consequence of the *völkische* state was denouncement if your neighbors disapproved of your behaviors. You were no longer recognized as a "reliable member of the racial community."¹⁷ As such, the humanitarian basis of medicine was co-opted by the intended creation of an ethnocentrically-defined Aryan "master race" (*Übermensch*). Only these individuals were worthy of a physician's ministrations.¹⁸ Thus the premises of racial hygiene defined the fate of those now considered to be subhuman (*Untermensch*).

IV. Ramifications of the Politicization of Medicine

The Holocaust remains the only example of medically-sanctioned genocide, in large part, due to the politicization of medicine that took place under the Third Reich. Comprehension of the ways in which medicine and politics converged can provide a valuable tool for insight into the behavior of physicians during this period. In his book, *The Nazi Doctors*, American psychiatrist Robert Jay Lifton offered the first in-depth study of how medical professionals rationalized their participation in the Holocaust. He described certain key examples of external and easily observed physician behaviors which reflect how medicine became politicized.¹⁹

¹⁵ Laurence Rees, *The Holocaust: A New History* (New York: Perseus Books, 2017), 100; the quotation in the abstract also from this book, 34.

¹⁶ *Ibid.*, 3.

¹⁷ *Ibid.*, 100.

¹⁸ Michael Grodin and George Annas, "Physicians and Torture: Lessons from the Nazi Doctors," *International Review of the Red Cross* 867, no. 89 (2007): 638.

¹⁹ Lifton, 14-18 and 458-465.

Beginning in the Weimar Republic, 45% of German physicians eventually became members of the Nazi Party, a greater percentage of enrollment than for any other profession.²⁰ Similarly, a great number of early Nazi joiners were medical students.²¹ Examples of confluent forces which led the biomedical enterprise to support Nazism included the economic devastation of Germany after World War I, unemployment, and the growth of 19th century eugenics which proclaimed that certain behaviors and social stations are inevitable.²²

In contrast, Jewish physicians and faculty were caricaturized as unethical, ostracized by their colleagues and prohibited from practicing medicine, except on their Jewish patients.²³ Not only did German physicians stigmatize their Jewish colleagues, they also prevented their physician colleagues from practicing at universities and hospitals.²⁴ Legislation was written to prevent enrollment of Jewish students into medical schools by 1938 and “nullified” the licenses of practicing physicians in order to purify the remaining German medical profession.²⁵ By excluding previous, respected authority-figures, including former teachers from academic and leadership positions, the organization of medicine lost its ability to mitigate the political influences of the Third Reich.²⁶ Excluding these esteemed authority figures and honored scholars had the dual result of removing political outliers and opening the door for abject Nazi supporters.

Silencing of dissenting voices and indoctrination, however, were not enough. The politicization of medicine required physicians’ cooperation and assistance in implementing early National Socialist legislation. For example, physicians served an instrumental role in writing the “Law for the Prevention of Genetically Defective Progeny (1933)” which permitted sterilization of those medically defined as unfit.²⁷ Physicians and other health personnel relinquished their professional codes of confidentiality by reporting individuals with disabilities under the guise of public health.²⁸ Another form of collaborative behavior included service as a voting member of the Heredity Health

²⁰ Barondess, 1658.

²¹ Omar A. Haque et al., “Why Did So Many German Doctors Join the Nazi Party Early?” *International Journal of Law and Psychiatry* 35 (2012): 476.

²² Barondess, 1657.

²³ Haque et al., 475.

²⁴ Michael A. Grodin, Erin L. Miller, and Johnathan I. Kelly, “The Nazi Physicians as Leaders in Eugenics and ‘Euthanasia’: Lessons for Today,” *American Journal of Public Health* 108 (2018): 53-57.

²⁵ Rees, 36-37.

²⁶ Jacob M. Kolman and Susan M. Miller, “Six Values Never to Silence: Jewish Perspectives on Nazi Medical Professionalism,” *Rambam Maimonides Medical Journal* 9, no. 1 (2018).

²⁷ López- Muñoz et al., 794, 796.

²⁸ Bruns and Chelouche, 4.

Courts once the above referrals occurred.²⁹ As members of this judicial court, physicians used legally-defined, “scientific” criteria to approve involuntary sterilizations. Of note, these eugenic sterilizations affected an estimated 400,000 German citizens.³⁰ An effect of this bureaucratically-efficient process on physicians was their desensitization to the humanity and human rights of these members of society now “medically” classified as being unfit. This allowed physicians to accept and ultimately participate in this form of incipient racism and dehumanization.³¹

As physicians became desensitized to the inherent humanity of their patients, they became more radicalized and complicit in their loyalty to the concept of *Volk* and their external behaviors became more atrocious as the *political system itself now became medicalized*. For example, in post-war interviews, physicians stated that “the oath of loyalty to Hitler which they took as SS military officers was much more real to them than a vague ritual performed at medical school graduation.”³² This became the higher good. Ironically, the National Socialist’s demeaning of the Hippocratic Oath is incongruous since the Oath was originally created in Ancient Greece in response to the generalized distrust and misconduct of physicians by Grecian society.³³ The creation of the Nuremberg Code serves as a parallel modern-day example of a societal response to physician misconduct. “Yet, in their preamble to the Nuremberg Code, the judges suggested that they spoke to this entire universe [by promulgating] ‘basic principles [that] must be observed in order to satisfy moral, ethical and legal concepts [in] the practice of human experimentation.’”³⁴

The next step towards medically-sanctioned genocide occurred when physicians took responsibility for selecting the candidates for the secret pediatric “euthanasia” program and subsequent adult “euthanasia” programs.³⁵ These programs were non-judicial situations whereby physicians acted on their own impulses and initiative when killing their patients. The procedural process included the completion of a form by placing a plus (+) or minus (-) sign on the paperwork. A plus sign designated the individual

²⁹ Lifton, 25.

³⁰ “The Biological State: Nazi Racial Hygiene 1933-1939,” Holocaust Encyclopedia, accessed September 5, 2019, <https://encyclopedia.ushmm.org/content/en/article/the-biological-state-nazi-racial-hygiene-1933-1939>.

³¹ López- Muñoz et al., 794.

³² Lifton, 207, 435.

³³ López- Muñoz, 792.

³⁴ Jay Katz, “The Nuremberg Code and the Nuremberg Trial,” *Journal of the American Medical Association* 276, no. 20 (1996): 1664.

³⁵ Lifton, 52, 56, 65, 76-79, 98.

was a candidate for “euthanasia.” There was no mechanism for advocacy or appeal and this entire administrative process was completed without a physical examination.³⁶

Doctors were inexplicably instrumental in evaluating the technical aspects of how this process should occur. Early, confidential discussions between trusted personnel required an assessment of which “euthanasia” techniques would be the most effective for killing and who would be personally responsible for carrying out these killings. For example, Viktor Brack, an administrative organizer of the subsequent *Aktion T4* euthanasia program stated: “The syringe belongs in the hand of the physician.”³⁷ Dr. Karl Brandt, Hitler’s personal physician, stated: “[...] only doctors should carry out the gassings.”³⁸ Instead of labeling these actions as murder or genocide, the process was euphemistically described as a “mercy death.” To reveal his benevolence, Hitler purportedly asked his consultant physicians, “which is the more humane way?”³⁹ The inviolate line between healing and killing was now blurred for leaders of both the National Socialist party and the medical profession.

The medicalization of politics also included correspondence from Adolf Hitler to *Reichsleiter* Bouhler and Dr. Karl Brandt which provided physicians with the authority and “legal” protection to perform a mercy death. Hitler’s personal stationery was used for this secret communication as a substitution for formal legislation. The authorizing document was backdated to September 1, 1939, the military invasion date of Poland. The intention of this correspondence was to link the euthanasia program with the war effort and to minimize anticipated resistance to the program. Logistically, the correspondence provided a mechanism to diffuse individual responsibility as Brandt let physicians know that in “Hitler’s name” they could carry out euthanasia.⁴⁰ This also diluted the personal responsibility of individual physicians and provided plausible deniability of the ultimate consequences of their behaviors. Although the euthanasia program was never legalized by the courts, the intention of the correspondence was to provide immunity for physicians from any potential legal consequences. The final draft of this letter was likely written by the psychiatrist, Dr. Max de Crinis.⁴¹ Of interest, physicians who participated

³⁶ Ibid., 52-53.

³⁷ Ibid., 71.

³⁸ Ibid., 72.

³⁹ Ibid., 72.

⁴⁰ Ibid., 51.

⁴¹ Ibid., 63.

in the euthanasia program were even protected from military duty since this work was considered “indispensable.”⁴²

V. Physician Transformation: From Healers to Killers

Physician oversight included the responsibility for identifying candidate patients for euthanasia and overseeing their transfer to the “specialized centers” where the euthanasia would occur.⁴³ These skills could result in administrative advancement as witnessed by the activities of Dr. Irmfried Eberl, whose prior experience in the *Aktion T4* program (a pseudonym for a euthanasia program for the mentally “unfit”) led to his eventual appointment as commander of the Treblinka concentration camp.⁴⁴ Physicians were instrumental in performing the lethal injections, writing orders for oral sedation, overseeing the systemic starvation of patients and managing the gas chambers.⁴⁵ Doctors were responsible for identifying individuals with specific medical diagnoses and systematizing requested autopsy specimens based on solicitations from colleagues or their own research interests.⁴⁶ An infrastructure was simultaneously created to falsify every death certificate to camouflage the “euthanasia” process.⁴⁷

Once they gained the requisite euthanasia experiences in various hospitals, physicians further abandoned their professional responsibility by organizing and mentoring the activities which occurred in the subsequent concentration camps. “Almost without exception, those physicians who had gained experience in ‘Aktion T4’ took charge of the Final Solution.”⁴⁸ A “medically” defined role for this generation of physicians occurred in the “Darwinian”⁴⁹ selection process which identified those individuals who were immediately sent to death or who were temporarily used for labor, upon arrival at the concentration camps, again, based on putative “medical criteria.”⁵⁰ These selections were almost always conducted under the authority of an SS doctor to preserve the fiction that this process was governed by scientific principles.⁵¹

⁴² Ibid., 59.

⁴³ Ibid., 53-54.

⁴⁴ Ibid., 123-124.

⁴⁵ Ibid., 18, 55, 57, 62, 71, 97, 102.

⁴⁶ Ibid., 60-61.

⁴⁷ Ibid., 18, 58, 74.

⁴⁸ Edvard Ernst, “Commentary: The Third Reich-German Physicians Between Resistance and Participation,” *International Journal of Epidemiology* 30, no. 1 (2001): 38.

⁴⁹ Lifton, 17.

⁵⁰ Ernst, 39.

⁵¹ Rees, 325.

Another category of physician-criminal behaviors includes Nazi research activities⁵² which occurred in the hospitals, universities and concentration camps. These illicit activities, which ignored pre-existing German regulations intended to protect human subjects, became acceptable in these instances because the prisoners being experimented on were considered to be sub-human. The hypothermia, high altitude and twin studies⁵³ are examples of research studies which incorporated subject deaths and torture within the research design. Other subjects were killed because their survival would be incriminating.⁵⁴ Experiments to further purify the German race included “practical methods of sterilization and mass killing.”⁵⁵ Other research questions differentiated between the variable efficacies between Zyklon B and carbon monoxide. “The fact that different death camps used different means of gassing Jews [...] demonstrates the extent to which the Nazi system encouraged subordinates to devise their own way of best fulfilling the overall vision.”⁵⁶ Gassing was more efficient and psychologically easier for SS soldiers than face-to-face killing where one could hear the screams of the individuals as they recognized their imminent death. The gas chambers themselves were relatively sound-proof to minimize awareness of the genocidal process.

It is important to note that researchers were given free rein to conduct experiments they would not have otherwise been able to perform because they had unlimited access to “guinea pigs” at their disposal in the form of prisoners of war. This became an uncomplicated way for young entrepreneurial German scientists to advance their careers, particularly because there were numerous positions vacated by Jewish doctors, professors and researchers who had been forced to flee or were captured.⁵⁷ The concepts of “enlightened” informed consent and respect for patient autonomy were absent and were subsequently addressed, along with the other criminal research atrocities, *vis-à-vis* the Nuremberg Code created as part of the Doctors’ Trial.⁵⁸ Ethical misconduct occurred not only with the substandard research designs, but also through multiple conflicts of interest within the researcher/physician role(s), via opportunistic ambitions for academic promotion and through coordination with ethically-conflicted pharmaceutical companies (who also

⁵² Ibid., 357-361.

⁵³ Lifton, 360-369.

⁵⁴ Ulf Schmidt, *Karl Brandt: The Nazi Doctor: Medicine and Power in the Third Reich* (New York: Continuum Books, 2007), 104.

⁵⁵ Ernst, 39.

⁵⁶ Rees, 422.

⁵⁷ Alexander Mitscherlich and Fred Mielke, *Doctors of Infamy* (New York: H. Schuman, 1949).

⁵⁸ Paul J. Weindling, *Nazi Medicine and the Nuremberg Trials: From Medical War Crimes to Informed Consent* (New York: Palgrave Macmillan, 2004), 287; Katz, 1662-1666.

needed research subjects). Purported justifications for this aberrant research included military rights during war, scientific curiosity and the professed benefits for society.⁵⁹ The lack of external constraints to the study design or mandates to adhere to previous guidelines permitted the ongoing, controversial research misconduct. One consequence of the inadequate peer review resulted in planned subject deaths during Rascher's hypothermia and altitude experiments. The safety of the study subjects was intentionally not included in the research methodology. In contrast, "societal necessity" as an argument to protect soldiers, provided a rationalization for these military-based experiments. However, this could never be a justification for the brutality incorporated in these research activities.

The sadistic treatment of research subjects and gratuitous cruelty⁶⁰ were reflected in the investigator's agnosticism to the suffering experienced by the patient and resulted in a further loss of the physician's moral bearings. Weindling further discusses the opportunistic use of psychiatric patients, children and prisoners as sources of research and autopsy specimens.⁶¹ Of note, the modern reader must be aware that research was not limited to the concentration camps, rather, the misconduct also occurred within hospitals and other health care institutions.

VI. Motivations and rationalizations

It should be noted that *there were limited protests* against these political-medical campaigns. Famous examples involve the White Rose society, a non-violent, medical resistance group which protested the Nazi party regimen (1942-1943),⁶² and Dr. Julius Moses who tried to warn physicians about the National Socialist Third Reich's attempts to usurp physician duties.⁶³ Other protest behaviors included intentional misdiagnosis of an underlying medical condition, publication of an oppositional *International Medical Bulletin*, and releasing the children from the hospital instead of transporting them to the specialized centers.⁶⁴

⁵⁹ Paul J. Weindling, "Consent, Care and Commemoration: The Nuremberg Medical Trial and its Legacies for Victims of Human Experiments," in *Silence, Scapegoats, Self-Reflection: The Shadow of Nazi Medical Crimes on Medicine and Bioethics*, eds. Volker Roelcke, Sascha Topp, and Etienne Lepicard, 29-46 (Gottingen: V & R Unipress, 2014), 29-46.

⁶⁰ Paul J. Weindling, *Victims and Survivors of Nazi Human Experiments: Science and Suffering in the Holocaust* (New York: Bloomsbury Books, 2015), 204-205, 190-193.

⁶¹ *Ibid.*, 63-67, 111-125.

⁶² Lifton, 39.

⁶³ Spitz, 2.

⁶⁴ Ernst, 41.

However, the clear majority of physicians *did not* protest. For many decades, we have tried to comprehend how physicians justified their behaviors. What were some of their rationalizations and coping techniques?

As part of his research, Lifton interviewed Nazi medical practitioners, non-medical professionals and prisoner survivors, including physician-prisoners for over 25 years. His work offers a *partial* historiographical understanding of the behaviors and motivations of individuals who experienced different facets of the Holocaust. It is essential to understand that the successful implementation of the Third Reich's racial hygiene policies required the active participation and ongoing support of physicians. One way for physicians to do this was to abandon their professional boundaries. The participating physicians were extremely methodical in their activities and overcame any innate reluctance to participate in this violence. Some individuals were actual zealots and were quite ambitious in their actions.⁶⁵ The initial socialization process of medical training and post-career activities created a sense of "normalcy"⁶⁶ which further perpetuated their actions. Lifton surmises that because physicians are accustomed to witnessing pain, they are better equipped to psychologically justify their participatory role as an act of duty, as a by-product of their everyday work.⁶⁷ Multiple interviewed individuals described a shared sense that "Auschwitz was morally separate from the rest of the world."⁶⁸ Instead of acting on a professional duty to warn, physicians felt in these circumstances, the individuals were already condemned to death, hence there were no perceived barriers to their research or clinical activities. Accordingly, the ethical concept of duty to warn when an individual underwent selection did not exist.⁶⁹

Other precipitating factors which might have affected physician behaviors included early membership in the Nazi Party. Through membership, one established a mechanism for upward mobility and financial security. Medical practitioners were further attracted to Nazism as a means of alleviating the feelings of powerlessness prevalent in the Weimar Republic and Third Reich. There were also separate financial motivations (after World War I) which served to relieve physicians from economic hardship based on an insufficient number of patients and unemployment due to an oversupply of physicians.⁷⁰

In their post-war interviews with Lifton, physicians detailed their sense of duty, not only as members of the military, but as members of the Nazi party

⁶⁵ Lifton, 194.

⁶⁶ Ibid., 193-213.

⁶⁷ Ibid., 421.

⁶⁸ Ibid., 200.

⁶⁹ Ibid., 202.

⁷⁰ Barondess, 1657-1659.

and members of society. In remembering this overriding duty, physicians described how Auschwitz killing was a “difficult but necessary form of personal ordeal.”⁷¹

Other historians provide alternative contexts for physician behaviors. For example, they note physicians may have been “scarred” during WWI by their wartime exposure to disease and death, and this might have increased their receptivity to Nazi ideology.⁷² This is a separate and distinct provocation from the humility associated with Germany’s WWI loss and the economic consequences of the hated Treaty of Versailles.⁷³ Further rationalizations were based on the patriotic establishment of a surrogate enemy. “If a soldier can convince himself that the enemy is the embodiment of evil, he can then maintain the perspective that murder is in the service of an altruistic and worthy cause.” This “killing self” is created on behalf of a transcendent cause.⁷⁴

Grodin and Annas describe the psychological technique of “splitting,” an ability to harbor and wall off conflict associated with contradictory attitudes, beliefs and behaviors which are maintained by a process of denial.⁷⁵ Splitting is a psychological method (typically subconscious) where one avoids internal conflict, especially moral conflict, about the consequences of one’s behavior. Lifton also described this process and labeled it as “doubling” where one can divide oneself into two functioning wholes, where one person can both fully proclaim the Hippocratic Oath while, at the same time, paradoxically and concurrently perform mass murder.⁷⁶ Lifton suggests that this coping process typically occurs in times of moral disruption. Utilizing this coping mechanism allowed physicians to rationalize killing people as part of their role as medical professionals while still allowing the individual to maintain a “normal” life with one’s family within society. Tiefenbrun offers Dr. Eduard Wirths, the Chief Medical Officer at Auschwitz, as an example. Although Wirths was described as a respected physician and scientist, he also served as an organizer of the “physician-generated death camp selection process.”⁷⁷

Gabbard, an academic psychologist, describes the utility and benefits of doubling and how it enables one to “tap into the *evil which is inherent in all of*

⁷¹ Lifton, 435.

⁷² Haque et al., 477.

⁷³ Rees, 12.

⁷⁴ Lifton, 431.

⁷⁵ Grodin and Annas, 640.

⁷⁶ Lifton, 430-465.

⁷⁷ Jonathan Tiefenbrun, “Doctors and War Crimes: Understanding Genocide,” *Hofstra Law & Policy Symposium* 3, no. 12 (1999): 125-136.

us while maintaining the myth that one is NOT EVIL.”⁷⁸ Because these disparate selves can and do remain unintegrated, existential conflict is diminished. So instead of experiencing a primary guilt response, physicians have an ability to adopt coping strategies which rationalize their behaviors as moral. Grodin and Annas further discuss where splitting, combined with numbing, further increases the ability of physicians to become indifferent.⁷⁹

The effects of self-deception, combined with Nazi ideology, and the intentional fragmentation of labor associated with medicalized-killing provided “sufficient detachment to minimize psychological discomfort and responsibility.”⁸⁰ Because one individual did not perform the entire spectrum of activities, the perpetrators could dismiss their perceived accountability and this allowed them to deny their proportionate guilt.⁸¹ Maintaining secrets from one’s family, colleagues and society about behaviors and experiences was another coping component which prevented a cogent analysis of causality, as did their secret participation in classified, bureaucratic decrees.

Some physicians maintained a singular form of self-deception by claiming they were providing “islands of humanity” within the camp, and as such they perceived they could “do a lot of good.”⁸² Others sustained the moral fabrication they were creating better medical facilities within the camps.⁸³ These rationales allowed one to maintain the fiction of a “good self or moral justification.” Hence, many physicians felt with absolute certainty and conviction, their behaviors were just.⁸⁴ In addition, physicians categorized their behaviors as scientific (i.e., applied biology) or as an enforcement of public health responsibilities (i.e., a form of quarantine).⁸⁵ Through eugenic cleansing, they would be able to create the “self-evident” advancement of the fittest “White European” race,⁸⁶ thus leading to an anticipated enhancement of society. Even after World War II, these physicians were able to return to a civilian life and reintegrate into their traditional careers through denial, silence, and exculpatory explanations.”⁸⁷ However, the evidence presented at

⁷⁸ Glen O. Gabbard, *The Psychology of “The Sopranos”* (New York: Basic Books, 2002), 39.

⁷⁹ Grodin and Annas, 641.

⁸⁰ Lifton, 213.

⁸¹ Grodin and Annas, 645.

⁸² Lifton, 203.

⁸³ Ibid., 201.

⁸⁴ Ibid., 205.

⁸⁵ Ibid., 202.

⁸⁶ Haque et al., 477.

⁸⁷ Barondess, 1660.

the Doctors' Trial served as a repository of evidence⁸⁸ of the medial malfeasance which occurred.

Although one could be partially protected from front line military duty through euthanasia work,⁸⁹ the foundational utilitarian justifications which permitted the earliest killings cannot be overlooked or overstated. Utilitarianism played a large role in the underpinnings of eugenic policy and practice. Karl Binding (a lawyer) and Alfred Hoche (a psychiatrist) published their radicalized eugenic ideas in the book *Allowing the Destruction of Life Unworthy of Living*. These ideas contradicted prior moral, legal and medical prohibitions against killing. The authors justified their positions by stating these individuals "had the ability neither to live nor to die, killing them would not infringe their will." Their "lives [are] unworthy of living [...] (f)or their relatives as well as for society, they are a terribly heavy burden."⁹⁰

Binding and Hoche felt that it was permissible to kill someone if other lives were saved and they thought there was a solid ethical basis to this analysis. Alfred Hoche was one of Brandt's early mentors⁹¹ and taught Brandt that euthanasia was a therapeutic goal. As such, by describing the destruction of life unworthy of life as "purely a healing treatment,"⁹² there were no discernible ethical repercussions. This moral indifference permitted the killing of children, the mentally ill and those defined as unfit. By this process, genocide became medicalized. The supreme sophistry of these arguments is how many skilled and talented individuals were murdered based on the religious ancestry.

When others were libeled and demonized as disgusting, dangerous, unclean or unethical, it became easier to morally justify the idea of extinguishing these targeted populations. Extermination of these defined groups was misrepresented as a public health necessity. Social order and social unity became more important than an individual's rights. And finally, this killing became re-defined as a form of healing, which would save the lives of those defined as more important.⁹³

Brandt expanded the application of the euthanasia arguments to justify research transgressions. Brandt stated he ordered experimentation of human beings based on a personal code of ethics that must give way to the total character of the war. Since the prisoners were theoretically condemned to death, their research deaths could save future, more worthy lives. Lifton

⁸⁸ Weindling, "Consent, Care and Commemoration," 33.

⁸⁹ Lifton, 59.

⁹⁰ Karl Binding and Alfred Hoche, in Schmidt, 35.

⁹¹ Schmidt, 33-34.

⁹² Lifton, 46.

⁹³ Schmidt, 474-475.

describes how Brandt inevitably came to see himself as a service to science and how it was his duty to save those things which could still be of possible scientific value.⁹⁴ Of interest, Brandt did volunteer to be a military research subject after his conviction even if it led to his (premature) death prior to his execution.⁹⁵

VII. Adaptive propensity to aberrant behaviors

Another perspective comes from the work of Grodin and Annas, who argue physicians may be psychologically pre-disposed to these aberrant behaviors. For example, to cope with the suffering of patients, ordinary physicians must develop psychological skills of dehumanization and numbing. These are separate skills from willing, opportunistic behaviors,⁹⁶ which result in harm. In contrast, physicians typically conform to the majority consensus or dominant socialization, which is subtly different from servile obedience. They are trained in hierarchical organizations where authority and rank result in legitimate respect, and acquiescence is rewarded, forcing the minimization of dissent. Professional coping skills must include the ability to compartmentalize and rationalize any actions which induce suffering.⁹⁷ These adaptive behaviors may further explain physician's participation in the collective violence against the vulnerable.

VIII. Creation of a torturer

A different perspective described by Michael Grodin and George Annas⁹⁸ chronicles the process of creating a torturer. Through their salient work in health law, Holocaust history, bioethics and human rights, these scholars illuminate a contemporary understanding of these anomalous behaviors.

Grodin and Annas raise important questions: "Why are physicians vulnerable to becoming perpetrators? Why would they forsake their moral standing?" Their illuminating work describes how medical training forces the process of compartmentalization and separately reinforces a personal sense of omnipotence.⁹⁹ Physicians are not supposed to become too emotionally attached to individuals. Otherwise, they would be unable to perform painful activities (e.g., surgery) on their patients. This training reveals the necessity

⁹⁴ Lifton, 106.

⁹⁵ Schmidt, 386.

⁹⁶ Grodin, Miller and Kelly, 57.

⁹⁷ Ibid., 57.

⁹⁸ Grodin and Annas, 645-655.

⁹⁹ Ibid., 641.

of causing pain in the process of healing. To effectively function, physicians must develop the skills of medical detachment to perform medically indicated, “scientific” violence (e.g., surgical interventions, amputations). They are forced to repress an awareness of violence and suffering especially when this torment is initiated through their own actions. This ability is a required adaptive splitting response and allows one to process the inherent healing violence of medicine.

The initiation rites of medicine typically begin on the initial day of class as the anatomy scalpel is used for the first time. The face is intentionally hidden which dehumanizes the corpse. Even in later training, during surgery the face is generally concealed behind drapes. Medicine also has its own language to describe and differentiate between different groups of individuals. Modern day ethical risks re-occur when physicians demean and redefine patients from a strictly paternalistic perspective and use science and military socialization to justify amoral actions. Grodin and Annas also describe potential motivations of voyeurism and sadism which would not otherwise be permitted in non-medical circumstances.¹⁰⁰

IX. Relevance of Holocaust History

Dr. Sherwin Nuland, a teacher of medicine and bioethics, describes his perspective when he attended the *Deadly Medicine: Creating the Master Race* Exhibition in 2004.

To my startled dismay, I found myself understanding why so much of the German medical establishment acted as it did. I realized that, given the circumstances, I might have done the same [...] what we learn from history comes far less in studying the events than in the recognition of human motivation – and the eternal nature of human frailty.¹⁰¹

There are moral lessons which we can learn from the Holocaust and Third Reich history. First, these behaviors were not limited to a few, aberrant individuals. The genocidal behaviors were ubiquitous because society failed to recognize all individuals have an intrinsic worth. The human rights of a patient became supplanted by the ambitions of physicians, scientists and

¹⁰⁰ Ibid., 647.

¹⁰¹ “Deadly Medicine: Physician and Scientist Profiles - Sherwin B. Nuland,” United States Holocaust Memorial Museum, accessed August 20, 2019, <https://www.ushmm.org/exhibition/deadly-medicine/profiles/>.

society allowing individuals to become expendable. Because political and social systems may act with expediency, we now know vulnerable groups require conscientious and sustained legal, medical and ethical protections from fabricated and corrupted ideologies.

However, we would be incorrect to conclude only a small cadre of Nazi physicians were capable of medical and research misconduct. During the 1960s with the publication of Henry K. Beecher's famous article, US scientists were reminded that they were not pristine nor immune from research misconduct. Beecher's article describes research misconduct in several major American institutions which occurred in the absence of infrastructure oversight and further illustrates the temptations and conflicts of interest which occur, even in times of peace.¹⁰² This relatively contemporaneous misconduct occurred even after the formulation of the Nuremberg Code and attests to the comparative impossibility of sustained moral self-regulation. External review and regulatory oversight remain a necessity.

X. Conclusion

In closing, how many of us would have the insight and fortitude to be a dissident or conscientious objector? How can we avoid becoming a bystander or perpetrator? Although many people categorize the Nazi regime as psychologically deviant, we risk repeating these behaviors if we do not recognize our own capacity for moral transgressions.

If, as psychiatry reminds us, we all have the capacity for self-deception in our behaviors and coping strategies, the first steps toward moral and integrated professionalism require a contemplative and psychological self-analysis of how we respond when we see amoral behavior or medical mistakes or ethical transgressions. Is our dissent visible or invisible? Are we advocates or bystanders? As Lifton describes, the language of duty provided a simplistic mechanism for absolving perpetrators of personal responsibility. They were able to perceive their participation in murder as a higher calling (i.e., to the inherent nationalistic concept of the *Volk*). Although they used euphemisms, physicians actually knew they were killing their patients, even when they "thought" there was a good reason for it. However, Barondess reminds us that a profound necessity of the medical profession training mandates a foundational system based in ethics and engagement.

¹⁰² Henry K. Beecher, "Ethics and Clinical Research," *The New England Journal of Medicine* 274 (1966): 1354-1360.

A practice based on Wiesel's concept of conscience inquiry¹⁰³ allows us to explore how one limits the dehumanization required for psychological compartmentalization without creating barbed wire tethers around our souls. Are there mindful mechanisms for physicians to integrate authentic moral behaviors and altruism into their daily activities? The psychologist Erwin Staub describes the following process:

Goodness, like evil, often begins in small steps. Heroes evolve; they aren't born. Very often the rescuers made only a small commitment at the start – to hide someone for a day or two. But once they had taken that step, they began to see themselves differently, as someone who helps. What starts as mere willingness becomes intense involvement.¹⁰⁴

From Staub's statement, there are additional clues for how to expand one's ego independence and moral reasoning. An initial step is the recognition that one's character and behaviors can change. This may require a courageous resilience to embrace an outsider status.

Ego independence is a mechanism to recognize slander and discern the difference between truth, propaganda and mythology. A correct analysis of the inherent socialization of language can become a technique for acquired tolerance to diversity and cultural differences. Understanding these concepts will help physicians skillfully identify and condemn disparate acts of evil. These socialized group identities do not need to become a self-fulfilling manifest destiny where we regard and rationalize the vulnerable as outside of our moral universe.

These precepts become especially important as we try and address the ethical problems which face contemporaneous medicine. What will be the societally-defined roles of genetic testing, confidentiality and online privacy as artificial intelligence becomes an essential technological tool? How will the misuse of these technologies be mitigated? Are there mechanisms to address the biological determinism of CRISPR, biological enhancement, genetically-modified pathogens, and emerging epidemics? What are the roles of medicine and an impartial judiciary in addressing the ongoing moral issues associated with human rights, immigration, torture, war and genocide? Who

¹⁰³ Elie Wiesel, "Without Conscience," in *Doctors from Hell: The Horrific Account of Nazi Experiments on Humans*, ed. Vivien Spitz (Boulder, Colorado: Sentient Publications: 2009), xvii.

¹⁰⁴ Erwin Staub, in Daniel Goleman, "Great Altruists: Science Ponders Soul of Goodness," *The New York Times*, March 5, 1985, <https://www.nytimes.com/1985/03/05/science/great-altruists-science-ponders-soul-of-goodness.html>.

will monitor any transgressions and who will have the authority for oversight? The psychological temptations for degradation and condemnation continue to affect all of us via social media; without exploring the implications of hate, racism and stereotyping within our joint histories, the moral errors of the past will re-occur. We avoid the redemptive echoes of history at our own risk.

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